DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: D3RK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00913

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245295**

2.STATE VENDOR OR MEDICAID NO.
(L2) **493226900**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE EMERALDS AT ST PAUL LLC**
(L4) **420 MARSHALL AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55102**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2019**

6. DATE OF SURVEY **12/10/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **116** (L18)

13.Total Certified Beds **116** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	116			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Sarah Grebenc, Unit Supervisor — 12/30/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Melissa Poepping, Enforcement Specialist — 12/30/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/16/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 30, 2021

CMS Certification Number (CCN): 245295

Administrator
The Emeralds At St Paul Llc
420 Marshall Avenue
Saint Paul, MN 55102

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 30, 2021 the above facility is certified for:

116 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 116 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 30, 2021

Administrator
The Emeralds At St Paul LLC
420 Marshall Avenue
Saint Paul, MN 55102

RE: CCN: 245295
Cycle Start Date: November 16, 2021

Dear Administrator:

On December 8, 2021, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 30, 2021

Administrator
The Emeralds At St Paul LLC
420 Marshall Avenue
Saint Paul, MN 55102

RE: CCN: 245295
Cycle Start Date: October 21, 2021

Dear Administrator:

On November 15, 2021, we notified you a remedy was imposed. On December 10, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 30, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 15, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 15, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 15, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 30, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: D3RK

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(L4) **420 MARSHALL AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55102**

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3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2019**

6. DATE OF SURVEY **10/21/2021** (L34)

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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
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04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
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(L37)	(L38)	(L39)	(L42)	(L43)

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17. SURVEYOR SIGNATURE Date :
Sarah Grebenc, Unit Supervisor 12/06/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 12/10/2021 (L20)

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____ 2. Facility is not Eligible
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(L41)

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(L25)

25. LTC EXTENSION DATE:
(L27)

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(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

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03-Risk of Involuntary Termination
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30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Please note that the Health and Life Safety Code surveys have been processed in seperate enforcement cylces.

Electronically delivered
November 19, 2021

Administrator
The Emeralds At St Paul LLC
420 Marshall Avenue
Saint Paul, MN 55102

RE: CCN: 245295
Cycle Start Date: November 16, 2021

Dear Administrator:

On November 16, 2021, a survey was completed at your facility by the Minnesota Departments of Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 16, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 16, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING _____ B. WING _____	C 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT ST PAUL LLC	**420 MARSHALL AVENUE SAINT PAUL, MN 55102**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 10/18/21 to 10/21/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey by Healthcare Management Solutions, LLC on behalf of the Minnesota Department of Health (MDH). The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/18/21 to 10/21/21, a standard recertification survey was conducted at your facility by Healthcare Management Solutions, LLC on behalf of the Minnesota Department of Health (MDH). A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5295215C (MN66586) and H5295221C (MN58809), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H5295216C (MN65433), H5295217C (MN67453), H5295218C (MN61617), H5295219C(MN61134), H5295220C (MN58415), H5295222C (MN62297), H5295223C (MN54901), and H5295224C (MN54905).	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/22/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING _____ B. WING _____	C 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT ST PAUL LLC	**420 MARSHALL AVENUE SAINT PAUL, MN 55102**

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F 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		11/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING _____ B. WING _____	C 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT ST PAUL LLC	420 MARSHALL AVENUE SAINT PAUL, MN 55102

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F 550	Continued From page 2 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to treat a resident with dignity by leaving a urinary catheter bag uncovered for 2 of 3 residents (R5 and R51) sampled for urinary catheter. Findings include: 1. Observations on 10/18/21, at 4:00 p.m., 10/19/21, at 1:15 p.m., 10/20/21, at 7:45 a.m. and 10/20/21, at 10:50 a.m. revealed R5 lying in bed in her room with a urinary catheter bag that hung from the bed frame uncovered. Review of R5's undated Admission Record, identified diagnoses that included: chronic urinary retention (lack of ability to urinate and empty the bladder), hydronephrosis (condition in which one or both kidneys become swollen due to incomplete emptying of the urinary tract), urinary	F 550	Preparation and execution of this plan of correction should not be construed as an admission of the deficiency or that the deficiency was cited correctly. F550-= S/S -D The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Resident 51 currently has foley catheter bag that is covered. Resident 51 agreeable to plan of care. To ensure other residents have a dignified existence similar type covered bag will be offered. An audit was preformed on 11/19/2021 and no further concerns were yielded.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE EMERALDS AT ST PAUL LLC	420 MARSHALL AVENUE SAINT PAUL, MN 55102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 tract infection, and diabetes mellitus. The admission record also indicated R5 had an indwelling urinary catheter. During an interview on 10/20/21, at 2:20 p.m. unit manager (UM) 1 stated the catheter should always be contained in a dignity bag. During an interview on 10/20/21, at 2:45 p.m. with certified nursing assistant (CNA) 1, confirmed a catheter bag should always be contained in a dignity bag. During an interview on 10/20/21, at 3:30 p.m., with the director of rursing (DON), stated the expectation would be for the catheter bag to contained in a dignity bag. 2. Observations on 10/19/21, at 5:30 p.m., 10/19/21, at 7:05 p.m., and 10/20/21 at 7:44 p.m. revealed R51 lying in bed on his back with his urinary catheter bag that hung from the left side of his bed uncovered and exposed to the view of the hallway. Review of R51's Admission Record, indicated diagnoses that included neuromuscular dysfunction of the bladder, and persistent vegetative state. Review of R51's Order Summary Report, revealed an order dated 03/10/21, for a Foley catheter due to the diagnoses of neurogenic bladder (a condition in which problems with the nervous system affect the bladder and urination) and urinary retention (lack of ability to urinate and empty the bladder). During an interview on 10/21/21, at 9:18 a.m.,	F 550	Staff education initiated on 11/11/2021 to the facility practice for ensuring the use of covered bags by Administrator or designee Monitoring will be accomplished through visibility audit to ensure that catheter bags are covered and residents receive a dignified experience relating to the use of catheters. Visibility audits will be completed by center administration x1 daily for 5 days, weekly for 4 weeks, and monthly or as indicated by QA committee. Results will be reported to the facility QAPI committee for review and follow-up. Deficient practices will be corrected upon identification Allegation of compliance is 11/30/2021.	

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	245295	A. BUILDING _____ B. WING _____	C 10/21/2021

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F 550	Continued From page 4 certified nursing assistant (CNA) 4 revealed she was trained to keep the urinary catheter bag covered for infection control and dignity. During an interview on 10/21/21, at 9:33 a.m., licensed practical nurse (LPN) 2 stated the urinary catheter bag should be always covered for infection control and dignity purposes. During an interview on 10/21/21, at 9:50 a.m., the assistant director of nursing (ADON) stated R51's urinary catheter bag had a cover that was attached to the collection bag, and it should remain covered for dignity and privacy reasons. He stated the cover sometimes slid when care was provided, or the resident was repositioned. The ADON further stated the nursing staff was responsible for recovering the urinary catheter bag when it became exposed. Review of the facility's policy titled, Catheter Care, Urinary revised September 2014, indicated, Place drainage bag into a cover bag while in bed or w/c [wheelchair].	F 550		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or	F 623		11/30/21

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F 623	Continued From page 5	F 623		

discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email),

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F 623	Continued From page 6	F 623		

and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of

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F 623	Continued From page 7 the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the resident and the resident's representative, in writing, of a transfer to the hospital for 1 of 2 (R51) reviewed for hospitalization. Findings include: Review of R51's progress notes, revealed the resident was hospitalized from 09/27/21 - 10/5/21. Review of R51's Bed-Hold Notice for Hospital Transfer and Therapeutic Leave dated 09/26/21, revealed the form did not include the following required contents: the reason of the transfer; statement of the resident's appeal rights; and the name, address, and phone number of the Office of the State Long-Term Care Ombudsman. During an interview on 10/20/21, at 2:13 p.m., the Administrator stated the transfer notice was a part of the bed hold policy as one complete document, entitled, Bed-Hold Notice for Hospital Transfer and Therapeutic Leave. She stated it was the nurses' responsibility to give this document to the resident or resident's representative upon transfer from the facility. During an interview on 10/20/21, at 2:50 p.m., the Administrator stated R51 was given an outdated form and confirmed R51 did not receive the appropriate transfer notice with all required	F 623	Preparation and execution of this plan of correction should not be construed as an admission of the deficiency or that the deficiency was cited correctly. F623-= S/S -D Notice before transfer. Before a facility transfers or discharges a resident, the facility must— (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. Resident 51 has not transferred out of the facility since identification of improper form used. A facility wide audit was conducted on 11/10/2021 and all notices of transfer were compliant. To ensure that current residents received proper notification of transfer rights facility staff were inserviced beginning on 11/11/2021 Monitoring will be accomplished by daily audits of transfer forms for 1 week. 5	

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F 623	Continued From page 8 information. She also stated the facility did not have a specific transfer policy and used the document entitled, Bed-Hold Notice for Hospital Transfer and Therapeutic Leave as their transfer policy.	F 623	residents audits of transfer weekly for 2 weeks. Then 10 audits of resident transfers monthly for 2 months. Results will be reported to the facility QAPI committee for review and follow-up. Deficient practices will be corrected upon identification. Allegation of compliance 11/30/2021.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		11/30/21

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F 656	Continued From page 9 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan to include the use of an indwelling urinary catheter for 2 of 4 residents (R5 and R51) reviewed for urinary catheter and/or Urinary Tract Infections (UTI). Findings include: 1. Review of R5's undated Admission Record, indicated the facility admitted the resident on 11/06/20, with a re-admission on 07/12/21. According to the face sheet, R5 had diagnoses of cerebral infarction (stroke), diabetes and retention of urine. Review of the Progress Note, dated 07/9/21, at 11:28 p.m. revealed R5 was transferred to the hospital due to altered mental status and a confirmed urinary track infection (UTI). R5 did not have a urinary catheter at the time of transfer.	F 656	Preparation and execution of this plan of correction should not be construed as an admission of the deficiency or that the deficiency was cited correctly. F656 s/s - D Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Resident 5 and 51's care plans were revised to include the use of catheters on 10/21/2021. A full house audit was conducted for all facility residents and completed on 11/12/2021 to ensure that residents who	

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F 656	Continued From page 10 Review of the Progress Note revealed R5 was readmitted to the facility on 07/12/21, from the hospital with a catheter in place. Review of Care Plan with revision date of 07/1/2021, R5's comprehensive care plan did not address the use of an indwelling urinary catheter. During an interview on 10/20/21 at 2:20 p.m., unit manager (UM) 1 stated she was responsible for the development of comprehensive care plans for residents. She confirmed the care plan did not address R5's catheter. 2. Review of R51's Admission Record, revealed an admission date of 03/04/19, and included, but was not limited to, the following diagnosis: neuromuscular dysfunction of the bladder. Review of R51's quarterly Minimum Data Set (MDS) dated 09/08/21, revealed the presence of an indwelling urinary catheter. Review of R51's physician's order, revealed an order dated 03/10/21, for a foley catheter (type of indwelling urinary catheter) for neurogenic bladder (a condition in which problems with the nervous system affect the bladder and urination) and urinary retention (lack of ability to urinate and empty the bladder). Review of R51's comprehensive care plan with revision date of 7/18/21, revealed the care plan did not include a plan for the resident's foley catheter. During an interview on 10/21/21 at 9:50 a.m., the assistant director of nursing (ADON) stated R51 should have a care plan for the foley catheter and	F 656	have catheters in place have a supporting plan of care. Facility DON completed education on 11/11/2021 in regard to completion of comprehensive care plans and timing and revision. Facility staff in serviced on 11/11/2021. Audit of the comprehensive care plans will be completed within one week after the care plan due date per the MDS schedule by the DON or designee for 30 days to ensure that any residents with a catheter have such need identified in the plan of care. Results will be reported to the facility QAPI committee for review and follow-up. Deficient practices will be corrected upon identification. Allegation of compliance 11/30/2021.	

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F 656	Continued From page 11 confirmed the resident did not have a foley catheter care plan. The ADON further stated care for the foley catheter was listed on the Resident Care Sheets, which are used by the Certified Nursing Assistants. Upon review of the Resident Care Sheets with the survey team, the ADON confirmed care for the foley catheter was not listed for R51 During an interview on 10/21/21 at 10:16 a.m., the MDS Coordinator stated she noted the use of a foley catheter on R51's MDS but failed to develop a care plan for the foley catheter. Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered revised December 2016, indicated, The comprehensive person-centered care plan will ...incorporate identified problem areas.	F 656		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		11/30/21

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and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 13 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure infection control measures were maintained related to indwelling urinary catheter use for 1 of 4 (R5) reviewed for catheter use and related to respiratory treatments for 1 of 3 (R70) reviewed for respiratory care. Findings include: 1. Review of R5's undated Admission Record, with diagnoses including but not limited to, chronic urinary retention (lack of ability to urinate and empty the bladder), hydronephrosis (condition in which one or both kidneys become swollen due to incomplete emptying of the urinary tract), urinary tract infection, and diabetes mellitus. During an observation on 10/18/21, at 4:00 p.m. , R5 was lying in bed in her room with an indwelling catheter that hung from the bed frame and the bottom tip of the bag was noted to touch the floor. During an observation on 10/19/21, at 1:15 p.m., R5 rested in bed in her room with the head of the bed raised approximately 35 degrees. R5's indwelling catheter bag hung from the raised	F 880	DPOC F880 S/S=D Equipment/Environment " Licensed nurses were educated beginning on 11/18/2021 to proper catheter storage and placement and nebulizer storage. " The facility identified that a total of 8 residents can be impacted by this practice regarding catheter care. The facility identified that a total of 31 residents can be impacted by this practice regarding nebulizers. Polices/Procedures/System Changes " The Director of Nursing and Infection Preventionist reviewed the policy on catheter care and nebulizers. The policy/procedure will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Training/Education " Facility educated licensed nurses and CNA□s to catheter bag changing and cleaning beginning on 11/18/2021. " Catheter bag audits were initiated for residents on 11/18/2021. " Nebulizer audits were initiated for residents on 11/18/2021.	

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F 880	Continued From page 14 portion of the bed frame, causing it to be above the level of the bladder. The bottom/drainage spout of the urine collection bag rested directly on the rail of the over bed table. During an observation on 10/20/21, at 10:50 a.m., R5 was lying in bed in her room. R5's indwelling catheter bag hung from the bed frame with the bottom of the catheter bag that directly touched the floor. Cloudy yellow urine was present in the catheter bag. During an interview on 10/20/21 at 2:20 p.m., unit manager (UM) 1 stated no part of the catheter should touch the floor. UM1 stated for infection control purposes, and due to R5 having a history of urinary track infections (UTI)'s, the bag should not touch the floor and should always kept below the level of the bladder. During an interview on 10/20/21, at 2:45 p.m., certified nursing assistant (CNA) 1, stated a catheter bag should not touch the floor. During an interview on 10/20/21, at 3:30 p.m., the director of nursing (DON) stated she expected her staff to ensure the catheter bag did not come into contact with the floor. The facility's policy provided titled, Catheter Care, Urinary, revised September 2014, ...be sure the catheter tubing and drainage bag are kept off the floor ... and ...the urinary drainage bag must be held or positioned lower than the level of the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder ... 2. Review of R70's undated Admission Record,	F 880	Monitoring/Auditing " The infection preventionist or designee will audit catheter placement and protection for 7 days on all 3 shifts. The infection preventionist or designee will audit nebulizer protection and dating for 7 days on all 3 shifts. The audit results will determine decrease in frequency.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15	F 880		

revealed the resident had diagnoses which included but were not limited to chronic respiratory failure with hypoxia (inadequate supply of oxygen), congestive heart failure, and diabetes mellitus.

Observation on 10/18/21, at 2:15 p.m. revealed R70's nebulizer mist treatments (NMT) mask setup, with medication cup still attached and condensation present, hung over her side rail with the mask that directly touched the floor. The NMT set up was not protected from environmental factors and was not dated.

During an observation on 10/19/21, at 1:20 p.m., R70's NMT set up rested directly on her nightstand with medication cup still attached. The NMT was not protected from potential environmental contamination, was not dated, and condensation was present in the medication cup.

During an observation on 10/20/21, at 10:00 a.m., R70's undated NMT set up was draped over the backside of her nightstand with the medication cup still attached, and condensation present. The NMT set up was not protected from environmental factors.

The October 2021 medication administration record (MAR) lacked documentation that showed staff had changed R70's NMT set up and associated tubing during this timeframe.

During an interview on 10/20/21, at 2:20 p.m., UM1 stated her expectation was for staff to clean the NMT set up/mask after each treatment and keep them covered between uses. UM1 further explained, staff were to take it apart and rinse the medication cup and leave it to air dry after each

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	245295	A. BUILDING _____ B. WING _____	C 10/21/2021

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F 880	Continued From page 16 use. The staff should then ensure it is protected from potential environmental contamination. She also stated the NMT set up should not be " ...draped ..." over the nightstand or touching the floor. UM1 reported NMT set ups were to be dated and changed weekly. The facility's policy titled, Nebulizer Treatment, dated November 2019, identified ...instruct and remind the client to clean nebulizer after treatment is complete. This prevents bacteria growth ...	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/16/2021. At the time of this survey, The Emeralds at St. Paul was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/22/2021

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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Emeralds at St. Paul is a 4-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1968 and was determined to be of Type II(222) construction. In 1982, an addition was constructed to the East side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building.	K 000		

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K 000	Continued From page 2 The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 116 beds and had a census of 82 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		11/30/21

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K 324	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the kitchen hood suppression system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1 and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, sections 10.1.2, 10.2.3.1, 10.2.6, and 10.2.7.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 11/16/2021 at 10:00 AM, it was revealed by observation that the piping for the nozzles above the cooktop was loose and not in the correct location to protect the cooking appliances. An interview with the Facility Maintenance Director verified the finding at the time of discovery.	K 324	K324- Cooking Facilities Hood nozzles were tightened by Maintenance Director on 11/19/2021. Hood nozzles will be maintained by monthly preventative maintenance program. Facility will monitor compliance though monthly review of documentation in PM system and a weekly audit for 4 weeks to ensure ongoing compliance. Facility is alleging compliance on 11/30/2021	
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the	K 741		11/30/21

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K 741	Continued From page 4 international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain its safe smoking facilities per NFPA 101 (2012 edition), Life Safety Code section 19.7.4, 4.6.1.1, and 4.6.1.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 11/16/2021 at 10:15 AM, it was revealed by observation there were (10) plastic bags full of leaves inside the smoking area used to block the wind from coming into the shelter. The use of dead, flammable plant matter should not be present in smoking areas where fires are likely to occur. An interview with the Facility Maintenance Director verified this deficiency finding at the time	K 741	K741 Smoking Regulations Excess combustibles were removed from the smoking area on 11/16/2021. Smoking area is maintained through weekly preventive maintenance monitoring. Facility will monitor compliance though daily review for 5 days and weekly review of the smoking areas by Maintenance Director. Review of documentation in PM system and a weekly audit for 4 weeks to ensure ongoing compliance. Facility is alleging compliance on 11/30/2021	

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K 741	Continued From page 5 of discovery.	K 741		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to utilize listed medical-grade power-taps with medical equipment per Life Safety Code NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.2.3.6, and CMS S&C: 14-46-LSC dated September 26, 2014. This deficient finding could have an isolated impact on the residents within the facility.	K 920	K920- Power cords and extension cords. The bed was moved to the wall outlet on 11/19/2021. To ensure the proper use of power and extension cords the facility has monthly visual inspections through the preventive maintenance program.	11/30/21

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K 920	Continued From page 6 Findings include: On 11/16/2021 at 0945 AM, it was revealed by observation that the bed in room 319 was plugged into a power strip that was not listed as UL 1363A. An interview with the Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 920	Facility will monitor compliance though monthly review of documentation in PM system and a weekly audit for 4 weeks to ensure ongoing compliance throughout facility by Maintenance Director. Facility is alleging compliance on 11/30/2021	

Please note that the Health and Life Safety Code surveys are being processed in seperate enforcement cycles.

Electronically delivered
November 15, 2021

Administrator
The Emeralds At St Paul LLC
420 Marshall Avenue
Saint Paul, MN 55102

RE: CCN: 245295
Cycle Start Date: October 21, 2021

Dear Administrator:

On October 21, 2021, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 15, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 15, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 15, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 15, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Emeralds At St Paul Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 15, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 21, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions

are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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THE EMERALDS AT ST PAUL LLC	420 MARSHALL AVENUE SAINT PAUL, MN 55102

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/18/21 to 10/21/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000	*****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has	

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	00913	A. BUILDING: _____ B. WING _____	C 10/21/2021

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2 000	Continued From page 1 these orders, and identify the date when they will be completed. The following complaints were found to be SUBSTANTIATED: H5295215C (MN66586) and H5295221C (MN58809), however NO however no licensing orders were issued. The following complaints were found to be UNSUBSTANTIATED: H5295216C (MN65433), H5295217C (MN67453), H5295218C (MN61617), H5295219C(MN61134), H5295220C (MN58415), H5295222C (MN62297), H5295223C (MN54901), and H5295224C (MN54905).	2 000	been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.	
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The	2 555		11/30/21

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2 555	Continued From page 2	2 555		

comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to develop a comprehensive care plan to include the use of an indwelling urinary catheter for 2 of 4 residents (R5 and R51) reviewed for urinary catheter and/or Urinary Tract Infections (UTI).

Findings include:

1. Review of R5's undated Admission Record, indicated the facility admitted the resident on 11/06/20, with a re-admission on 07/12/21. According to the face sheet, R5 had diagnoses of cerebral infarction (stroke), diabetes and retention of urine.

Review of the Progress Note, dated 07/9/21, at 11:28 p.m. revealed R5 was transferred to the hospital due to altered mental status and a confirmed urinary track infection (UTI). R5 did not have a urinary catheter at the time of transfer.

Review of the Progress Note revealed R5 was readmitted to the facility on 07/12/21, from the hospital with a catheter in place.

Review of Care Plan with revision date of 07/1/2021, R5's comprehensive care plan did not

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2 555	Continued From page 3 address the use of an indwelling urinary catheter. During an interview on 10/20/21 at 2:20 p.m., unit manager (UM) 1 stated she was responsible for the development of comprehensive care plans for residents. She confirmed the care plan did not address R5's catheter. 2. Review of R51's Admission Record, revealed an admission date of 03/04/19, and included, but was not limited to, the following diagnosis: neuromuscular dysfunction of the bladder. Review of R51's quarterly Minimum Data Set (MDS) dated 09/08/21, revealed the presence of an indwelling urinary catheter. Review of R51's physician's order, revealed an order dated 03/10/21, for a foley catheter (type of indwelling urinary catheter) for neurogenic bladder (a condition in which problems with the nervous system affect the bladder and urination) and urinary retention (lack of ability to urinate and empty the bladder). Review of R51's comprehensive care plan with revision date of 7/18/21, revealed the care plan did not include a plan for the resident's foley catheter. During an interview on 10/21/21 at 9:50 a.m., the assistant director of nursing (ADON) stated R51 should have a care plan for the foley catheter and confirmed the resident did not have a foley catheter care plan. The ADON further stated care for the foley catheter was listed on the Resident Care Sheets, which are used by the Certified Nursing Assistants. Upon review of the Resident Care Sheets with the survey team, the ADON confirmed care for the foley catheter was not	2 555		

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2 555	Continued From page 4 listed for R51 During an interview on 10/21/21 at 10:16 a.m., the MDS Coordinator stated she noted the use of a foley catheter on R51's MDS but failed to develop a care plan for the foley catheter. Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered revised December 2016, indicated, The comprehensive person-centered care plan will ...incorporate identified problem areas. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to plan of care. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are comprehensively developed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	21385	No poc	11/30/21

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review, the facility failed to ensure infection control measures were maintained related to indwelling urinary catheter use for 1 of 4 (R5) reviewed for catheter use and related to respiratory treatments for 1 of 3 (R70) reviewed for respiratory care.

Findings include:

1. Review of R5's undated Admission Record, with diagnoses including but not limited to, chronic urinary retention (lack of ability to urinate and empty the bladder), hydronephrosis (condition in which one or both kidneys become swollen due to incomplete emptying of the urinary tract), urinary tract infection, and diabetes mellitus.

During an observation on 10/18/21, at 4:00 p.m. , R5 was lying in bed in her room with an indwelling catheter that hung from the bed frame and the bottom tip of the bag was noted to touch the floor.

During an observation on 10/19/21, at 1:15 p.m., R5 rested in bed in her room with the head of the bed raised approximately 35 degrees. R5's indwelling catheter bag hung from the raised portion of the bed frame, causing it to be above the level of the bladder. The bottom/drainage spout of the urine collection bag rested directly on the rail of the over bed table.

During an observation on 10/20/21, at 10:50 a.m., R5 was lying in bed in her room. R5's indwelling catheter bag hung from the bed frame with the bottom of the catheter bag that directly touched the floor. Cloudy yellow urine was present in the catheter bag.

During an interview on 10/20/21 at 2:20 p.m., unit

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manager (UM) 1 stated no part of the catheter should touch the floor. UM1 stated for infection control purposes, and due to R5 having a history of urinary track infections (UTI)'s, the bag should not touch the floor and should always kept below the level of the bladder.

During an interview on 10/20/21, at 2:45 p.m., certified nursing assistant (CNA) 1, stated a catheter bag should not touch the floor.

During an interview on 10/20/21, at 3:30 p.m., the director of nursing (DON) stated she expected her staff to ensure the catheter bag did not come into contact with the floor.

The facility's policy provided titled, Catheter Care, Urinary, revised September 2014, ...be sure the catheter tubing and drainage bag are kept off the floor ... and ...the urinary drainage bag must be held or positioned lower than the level of the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder ...

2. Review of R70's undated Admission Record, revealed the resident had diagnoses which included but were not limited to chronic respiratory failure with hypoxia (inadequate supply of oxygen), congestive heart failure, and diabetes mellitus.

Observation on 10/18/21, at 2:15 p.m. revealed R70's nebulizer mist treatments (NMT) mask setup, with medication cup still attached and condensation present, hung over her side rail with the mask that directly touched the floor. The NMT set up was not protected from environmental factors and was not dated.

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21385	Continued From page 7 During an observation on 10/19/21, at 1:20 p.m., R70's NMT set up rested directly on her nightstand with medication cup still attached. The NMT was not protected from potential environmental contamination, was not dated, and condensation was present in the medication cup. During an observation on 10/20/21, at 10:00 a.m., R70's undated NMT set up was draped over the backside of her nightstand with the medication cup still attached, and condensation present. The NMT set up was not protected from environmental factors. The October 2021 medication administration record (MAR) lacked documentation that showed staff had changed R70's NMT set up and associated tubing during this timeframe. During an interview on 10/20/21, at 2:20 p.m., UM1 stated her expectation was for staff to clean the NMT set up/mask after each treatment and keep them covered between uses. UM1 further explained, staff were to take it apart and rinse the medication cup and leave it to air dry after each use. The staff should then ensure it is protected from potential environmental contamination. She also stated the NMT set up should not be " ...draped ..." over the nightstand or touching the floor. UM1 reported NMT set ups were to be dated and changed weekly. The facility's policy titled, Nebulizer Treatment, dated November 2019, identified ...instruct and remind the client to clean nebulizer after treatment is complete. This prevents bacteria growth ... SUGGESTED METHOD OF CORRECTION: The	21385		

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21385	Continued From page 8 ICP or designee could review facility policies/procedures regarding appropriate infection control techniques. The ICP or designee could provide staff education regarding the policies and educate staff on appropriate IC techniques. The ICP or designee should complete timely audits to ensure policies are being followed to ensure on-going competence. The ICP, or designee should take education verifications and the audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: 21 (twenty-one) DAYS	21385		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to treat a resident with dignity by leaving a urinary catheter bag uncovered for 2 of 3 residents (R5 and R51) sampled for urinary catheter. Findings include: 1. Observations on 10/18/21, at 4:00 p.m., 10/19/21, at 1:15 p.m., 10/20/21, at 7:45 a.m. and	21805	no poc	11/30/21

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21805	Continued From page 9 10/20/21, at 10:50 a.m. revealed R5 lying in bed in her room with a urinary catheter bag that hung from the bed frame uncovered. Review of R5's undated Admission Record, identified diagnoses that included: chronic urinary retention (lack of ability to urinate and empty the bladder), hydronephrosis (condition in which one or both kidneys become swollen due to incomplete emptying of the urinary tract), urinary tract infection, and diabetes mellitus. The admission record also indicated R5 had an indwelling urinary catheter. During an interview on 10/20/21, at 2:20 p.m. unit manager (UM) 1 stated the catheter should always be contained in a dignity bag. During an interview on 10/20/21, at 2:45 p.m. with certified nursing assistant (CNA) 1, confirmed a catheter bag should always be contained in a dignity bag. During an interview on 10/20/21, at 3:30 p.m., with the director of reusing (DON), stated the expectation would be for the catheter bag to contained in a dignity bag. 2. Observations on 10/19/21, at 5:30 p.m., 10/19/21, at 7:05 p.m., and 10/20/21 at 7:44 p.m. revealed R51 lying in bed on his back with his urinary catheter bag that hung from the left side of his bed uncovered and exposed to the view of the hallway. Review of R51's Admission Record, indicated diagnoses that included neuromuscular dysfunction of the bladder, and persistent vegetative state.	21805		

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21805	Continued From page 10 Review of R51's Order Summary Report, revealed an order dated 03/10/21, for a Foley catheter due to the diagnoses of neurogenic bladder (a condition in which problems with the nervous system affect the bladder and urination) and urinary retention (lack of ability to urinate and empty the bladder). During an interview on 10/21/21, at 9:18 a.m., certified nursing assistant (CNA) 4 revealed she was trained to keep the urinary catheter bag covered for infection control and dignity. During an interview on 10/21/21, at 9:33 a.m., licensed practical nurse (LPN) 2 stated the urinary catheter bag should be always covered for infection control and dignity purposes. During an interview on 10/21/21, at 9:50 a.m., the assistant director of nursing (ADON) stated R51's urinary catheter bag had a cover that was attached to the collection bag, and it should remain covered for dignity and privacy reasons. He stated the cover sometimes slid when care was provided, or the resident was repositioned. The ADON further stated the nursing staff was responsible for recovering the urinary catheter bag when it became exposed. Review of the facility's policy titled, Catheter Care, Urinary revised September 2014, indicated, Place drainage bag into a cover bag while in bed or w/c [wheelchair]. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review/revise policies on dignity and educate all staff on those policies. The DON and/or designee could conduct audits of resident cares to ensure residents with catheters that dignity and privacy is	21805		

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21805	Continued From page 11 maintained. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21805		