

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245587	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/25/2024
NAME OF PROVIDER OR SUPPLIER  Ebenezer Integrated Care & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  45 West 10th Street 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48300</p> <p>Based on interview and document review, the facility failed to provide adequate supervision when staff allowed a family member to take a resident into the community where R4 subsequently fell and was hospitalized .</p> <p>R4's significant change Minimum Data Set (MDS) dated [DATE], indicated R4 had impaired cognition with diagnoses including dementia.</p> <p>R4's care plan dated 7/24/24, indicated was an elopement risk due to cognitive ability, and history of wandering during the night and when out in the community. R4 was also a fall risk due to confusion and deconditioning.</p> <p>R4's hospital discharge summary dated 4/26/24, included a note by the hospital social worker which indicated there was an open vulnerable adult protection case as of 4/21/24. R4 had been placed in an assisted living and family member (FM)-B removed R4 against medical advice. FM-B also had lost R4 in their apartment building. She was unable to locate R4 and external parties were involved in locating R4. The note further indicated there would likely be concerns from the long-term care facilities about FM-B removing R4 against medical advice. Additionally, the note indicated part of the hospital discharge plan was for the receiving facility to not allow FM-B to bring R4 out of the facility.</p> <p>R4's Electronic Health Record (EHR) included special instructions: resident is not to go on outings or leave of absence with family, and call security for assistance as needed.</p> <p>On 7/24/24, a progress note indicated FM-B asked the nurse if she could take R4 out of the building. The nurse said she could not, and directed FM-B to talk to the nurse manager. At 3:50 p.m. R4 was discovered missing, and FM-B was called. FM-B told staff they were at the train station, and R4 had fainted. Staff went to the train station then called 911. Emergency medical services (EMS) transported R4 to the hospital for possible stroke.</p> <p>On 7/25/24 at 2:44 p.m., registered nurse (RN)-B stated there was information placed in R4's EHR on admission to not let him go out with FM-B because there were some problems with FM-B not keeping track of him in the community.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/25/24 at 3:48 p.m., RN-C stated she had told FM-B she could not take R4 out of the building. RN-D told FM-B she could take R4 out of the building because she was his primary contact. Later, when R4 was discovered missing, RN-B told RN-C FM-B was not allowed to take R4 out of the building. RN-C stated she did not see the information in the EHR about R4 not going out of the building with family.</p> <p>On 7/25/24 at 4:57 p.m., nursing assistant (NA)-A stated FM-B had requested a four wheeled walker so she could take R4 into the community. She relayed the request to RN-C and RN-D. The nurses requested NA-A to find out FM-B's name so they could confirm FM-B was allowed to take R4 into the community. Upon confirming FM-B's name, RN-D stated it was ok for FM-B to take R4 into the community. NA-A opened the locked memory care door for FM-B because RN-D confirmed it was ok. NA-A had gone to the train station three blocks away after FM-B informed the facility R4 had fainted. NA-A checked for a pulse and breathing then called 911. NA-A stated R4 was stiff and would not wake up.</p> <p>On 7/25/24 at 5:34 p.m., the director of nursing (DON) stated at the beginning of R4's stay, staff were nervous because of what they had been told about FM-B from hospital staff. R4 had a WanderGuard (alarm) placed on admission to prevent FM-B from removing R4 from the unit, but R4 was not exit seeking and FM-B had not visited, so it was removed. R4 continued to remain on the locked memory care unit where a staff badge was required for exit. The DON confirmed staff should not have allowed FM-B to remove R4 from the unit. R4 had been admitted to the hospital on 7/24/24 for suspected seizure.</p> <p>A policy on allowing visitors to take residents out of the building was requested but not provided.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48300</p> <p>Based on interview and document review, the facility failed to ensure residents were free of significant medication errors for 2 of 3 residents (R2, R3) reviewed for medication errors.</p> <p>R2's admission Minimum Data Set (MDS) dated [DATE] indicated R2 had severely impaired cognition, with diagnoses including dementia and depression.</p> <p>R2's hospital discharge orders dated 6/14/24 included vortioxetine (an antidepressant medication) 5 milligrams (mg) daily for adjustment disorder with mixed anxiety and depressed mood.</p> <p>R2's Medication Administration Records (MAR) for June 2024 and July 2024 lack indication vortioxetine was administered. R2 missed 16 doses in June 2024 and 17 doses in July 2024.</p> <p>R2's Consultant Pharmacist (CP) note dated 7/17/24 indicated the hospital discharge order for vortioxetine could not be located in R2's electronic health record (EHR) Physician Orders list.</p> <p>A facility report to the State Agency (SA) on 7/18/24 indicated R2 had not received vortioxetine since admission on 6/14/24.</p> <p>R3's quarterly MDS dated [DATE] indicated R3 had moderately impaired cognition, with diagnoses including depression, anxiety, and psychosis.</p> <p>R3's provider Telephone Order (TO) dated 6/7/24 instructed Abilify 5 (antidepressant) mg PO (by mouth) daily and 2mg PO Q2H (every 2 hours) PRN (as needed) x 14 days for delusion, paranoia, and hallucinations.</p> <p>R3's handwritten TO dated 7/22/24 instructed Abilify oral tablet give 5mg by mouth daily for paranoia. There are no initials in the column that indicated the order was transcribed into Point Click Care electronic medication administration record (eMAR) or that the order was second checked.</p> <p>R3's June MAR indicated Abilify 5 mg by mouth one time a day for delusions, paranoia, hallucinations for 14 days. It was administered daily from 6/8/24 through 6/21/24. There were no administrations of Abilify from 6/22/24 through 6/30/24 (8 doses).</p> <p>R3's July MAR lacked instruction to administer Abilify from 7/1/24 through 7/25/24 (25 doses).</p> <p>On 6/19/24 R3's psychiatrist note indicated Abilify seemed to have helped with targeting hallucinations as staff reported there have been no notes or concerns regarding psychosis or concerns of bugs crawling all over her.</p> <p>On 6/26/24 R3's behavior note indicated R3 told the trained medication assistant there were bugs crawling all over her body.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/10/24 R3's nurse practitioner (NP)-A note indicated R3 reported seeing bugs on her body and bed. R3 was anxious about this and wanted medication adjustment as able. NP-A indicated Oxycodone would be restarted because that has been the first medication change which perhaps prompted the hallucinations of bugs. The medication list on NP-A's note did not list Abilify.</p> <p>On 7/22/24 R3's NP-A note indicated R3 reported worsening hallucinations of seeing bugs all over her body, into her hair and into her eyes. R3's left eye was visibly red suspected to scratching eye. Also, various scratch marks over face, chin and chest. R3 was moderately distressed given hallucination complaints. NP-A reached out to R3's psychiatrist with current medication orders. It was discovered R3's scheduled and PRN Abilify had been discontinued instead of just the PRN order. NP-A advised to monitor for worsening symptoms of hallucinations and delusions. NP-A ordered to restart Abilify 5mg daily per psychiatrist recommendations.</p> <p>On 7/25/24 at 10:52 a.m., family member (FM)-A stated R3 had hallucinations a while ago, but then they went away. The hallucinations were back again. R3 was feeling bugs crawl on her, so she was scratching at her skin. FM-A thought the hallucinations were disturbing to R3.</p> <p>On 7/24/24 at 3:22 p.m., licensed practical nurse (LPN)-A verified R3 did not have an active order for Abilify.</p> <p>On 7/25/24 at 12:02 p.m., registered nurse (RN)-A stated she transcribed the order for Abilify on 6/7/24. She thought both the scheduled and PRN dosing were for 14 days. She should have clarified with the provider. There was no procedure for nursing to follow up with a provider when a medication was ordered for a specific time frame. She would assume the provider would be reassessing automatically. The nurse would only follow up if the order specified to follow up with provider.</p> <p>On 7/25/24 at 4:42 p.m., psychiatrist (MD-A) stated R3 was prescribed Abilify for tactile hallucinations. She was contacted by NP-A regarding R3's increased hallucinations on 7/22/24. She reviewed R3's medication orders because she wanted to increase R3's Abilify dose. The Abilify was not on R3's current medication list. She communicated to NP-A to reorder Abilify. She confirmed she had not given an order to discontinue the Abilify, and the scheduled dose should not have been transcribed for 14 days. Missing doses of Abilify may have contributed to R3's increased hallucinations. She expected orders to start the day after she wrote the order to give the facility time to obtain the medication from the pharmacy. Abilify should have been administered starting 7/23/24.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/25/2024 at 5:34 p.m. director of nursing (DON) stated when a new admission arrived at the facility, provider orders were first entered by the health unit coordinator or by a nurse. All orders must be second checked by a nurse. All pages of a resident's discharge order summary should be checked for provider orders. R2's discharge order summary had been double checked, but the order for vortioxetine was on the top of the last page of orders and had been missed by both nurses. The missing order was discovered by the consulting pharmacist. A facility wide chart audit was not completed to assess if there were any other medications that had not been transcribed. R3's Abilify order should have been clarified by the provider before entering the 14-day time frame. R3's provider order dated 7/22/24 for Abilify was not transcribed according to facility policy. There should have been initials in the column that indicated the order was transcribed into Point Click Care electronic medication administration record (eMAR) or that the order was verified. Handwritten provider orders should be placed in appropriate bins for order to be entered, second checked then uploaded. It appeared the order was placed into the to be uploaded bin before the order was transcribed. Abilify had been ordered for R3 to treat hallucinations.</p> <p>The Transcription of Physician's Orders policy dated 8/23 directed to ensure accurate transcription of physician orders the order is documented by physician or nurse practitioner. The HUC or nurse transcribes the order into Point Click Care and signs off. The order is faxed to pharmacy. The order is double checked by a nurse and signed off as checked. HUC uploads any paper copies of orders into point Click Care.</p>		