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	01/28/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure all required discharge documentation was provided to the resident and receiving facility; and failed to ensure transfer and discharge notices were sent to the Office of the State Long-Term Care Ombudsman (OOLTC) for 1 of 1 resident (R37) reviewed for discharge.Findings include: R37's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition, independent with dressing, hygiene and mobility. There was no active discharge planning in place and medications included anticoagulants and anticonvulsants.R37's care plan dated 7/24/25, identified resident desires to transfer to assisted living when opening is available. Interventions included social services will assist in finding assisted living per doctor's orders. R37's Order Recap Report dated 1/01/25 through 1/31/26, lacked an order to discharge.R37's provider visits summaries dated 9/11/25 and 11/13/25, lacked information or orders related to discharge. R37's progress note dated 11/18/25 at 8:00 a.m., identified R37 discharged to an assisted living location in another state. Scheduled morning meds were administered prior to discharge. Resident was given all available medications; eye drops and ointments. Transfer discharge record, administration record, order summary, advanced directives, pertinent notes and labs sent. The progress note lacked inclusion of a recapitulation of R37's stay, a final summary of their status and reconciliation of all pre-discharge and post-discharge medication. R37's Transfer/Discharge Report dated 1/27/26, lacked inclusion of a recapitulation of R37's stay, a final summary of their status and reconciliation of all pre-discharge and post-discharge medication. R37's list of assessments from admission to discharge date d 7/25/24 through 11/18/25, lacked evidence a recapitulation of R37's stay, a final summary of their status and reconciliation of all pre-discharge and post-discharge medication was completed and lacked notation if the OOLTC was updated on the discharge.During an interview on 1/27/26 at 9:03 a.m., registered nurse (RN)-A stated for a resident discharge an order was needed, and a discharge summary assessment would need to be completed in the facility's electronic medical record. During an interview on 1/27/26 at 10:10 a.m., licensed practical nurse (LPN)-A stated for a resident to discharge there needed to be a doctor order and a discharge summary assessment would need to be completed in the facility's electronic medical record.On 1/27/26 at 10:37 a.m., a phone interview was attempted with family member (FM)-A, however a return call was not received.During an interview on 1/27/26 at 1:16 p.m., the director of nursing (DON) stated they could not find R37's discharge summary which included a recapitulation of R37's stay, a final summary of their status and reconciliation of all pre-discharge and post-discharge medication. The DON stated their discharge process needed some work to ensure the regulations were met.On 01/28/26 at 9:40 a.m., a phone interview was attempted with R37, and no return call was received. During an interview on 1/28/26 at 11:57 a.m., the administrator stated he was not sure who was updating the OOLTC on transfers and discharges, and he found a binder in the social services office which indicated the last transmittal to OOLTC was in 2023. The administrator stated it looked like there was a process, however the process was not maintained.During an interview on 1/28/26 at 12:22 p.m., the DON stated there was not a policy or procedure developed yet for the transfer and discharge process.In an email correspondence dated 1/28/26 at 5:04 p.m., the OOLTC identified their last transfer and discharge notice received from the facility was on 12/18/24.The facility's Admission, Discharge and Transfer (ADT) Report dated 1/1/25 through 1/28/26, identified there were five residents who were discharged , and 12 residents transferred out to the hospital.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene care (i.e., nail care) was provided for 1 of 1 resident (R19) reviewed for activities of daily living (ADLs), and who was dependent on staff for her care.Findings include:R19's quarterly Minimum Data Set (MDS) dated [DATE] indicated R19 had moderate cognitive impairment, had no behaviors, and did not refuse personal cares. R19's MDS indicated she was independent with hygiene, bathing, transfers and used a rolling walker for mobility.R19's medical diagnosis report dated 1/28/26, indicated diagnoses of congestive heart disease, cerebral infarction (stroke) without residual deficits, dementia, back pain, and hypertension.R19's care plan dated 1/28/26, indicated R19 was independent with dressing and needed limited assistance of one staff member with personal and toileting hygiene. This care plan directed one staff member to assist R19 with dressing and applying shoes. R19's Kardex indicated she received showers on Monday mornings. R19's electronic medical record (EMR) indicated a skin assessment was completed on 10/20/25, and a comprehensive skin assessment was done on 1/24/25. There was no progress note about R19's shower, skin assessment or nail care provided on 1/26/25. During observation on 1/26/26 at 3:45 p.m., R19 was sitting up watching television. R19 was not wearing shoes or socks. R19's toenails were yellowish and about 1 centimeter long from the end of the toe. During interview on 1/27/26 at 9:31 a.m., nursing assistant (NA)-A stated R19's medical record indicated she received a shower yesterday, Monday 1/26/26.During interview on 1/27/26 at 11:26 a.m., director of nursing (DON) stated a skin assessment needed to be done every week on shower days. DON reviewed R19's EMR and verified there was no documentation of a skin assessment and/or nail care being performed on Monday 1/26/26. DON stated the nursing assistants should cut resident's nails, unless the residents were diabetics. DON stated she expected staff to check the residents' skin and nails every week on shower days, and document in residents EMR. The concern about not assessing the residents' skin was the staff might not be able to catch a skin or nail issue before it became a problem.During observation and interview on 1/28/26 at 10:50 a.m., DON verified R19's toenails were long and said, they need to be trimmed.Requested a facility's nail care policy and procedure but it was not provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure narcotic and controlled substances destruction was completed in accordance with established policies and procedures to reduce the risk of diversion and/or theft for 1 of 1 resident (R7) reviewed for fentanyl patch removal. Findings include:R7's quarterly Minimum Data Set (MDS) date 1/14/26, indicated R7 was cognitively intact, required substantial/maximal assistance with most activities of daily living (ADLs) and mobility, and experienced almost constant pain. The MDS indicated R7 was taking opioids as scheduled pain medication regimen. R7's diagnoses included Parkinson's disease (neurological disease affecting movement), respiratory failure, and chronic pain.R7's care plan dated 5/27/25, indicated R7 required pain management due to chronic pain as a result of osteoarthritis, kyphosis (condition of humpback), scoliosis (abnormal curvature of the spine), and dorsalgia (pain anywhere in the back). R7's physician orders included:-Fentanyl Transdermal Patch 72 hour 12/mcg/hr.apply 1 patch transdermal every 72 hours for pain. Order date 4/12/25.-Documentation of removal and destruction of Fentanyl patch by two licensed staff nurses. Nurse #1 signature every 72 hours for destruction of used patch. Order date 1/5/25.-Documentation of removal and destruction of Fentanyl patch by two licensed staff nurses. Nurse #2 signature every 72 hours for destruction of used patch. Order date 1/5/25. R7's monthly pharmacy consultation report (MRR) dated 11/24/25, indicated, review of eMAR documentation for Fentanyl removal/destruction = 4 of 8 entries have same staff signature. The MRR indicated acknowledgment with a handwritten Noted to watch and signed on 12/1/25. R7's November 2025 medication administration record (MAR) indicated 4 of 10 entries had the same staff initials documented under removal and destruction of fentanyl patch nurse #1 and nurse #2 on the same dates. On 11/29/25, there was a nurse #1 entry with no corresponding nurse #2 entry. R7's December 2025 MAR indicated 6 of 10 entries had the same staff initials documented under removal and destruction of fentanyl patch nurse #1 and nurse #2 on the same dates. On 12/2/25, there was a nurse #1 entry with no corresponding nurse #2 entry. R7's January 2026 MAR indicated 7 of 10 entries had the same staff initials documented under removal and destruction of fentanyl patch nurse #1 and nurse #2 on the same dates. On 1/28/26, there was a nurse #1 entry with no corresponding nurse #2 entry.When interviewed on 1/28/26 at 10:46 a.m., registered nurse (RN)-B stated the process for fentanyl patch removal was for two nurses to witness the destruction of the patch after removal. The patch would be placed in a drug disposal container stored under the sink in the med room. Then each nurse would log in separately and sign off the removal and destruction of the patch in the resident's MAR. RN-B stated she removed R7's fentanyl patch this morning and the nurse from nights had witnessed the disposal, but must have forgotten to log in and sign it off in R7's chart. When interviewed on 1/28/26 at 11:13 a.m., director of nursing (DON) stated expectation that two staff witness destruction of the fentanyl patch after removal. They each have to log in and document under a nurse #1 and nurse #2 respectively to indicate the fentanyl patch was removed and destroyed appropriately. DON stated this process required two different staff nurses to complete. DON further stated this process should have been monitored more closely to ensure compliance. When interview on 1/28/26 at 12:14 p.m., consultant pharmacist (CP) stated expectation that there would be two different nurses witnessing and signing off the destruction of the fentanyl patches after removal. CP stated a breakdown in this process had been identified in the November 2025 MRR and should have been monitored by the facility. CP further stated this process was in place to reduce the likelihood of drug diversion or inappropriate use of the medications by staff. Facility policy Prescribing, Administration and Disposal of Fentanyl Transdermal Systems dated 9/15/24, indicated, Used fentanyl transdermal system should be folded so that the adhesive side of the patch adheres to itself.Place folded system in commercially available disposal kit and dispose per package directions. The policy further indicated, Two nurses or a nurse and another professional should witness the disposal of used and unused patches.