STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Sisters of the Poor	330 Exchange Street South Saint Paul, MN 55102

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46885 Based on observation, interview, and document review, the facility failed to ensure oxygen was administered according to physicians orders for 1 of 2 residents (R11) reviewed for respiratory care. Findings include: R11's Optional State Assessment (OSA) dated 10/10/24, indicated moderate cognitive impairment, did not reject cares, did not have shortness of breath, and used oxygen. R11's medical diagnoses form indicated the following diagnosis: pulmonary fibrosis (scarring and thickening of the tissue and between the air sacs in the lungs). R11's physician's orders dated 6/26/24, indicated the following order: oxygen 1 to 6 liters per minute per nasal cannula or mask as needed for dyspnea (shortness of breath keep oxygen saturations greater than 91% and notify the physician). R11's medication administration record (MAR) and treatment administration record (TAR) dated November 2024, indicated R11 used oxygen on 11/1,24, 11/3/24, and 11/7/24. The MAR and TAR lacked information regarding R11's oxygen saturation levels. R11's MAR and TAR dated December 2024, and printed on 12/11/24, indicated R11 did not use oxygen. Additionally, the MAR and TAR lacked information regarding R11's oxygen saturation levels. R11's O2 Sats Summary form indicated R11's oxygen saturation levels on the following dates: 11/3/24, at 7:27 a.m., R11's oxygen saturation was 93% with oxygen via nasal cannula. 11/3/24, at 12:06 p.m., R11's oxygen saturation was 93% on room air. 11/4/24 at 9:59 a.m., R11's oxygen saturation was 85% on room air and at 11:00 a.m., was 95% with oxygen. 11/5/24 at 1:30 a.m., and 5:10 a.m., R11's oxygen saturation was 95% with oxygen and at 5:15 a.m., was 92% with oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/2/24 at 11:22 a.m., R11's oxygen saturation was 93% on room air. 12/9/24 at 8:13 p.m., R11's oxygen saturation was 99% on room air. The O2 Sats Summary form lacked information what R11's oxygen saturation levels were on other dates in November and December to know whether R11 required oxygen or not. R11's nursing progress notes were reviewed and R11 utilized oxygen on the following dates: 11/27/24, oxygen saturations were 82-83% on room air and was placed on 1.5 liters of oxygen. R11's Care Guide form undated, lacked information R11 utilized oxygen. R11's care plan was reviewed and lacked information R11 utilized oxygen. During interview and observation on 12/9/24 between 12:45 p.m., and 12:48 p.m., R11's oxygen was not turned on. R11 asked if oxygen was going to be applied because she stated she needed oxygen. R11's call light was activated and at 12:48 p.m., nursing assistant (NA)-A answered R11's call light and stated R11 used oxygen at night when going to bed, but did not need oxygen while up in the chair. During observation on 12/10/24 at 3:02 p.m., R11 was in bed and had oxygen on at 1.5 liters per minute. The MAR and TAR lacked information R11 utilized oxygen. During interview and observation on 12/11/24 at 6:56 a.m., and 6:57 a.m., R11 was in bed and the oxygen was off. NA-A stated at 6:57 a.m., R11 had the oxygen on, but NA-A turned it off. During interview on 12/11/24 between 7:01 a.m., and 7:04 a.m., licensed practical nurse (LPN)-A viewed R11's MAR and TAR and stated R11 did not have oxygen signed off as administered in the MAR and TAR. LPN-A stated R11 wore oxygen at night and the evening shift applied the oxygen. LPN-A stated R11 had oxygen on last night. Further, LPN-A stated she had inquired during report about acknowledging they were applying oxygen every night. During interview on 12/11/24 at 8:33 a.m., the director of nursing (DON) stated she expected staff take oxygen saturations as needed for dyspnea to keep oxygen saturations greater than 91%. A policy, Respiratory Care, dated 3/2024, indicated oxygen was administered under orders of the attending physician, except in the case of an emergency. Check the resident's oxygen saturations as ordered by the physician.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review the facility failed to comprehensively assess and implement individualized person centered dementia care for 1 of 2 residents (R2) reviewed for dementia care. Findings include: R2's Clinical Diagnosis form, indicated the following diagnoses: vascular dementia with agitation, age-related macular degeneration, legal blindness, other symptoms and signs involving cognitive functions and awareness, primary generalized osteoarthritis, unilateral primary osteoarthritis of the left knee, aphasia (a language disorder making it difficult to communicate), insomnia, cerebral infarction (stroke) due to embolism (blood clot), type two diabetes mellitus with polyneuropathy (a complication where peripheral nerves are damaged throughout the body), and other cerebrovascular disease (a condition that affects blood flow to the brain). R2's Annual Minimum Data Set (MDS) dated [DATE], indicated R2 had unclear speech, had short and long-term memory problems, severely impaired cognitive skills for daily decision making, did not have delirium, inattention, disorganized thinking, or altered level of consciousness, did not have hallucinations or delusions, did not have physical symptoms such as hitting, grabbing others, pushing, or scratching, verbal, or other behavioral symptoms and did not reject care. Further, the MDS indicated R2 had an impairment of range of motion to both upper extremities, utilized a wheelchair, was dependent on staff for transfers, oral hygiene, toileting hygiene, showering and bathing, dressing, and personal hygiene, and was always incontinent of bowel and bladder, was at risk for development of pressure ulcers, took antipsychotics, antidepressants and a gradual dose reduction was contraindicated. R2's Area Assessment (CAA) dated 9/19/24, indicated R2 had severe difficulty communicating due to expressive aphasia from a stroke and progressive dementia and staff needed to anticipate all needs. Weepiness, moving self in wheelchair in the hall, or repetitious non intelligible content, and grimaces was R2's way of reporting discomfort. Additionally, R2 had severely impaired cognition and took psychotropic medications for depression and anxiety. The CAA did not trigger for behavior symptoms, or pain. R2's Care Guide undated, indicated R2 transferred with a Hoyer lift, was assist of 2 staff, required the wheelchair at the bedside with the brakes locked, required toileting before and after meals, at bedtime and as needed, had a tub bath on Wednesday and Friday a.m. shift, if agitated staff were to reapproach when calm for activities of daily living and report to the nurse if resident exhibited exit seeking behaviors. Further, the guide indicated R2 had behaviors and staff were to reapproach when agitated and provide time for R2 to calm down. R2's care plan dated 11/15/24, indicated R2 did not always have to have glasses on as R2 may remove glasses in periods of heightened anxiety and agitation. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's care plan dated 9/18/24, indicated R2 had functional mobilities and unsteadiness with transfers, decreased range of motion in upper extremities and an intervention revised on 12/9/24, indicated R2 was non ambulatory. Other interventions indicated R2 required extensive assist of two staff for bed mobility, Hoyer transfers with two persons, wheelchair at bedside and locked at night, two assist for safety with bathing with getting in and out of the tub, baths completed on Tuesday and Friday morning shift, total assist of 2 with upper and lower body dressing, total assist of one to two in all areas of personal hygiene and oral care, and reapproach for any self care assistance if and when R2 declined. R2's careplan dated 11/13/24, indicated R2 had difficulty falling asleep and wandered and interventions included providing medications for sleep, offering one to one support, snacks, coke as needed, and when R2 was agitated staff were to ensure their safety and reapproach when calm for activities of daily living (ADLs). R2's care plan dated 9/16/24, indicated R2 required assistance to toileting before and after meals and before bed as R2 accepted. R2's care plan dated 10/16/24, indicated R2 had recurrent MASD (moisture associated skin damage) and interventions indicated to apply moisture barrier creams, assist to reposition every two hours to prevent skin breakdown, offer and assist with toileting and pericare every two hours while awake. R2's care plan dated 9/12/24, indicated R2 could not report pain and had restless legs associated with neuropathy, osteoarthritis, knee replacements, peritoneal adhesions, history of shingles, history of decreased range of motion to the right shoulder rotator cuff, hand and right knee pain, chronic gastrointestinal discomfort. R2's scheduled narcotic was discontinued on 8/5/24. Interventions included observing for pain and notifying the physician as needed for inadequate pain relief, observe for signs of pain such as facial expressions, rubbing at painful area, increased behavioral symptoms because she cannot express pain due to aphasia and cognitive loss and update the physician on neuropathy as needed. R2's behavior care plan dated 11/13/24, indicated R2 was at risk for elopement and was not easily redirectable. Interventions included to assess for falls risk, disguise exits, monitor for fatigue and weight loss, provide activities toileting, walking inside and outside, reorientation strategies, pictures and memory boxes. R2's psychotropic medication care plan dated 9/12/24, indicated R2 started Lexapro an antidepressant on 6/10/22, had Cymbalta discontinued on 6/22, trazodone was decreased on 3/15/24 for insomnia and restlessness, and Seroquel an antipsychotic was started on 9/29/23, and a dose reduction was contraindicated. Interventions included monitoring and documenting and reporting the physician as needed ongoing signs and symptoms of depression unaltered by antidepressant medications, sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, negative mood and comments, slowed movement, agitation, disrupted sleep, fatigue, and lethargy. R2's Physician Orders form indicated the following orders: 6/20/19, acetaminophen 500 mg tablet give 2 tablets by mouth three times a day for chronic pain. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/29/21, lidocaine patch 4% apply to lower back topically in the morning for lower back pain and remove per schedule. 7/21/21, staff may offer aromatherapy, hand massages, topical analgesic to hands, and one to one time with resident which may help her to cooperate with allowing treatments and activity of daily living (ADL) cares. Staff may reapproach when resident refuses cares every shift for cares and comfort. 6/11/22, escitalopram oxalate 10 mg tablet give 1 tablet by mouth one time a day for depression. 9/23/23, Reapproach resident if she refuses her medications and document all refusals every shift for anxiety and paranoia. 12/5/23, monitor for paranoia and agitation evidenced by behaviors of hitting, screaming, kicking, refusing medications every shift for order of Seroquel. 3/15/24, trazodone 50 mg at bedtime for insomnia. 3/28/24, Seroquel 25 mg (milligrams) give 25 mg by mouth one time a day for agitation and paranoia. Give Seroquel in the evening. 3/28/24, gabapentin 300 mg by mouth in the evening for neuropathy pain. 3/28/24, document all behaviors for resident hitting, kicking, scratching, resistive to cares, pushing nurses hands, and any other behavior resident exhibits every shift for cognition. 7/16/24, Voltaren external gel 1% apply to both knees topically two times a day for pain apply two grams. 11/18/24, Voltaren external gel 1% apply to back and both hips topically two times a day for fall. Apply 2 grams to back and bilateral hips twice daily. R2's 30 day behavior symptoms task form printed 12/11/24 at 12:34 p.m., indicated R2 had no documented behaviors in the past 30 days. R2's nursing progress note dated 11/23/24, at 2:03 p.m., indicated, ok to use Hoyer lift assist of 2-3 with one staff to engage resident in attempt to ease anxiety. If any signs of resistance/aggression/fighting-do not use Hoyer. every shift for Transfer protocol. Using EZ stand. R2's nursing progress notes from 11/1/24, to 12/11/24, were reviewed and indicated R2 displayed behaviors or agitation on 11/8/24, 11/12/24, 11/14/24, 11/28/24, 12/4/24, and 12/11/24. R2's physician progress note dated 8/5/24, indicated R2 could not communicate verbally and agitation was similar in the past months with increased confusion and R2's oxycodone (opioid pain medication) was recently decreased, and moved both hips, knees and ankles without any pain. R2 had dementia, and agitation and agitation was improved with a scheduled low dose oxycodone and Seroquel, further the note indicated to continue the low dose of oxycodone 2.5 mg three times a day. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's physician progress note dated 9/30/24, indicated R2's behavior was stable oxycodone dose was decreased, and to continue on Plavix and Seroquel. R2's physician progress note dated 11/11/24, indicated agitation was similar in the past months with increased confusion and R2's oxycodone was recently decreased, and moved both hips, knees, and ankles without any pain. Further R2 had agitation and plan to continue on Plavix and Seroquel as behavior was stable. During interview and observation between 12/9/24 at 1:18 p.m., to 1:26 p.m., R2 was heard yelling in her room. Nursing assistant (NA)-B stated she worked at the facility about 4 months and they planned to toilet R2. NA-A stated when R2 transferred from bed to chair, they used a Hoyer lift and they used a stand lift because it was too difficult to tuck in the Hoyer sling because R2 fights. Staff brought in the EZ stand lift and stated it was part of the plan of care because it was so difficult to apply the sling for the Hoyer and was their only choice because R2 was combative. NA-A stated she had worked at the facility for [AGE] years. At 1:26 p.m., R2 was vocalizing and staff stopped and took out the stand lift and stated they would come back and did not transfer R2. During interview and observation on 12/9/24 from 1:59 p.m., to 2:12 p.m., NA-A and NA-B brought the EZ way stand lift into R2's room. At 2:01 p.m., the sling was placed behind R2's back and R2 was hitting at staff when trying to put the sling under R2's arm. At 2:02 p.m., staff put R2's legs on the lift and R2 started making repetitive vocalizations, I, I, I, I, and was pushing the EZ lift away. R2's legs were strapped in the lift. At 2:03 p.m., staff attached the sling and instructed R2 to hold the handles and R2 grabbed the handles of the lift on the left and right side and resident kept stating I, I, I, I, and was transferred from the chair to the bed and R2's vocalizations slowed but continued yelling, I, I, I. R2 was positioned on the left side and vocalizations stopped. AT 2:06 p.m., staff started helping to change R2's pants and R2 began yelling out again and kicking her legs. Vocalizations stopped when staff completed the task. Staff engaged R2 with her stuffed animals and changed her brief at 2:07 p.m., and R2 was pushing away with the repetitive vocalizations. NA-A was trying to apply a new brief and R2 began hitting at NA-A. At 2:10 p.m., R2 was covered and the bed was lowered. R2 was not vocalizing and the wheelchair was placed by NA-A at the bedside but not locked. NA-B locked the brakes on the wheelchair at 2:11 p.m., and NA-A wiped down the EZ stand lift. At 2:12 p.m., R2 was quiet. NA-A stated registered nurse (RN)-A directed staff to use the EZ stand and further stated she spoke with RN-A about a month ago because the care plan indicated a Hoyer lift. NA-A stated RN-A observed them and further NA-A stated it was an every day struggle with R2 to toilet R2 because of her sling and added R2 holds the EZ stand and stands up and further stated they placed a chair by R2's bed because R2 tries to stand up and self transfer. During observation on 12/10/24 at 8:37 a.m., licensed practical nurse (LPN)-A introduced herself to R2 and offered her medication. R2 was softly stated, doe, doe, doe, doe. LPN-A gave the medication on a spoon to R2 and R2 put the medication into her mouth. During observation on 12/10/24 at 10:24 a.m., NA-A was pushing R2 in her wheelchair and R2 was making nonsensical vocalizations. During observation on 12/10/24 at 3:11 p.m., R2 was in bed and was not making any vocalizations. During observation on 12/11/24 at 7:21 a.m., R2's room was dark except the bathroom light was on and the curtain was pulled in R2's room. R2 was in bed and was not making any vocalizations. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 12/11/24 at 9:24 a.m., NA-A stated she knew what kind of cares a resident received based on the care guide and stated R2 was dependent for cares and was a Hoyer lift now and two assist for everything because it was difficult R2 was combative every day and at night, R2 sleeps, but in the mornings, R2 does not want to be bothered and makes noises. NA-A stated R2 becomes upset when she is touched or when she is undressed, becomes angry and kicks and stated R2 was like that every day and only with the activities of daily living and when in the chair was fine and further stated it has been going on a while and was especially difficult on Wednesdays and Saturdays because it was R2's bath days and added R2 was probably in pain and stated the nurse documented behaviors and the NA's also had to document. During interview on 12/11/24 at 9:19 a.m., NA-C stated they looked to the care plan to know what cares a resident required and stated R2 hits if she doesn't sleep well and stated she was very aggressive and that was why they were letting her sleep in, but did not know how often R2 had behaviors because she did not normally work on this floor. During interview on 12/11/24 at 9:09 a.m., registered nurse (RN)-A stated R2 was supposed to be transferred with a Hoyer lift and stated she was aware staff used the EZ stand and saw the transfer as safe. RN-A stated R2 did not like physical care and when talking with her R2 will calm down and most of the time got upset and did not like toileting, and bathing and added even though R2 beats us up, R2 was sweet. RN-A stated behaviors should always be documented and added the NA's document in the medical record and report to nurses and then the nurse can document the behavior in the medical record. RN-A stated it was important to document because R2 was on Seroquel and they needed to see what behaviors R2 had and the necessity of the drug. RN-A stated overall R2's behaviors still existed and was not sure why R2 was combative with cares but did have long standing insomnia and stated overall, R2's behavior was better. During interview on 12/11/24 at 10:33 a.m., the director of nursing (DON) stated behaviors should be documented right after they occur. Staff would finish their task first and then document when the situation was safe to do so. The DON further stated it was important to document behaviors to have the documentation to see if there were any patterns and they could look at the root cause to find what triggered the behaviors and come up with interventions that help the resident whether they are cold, hot, hungry, tired, or in pain. The DON viewed the NA task form and verified there were no behaviors documented in the 14 day look back period. The DON further stated she was aware they had a problem with behavior documentation. A policy, Behavior Management, dated August 2017, indicated all behavior was an attempt to communicate a need and some behaviors interfered with the giving of safe care. Staff will be constantly vigilant for behaviors of residents that communicate a need and staff will communicate these observations to the nurse, who in turn will see that needs are addressed in care planning. Medications and environmental interventions may be utilized in managing the need underlying the behaviors. Problem behaviors are behaviors that either occur frequently and disrupt care or occur infrequently, but pose a serious safety concern for the resident and or staff. Staff is to record each occurrence or a shift total of behaviors for residents. Care-giving staff is to communicate with the nurse about the occurrence of target behaviors. It is the responsibility of the nurse to document on the behavior tracking sheet and an entry is made each time a target behavior occurs and if there is no entry, it is assumed that the behavior did not occur on a particular shift.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on interview and document review, the facility failed to ensure consultant pharmacist recommendations were acted upon timely for 2 of 5 residents (R2, R29) reviewed for unnecessary medications. Findings include: R2's annual Minimum Data Set (MDS) dated [DATE], indicated R2 had a short-term and long-term memory problem, did not have physical, verbal, or other behavioral symptoms, did not reject cares, had diagnosis of non-traumatic brain dysfunction, hypertension (high blood pressure), diabetes mellitus, aphasia (a disorder that affects how you communicate), and non-Alzheimer's dementia. Further, R2 had applications of ointments and medications other than to feet, and R2 took an antipsychotic. R2's physician orders indicated the following orders: 7/29/21, nystatin powder apply to affected areas topically as needed for moist, abdominal, groin, breast folds that become red or odorous add routine for 7 to 10 days when rash recurs and continue as needed dose after treatment completed. 1/15/24, nystatin powder apply to abdomen fold topically two times a day for moist fold. R2's medication administration record (MAR) and treatment administration record (TAR) dated December 2024, indicated R2 was receiving nystatin powder twice daily in the morning and p.m. R2's pharmacy consultation report dated 10/17/24, indicated R2 received a topical antifungal, nystatin powder apply to abdomen fold topically two times a day for moist fold for greater than 8 weeks without a stop date. Of note, R2 also has an order for nystatin powder apply to affected areas topically as needed for moist, abdominal/groin/breast folds that become red or odorous add routine for 7 to 10 days when rash recurs and continue as needed (PRN) dose after treatment completed. The pharmacist consultant recommended re-evaluating the ongoing topical antifungal use because prolonged use may increase the risk of adverse consequences, including the development of drug resistant organisms. Under the heading, Physician's Response, was undocumented and there was no physician signature to indicate the medication was addressed with the physician. During interview on 12/11/24 at 9:00 a.m., the director of nursing (DON) stated the previous DON didn't follow up on previous recommendations from October. During interview on 12/11/24 at 12:09 p.m., the pharmacist consultant (PC) stated each month she includes a pending report indicating which reports are not followed up on and spoke with the director of nursing (DON) and realize there has been a delay in getting the recommendations done and further, state anything over 30 days or more were being worked on to get completed. R29's Optional State Assessment (OSA) dated 9/11/24, indicated R29 had depression and took an antidepressant. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R29's Medical Diagnosis form indicated R29 had major depressive disorder. R29's Physician's Orders form indicated the following order: 3/20/24, duloxetine oral capsule delayed release particles, give 60 milligrams (MG) by mouth in the evening related to major depressive disorder. R29's MAR and TAR dated December 2024, indicated R29 received duloxetine every 5:30 p.m. R29's pharmacy consultation report dated 9/18/24, indicated R29 received duloxetine 60 mg every p.m., for depression since admission 3/2024. Progress note dated 5/20/24, indicated depression was stable and Federal regulation required an evaluation for dose reduction because dose reductions should occur in modest increments over adequate periods of time to minimize withdrawal symptoms and to monitor symptom recurrence and recommended a gradual dose reduction (GDR) for duloxetine. Under the heading, Physician's Response, was undocumented and there was no physician signature to indicate the medication was addressed with the physician. During interview on 12/11/24 at 12:13 p.m., the PC stated she would have expected follow up on the recommendation within 60 days and stated she resent the recommendation on 12/10/24. During interview on 12/11/24 at 8:41 a.m., the DON stated pharmacy recommendations were not being followed up on prior to November and did not know why they were not completed and stated R29's GDR was not followed up on, but going forward have a new process. A policy, Medication Regimen Review, dated March 2017, indicated each resident would have a medication regimen review by a licensed pharmacist. Irregularities identified would be documented on a separate, written report and sent to the attending physician, medical director, and director of nursing, listing the resident name, relevant drug and irregularity the pharmacist identified.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on interview and record review the facility failed to ensure a topical antibiotic was transcribed as written and further failed to ensure the topical antibiotic was still necessary for 1 of 1 residents (R14) reviewed for antibiotic use. Findings include: R14's quarterly MDS dated [DATE], indicated R14 was cognitively intact and had diagnoses of diabetes and hidradenitis suppurativa (disease causing puss filled boils on the skin). Furthermore, R14 was on an antibiotic. R14's dermatology provider note dated [DATE], indicated R14 was seen for a skin check. The note indicated R14s hidradenitis was clear and ordered R14 to continue the clindamycin lotion (antibiotic) for 1 year. R14's active provider orders indicated on [DATE], R14 required clindamycin phosphate 1% lotion to be applied to the abdomen/groin topically for hidradenitis. R14's clindamycin order had no end date. R14's medication administration record (MAR) dated ,d+[DATE], indicated clindamycin 1% lotion as an active order. The MAR further indicated it was unknown if R14 was using the medication as she was able to self-administer and store medications unsupervised. A review of R14's nursing progress notes indicated: -on [DATE] at 11:02 p.m., R14's skin was warm and intact with no skin concerns. -on [DATE] at 4:26 p.m., R14 had no skin issues. -on [DATE] at 9:17 p.m., R14 had no skin issues. -on [DATE] at 10:28 p.m., R14 had no new skin issues. R14's care plan revised [DATE], lacked indication R14 was prescribed an antibiotic. When interviewed on [DATE] at 12:53 p.m., R14 stated they had tumor like things on their groin area and that was why they were taking the clindamycin lotion. R14 verified they were still taking it daily. R14 further stated staff had been unable to get a refill and so she was working with her dermatologist. R14's dermatologist has said they would give 2 more refills but would not do any more until seen again. R14 stated once starting the clindamycin they were able to feel the little pockets under her skin but stated everything else cleared up right away. R14 stated when she had trouble getting it refilled, she was using the lotion every other day or so so it would last. R14 stated during the time of taking it sparingly, her skin had no change. R14 stated the facility or provider had not talked about any risks of long-term antibiotic use. (continued on next page)

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	245524	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Sisters of the Poor	330 Exchange Street South Saint Paul, MN 55102

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on [DATE] at 2:22 p.m., registered nurse (RN)-B stated when residents on antibiotics required monitoring of symptoms and tracking to determine if they are improving. This was documented as a progress note. When a resident has a topical antibiotic, the nurse would then monitor the skin. RN-B was not aware R14 was on the clindamycin topical ointment but verified the order and noted there was no end date. RN-B was not aware of any skin altercations or infections for R14 and wasn't sure if the antibiotic lotion was needed. RN-B stated R14 used an outside provider and it was more difficult as R14 handled her own medications. When interviewed on [DATE] at 2:50 p.m., with the infection preventionist (IP) and the Director of Nursing (DON), the IP verified R14's antibiotic was not included in the facility's tracking for antibiotic. IP stated this was not currently tracked and would need to investigate it further. When interviewed on [DATE] at 12:18 p.m., the Director of Nursing (DON) verified R14's dermatology note indicated the clindamycin lotion was to be used for a year and the order should have expired in ,d+[DATE]. DON was not sure R14 still required the medication and stated a risk and benefit was needed if she wanted it continued. R14 managed her medications and communications with the dermatologist and the DON stated collaboration was sometimes challenging. Furthermore, DON verified the antibiotic list the IP had been pulling from the electronic medical record was only oral antibiotics and had not included topical. DON expected all antibiotics to be tracked for residents in the facility. A facility policy titled Antibiotic Stewardship Policy 2024, directed the provider to ensure a duration was included in an antibiotic order. Furthermore, the policy directed the nurse to monitor and evaluation the effectiveness of the antibiotic and the residents response to the antibiotic to identify if the antibiotic was still indicated.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 46885 Based on interview, and document review, the facility failed to ensure physician notification of an abnormal lab for 1 of 1 resident (R29) reviewed for diabetes. Findings include: R29's Optional State Assessment (OSA) dated 9/11/24, indicated intact cognition, had diabetes mellitus, and received insulin injections 7 of 7 days. R29's Admission Orders form dated 3/19/24, indicated a check box, Yes R29 could use Standing House Orders. Directly under the line, May use Standing House Orders, indicated a heading, Diabetes Mellitus Standing Orders If Applicable, with check boxes for Yes, No, or N/A. None of the check boxes were marked. A form, Standing Orders for Skilled Nursing Facilities revised 2023, indicated the following standing orders for diabetes management: Notify the provider if two BG (blood glucose) results are less than 70 or greater than 400 in a 24 hour timeframe and or change in condition; if no condition change, notify provider on the next business day. For a BG less than 70, if patient is symptomatic, administer 6 ounces of fruit juice, milk, other high carbohydrate beverage, or glucose tabs or gel orally and if after 2 attempts to treat and BG is still less than 70, notify provider. A form, Diabetes Mellitus Standing Orders form dated 1/2010, directed, treatment for residents able to swallow or with a feeding tube as follows: For hypoglycemia (Blood sugar less than 70) Give 15 grams of glutose or 8 ounces of fruit juice, have resident rest, check BG in 15 minutes and if still below 70, repeat these steps. On the third test if blood sugar is still below 70 and resident continues to be alert and able to swallow, check equipment, clean meter if possible, check for accuracy, and look at the date and appearance of blood sugar strips. If all of these tests appear correct, give resident 115 grams of Glutose. On the fourth test, if blood sugar is below 70, notify the nurse practitioner or physician. A form, Guidelines for Action, Notification and Documentation dated March 2013, indicated the following guidelines for blood glucose and signs and symptoms of hypoglycemia: Notify the physician if BG is still up or down after rechecking and or intervention for gradual increase or decrease notify physician with routine call. Under a heading, Comments, follow diabetes standing orders if appropriate. R29's physician's orders indicated the following orders: (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/20/24, blood glucose (BG) before meals related to diabetes mellitus at 7:30 a.m., 11:30 a.m., and 1730 a. m. 4/2/24, Insulin lispro 100 unit/milliliter (ML) inject 12 units subcutaneously in the morning before breakfast, 20 units subcutaneously before lunch, and 10 units with supper. 9/30/24, Lantus (a long acting insulin) 100 unit/milliliter (ML) inject 60 units subcutaneously at bedtime for diabetes. 12/10/24 at 4:15 a.m., Hypoglycemic (low blood glucose) (BG) less than 70. Administer 6 ounces fruit juice, milk, other high carbohydrate beverage, or glucose tabs, gel orally repeat BG after 15 minutes, if less than 70, notify the provider as needed for diabetic management and treatment. R29's medication administration record (MAR) and treatment administration record (TAR) dated December 2024, indicated R29 received Lispro insulin with supper, and received Lantus insulin at bedtime on 12/9/24. The MAR and TAR indicated on 12/10/24, at 7:30 a.m., R29's blood glucose (BG) was 78. R29's Blood Sugar Summary report indicated the following BG levels: 12/10/24 at 4:00 a.m., 52 milligrams (MG)/Deciliter (DL). 12/10/24 at 4:07 a.m., 75 mg/dl. 12/10/24 at 4:29 a.m., 114 mg/dl. 12/10/24 at 4:31 a.m., 129 mg/dl. 12/10/24 at 7:00 a.m., 69 mg/dl. 12/10/24 at 7:20 a.m., 62 mg/dl. 12/10/24 at 8:45 a.m., 149 mg/dl. 12/10/24 at 12:33 p.m., 129 mg/dl. R29's care plan dated 11/15/24, indicated R29 had diabetes and interventions included to monitor, document, and report to physician as needed signs and symptoms of hypoglycemia (low BG) such as sweating, and tremors, increased heart rate, pallor, nervousness, confusion, slurred speech. R29's nursing progress notes dated 12/10/24 at 4:17 a.m., indicated R29's Dexcom (a company that specializes in continuous glucose monitoring) alarm was sounding and R29's BG level was 52 mg/dl. R29 requested orange juice and a glucose tablet and R29's BG was rechecked with a glucometer that indicated BG was 75 mg/dl. R29 had symptoms of being SHAKEY. R29 drank orange juice, had 2 glucose tablets and at 4:25 a.m., the Dexcom reading was 114 and shakiness was better. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R29's license practical nurse (LPN)-A's nursing progress notes dated 12/10/24 at 7:17 a.m., indicated R29's BG at 7:00 a.m., was 69 and R29 requested a glucose tablet. At 7:25 a.m., R29's blood glucose was 62 and at 7:45 a.m., blood glucose was 78 and R29 reported feeling dizzy. The note further indicated R29 admitted she did not eat her snack the previous evening due to feeling too full. The note lacked information the physician was notified of the low BG. During interview on 12/11/24 at 7:32 a.m., licensed practical nurse (LPN)-A stated with labs you want to be timely on what you need to call the doctor for. LPN-A stated if you have to notify the physician, the notification is documented in the progress notes. LPN-A stated the guidance indicated it was the nurses discretion at notifying the physician and stated they used the standing orders and hypoglycemia was a BG less than 70. LPN-A further stated if after 2 attempts to treat and the BG was still less than 70 the physician should be notified and stated she did not notify the physician. LPN-A viewed R29's medical record and verified there was no documentation to indicate the physician was notified. During interview on 12/11/24 at 8:41 a.m., the director of nursing (DON) verified R29 could use standing house orders and stated staff should have notified the physician and it was important to notify the physician because it could indicate a change in condition, it could be a sign something is not correct such as not eating snacks and the physician could order changes in insulin, maybe the resident is not eating and the doctor may order further labs. During interview on 12/11/24 between 10:19 a.m., and 10:20 a.m., the DON stated their medical director clarified the blood glucose orders for R29 today to notify the physician of a blood glucose greater than 450 and less than 60. The DON further stated they were working on cleaning up the standing orders and the medical director wanted to look at everything.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on observation, interview, and record review the facility failed to ensure open refrigerated items were dated and covered. Furthermore, the facility failed to ensure expired items were removed from storage. This had the potential to impact all 32 residents residing in the facility. Findings include: An observation on [DATE] at 11:40 a.m., the main kitchen was reviewed. A walk-in refrigerator contained an open package of Hillshire Farm sliced turkey lunchmeat. The lunchmeat was wrapped in saran wrap and had no label or date. At 11:57 a.m., the walk-in dairy refrigerator was reviewed. The refrigerator contained 4 half gallons of [NAME] 2% milk. The best by date for all 4 containers was [DATE]. Dietary aide (DA)-A verified the expired milk and stated they should be thrown away. At 11:59 a.m., the DietaryDirector entered the refrigerator and verified the expired milk. Dietary Director stated they were aware the date was close and didn't realize it had been expired for that long. after reviewed the date verified that date was a while back. At 12:04 p.m., an upright freezer was reviewed in the main kitchen. In the freezer was a tray of vanilla ice cream served up in parfait cups. They were not covered or dated and appeared to be freezer burnt. When interviewed at 12:07 p.m., cook-A verified the sliced lunchmeat contained no date of when it was opened. Cook-A was not sure when it was opened and further stated a date should've been placed. Cook-A further verified the ice cream and stated they must have been served up over the weekend. Cook-A stated the ice cream should be covered and dated. Cook-A stated the dietary director or himself review for expired items and remove them as they were found. An observation on [DATE] at 11:25 a.m., the 3rd floor kitchenette was reviewed. The refrigerator contained an unopened container of Hormel thicken-it juice. The use by date was [DATE]. When interviewed on [DATE] at 11:30 a.m., DA-B verified the expired thicken-it juice. DA-B wasn't sure why it was still in the refrigerator and removed it. DA-B further stated dietary staff reviewed items to ensure none were expired weekly and the juice must have been missed. When interviewed on [DATE] at 7:45 a.m., the Dietary Director acknowledged there were some improvements needed for food storage and further stated with the census being lower, items were not getting used as frequently. Dietary Director expected staff to be reviewing refrigerators for expired items and removing them when found. Dietary Director further expected all opened food items to be covered, labeled, and dated. When interviewed on [DATE] at 10:46 a.m., the Administrator expected expired items to be discarded and all opened items should be covered and labeled. A facility policy titled Accepting Food Deliveries no date, directed staff to properly covered, labeled and dated and stored as approporiate.