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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EZXR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00571

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245067**

2.STATE VENDOR OR MEDICAID NO.
(L2) **470618800**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE EMERALDS AT FARIBAULT LLC**
(L4) **500 SOUTHEAST FIRST STREET**
(L5) **FARIBAULT, MN** (L6) **55021**

4. TYPE OF ACTION: **7** (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)

6. DATE OF SURVEY **06/04/2019** (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 **90** (L18)
13.Total Certified Beds **90** (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
	90			
(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 :
Susanne Reuss, Unit Supervisor 07/10/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 07/10/2019 (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
01/01/1967
(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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/28/2019
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 10, 2019

Administrator
The Emeralds At Faribault Llc
500 Southeast First Street
Faribault, MN 55021

RE: Project Number S5067031 and H5067019

Dear Administrator:

On June 4, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 7, 2019 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245067

July 10, 2019

Administrator
The Emeralds At Faribault Llc
500 Southeast First Street
Faribault, MN 55021

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 June 4, 2019 the above facility is certified for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 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,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EZXR

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Facility ID: 00571

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(L3) **THE EMERALDS AT FARIBAULT LLC**
(L4) **500 SOUTHEAST FIRST STREET**
(L5) **FARIBAULT, MN** (L6) **55021**

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)

6. DATE OF SURVEY **04/25/2019** (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
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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

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Compliance Based On:
___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
	90			
(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:
Thomas O'Brien, HFE NE II — 05/28/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 06/28/2019 (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)

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(L24)

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(L41)

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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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
May 14, 2019

Administrator
The Emeralds At Faribault Llc
500 Southeast First Street
Faribault, MN 55021

RE: Project Number S5067031, H5067019C, and H5067020C

Dear Administrator:

On April 25, 2019, a standard survey was completed at your facility by the Minnesota Departments of Health and 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the April 25, 2019 standard survey, the Minnesota Department of Health, completed an investigation of complaint number H5067019C and H5067020C that was found to be unsubstantiated.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is June 4, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (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 a 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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- Civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Eva Loch, Unit Supervisor
Metro D Survey Team
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: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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 July 25, 2019 (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 October 25, 2019 (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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT FARIBAULT LLC	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

(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 A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 4/22/19 through 4/25/19, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 4/22/29 through 4/25/19, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. In addition, complaint investigations were also completed at the time of the survey. The following complaints were found to be not substantiated: H5067019C and H5067020C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4)	F 585		6/4/19

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

Electronically Signed | 05/23/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT FARIBAULT LLC	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

(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 585	Continued From page 1 §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT FARIBAULT LLC	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

(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 585	Continued From page 2 to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance,	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 585	Continued From page 3 and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure grievances were documented, investigated and corrective actions taken for 3 of 3 (R68, R33, and R36) residents reviewed who had grievances. Findings include: When interviewed on 4/22/19, at 6:30 p.m. R68, along with family members (FM)-D and FM-E stated they have filed many official grievances with the facility and have not received any response. "If we talk to the administrator it gets us nowhere. We have written multiple grievances regarding licensed practical nurse (LPN)-C. We have not heard a response from anybody regarding any of them." FM-A brought in copies of the 10 grievances they had given to social services. Grievances were filled out on 4/15/19, 4/11/19, 4/6/19, 4/1/19, 3/15/19,1/20/19, 1/15/19, and 3 separate grievances for 10/1/18. The grievance dated 3/15/19 was followed up on by the facility. None of the others had any facility response. The majority of the grievances brought	F 585	Immediate Corrective Action: Residents #68, #33 and #36 were interviewed to assure any concerns were immediately addressed. Family members D and E were also interviewed to assure any concerns were immediately addressed. Corrective Action as it applies to others: The Grievance Policy remains current. Immediate re-education on the grievance process was provided to the DON, Social Services and Nurse Managers. Re-education on the Grievance Policy was held on 5/6/2019 for leadership and will be held on 5/30 for all other staff. Grievance review will be added to morning Quality Conference meeting ongoing to assure any concerns are documented on a Grievance Form and timely investigation and follow-up with the complainant occur. Date of Compliance: 6/4/2019 Recurrence will be prevented by: Audits of all grievances will occur weekly x 4 and monthly x 2 to assure the Grievance	

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	245067	A. BUILDING _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT FARIBAULT LLC	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

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F 585	Continued From page 4 in by the family had to do with LPN-C or other staff that cared for their mother. When interviewed on 4/22/19, at 1:58 p.m. R33 stated he had over heard LPN-C talk about another resident, "I gave him morphine maybe that will shut him up." R33 also stated, "I don't want this to keep happening to me or anyone else." R33 also had concerns that when he was not feeling well and his heart was racing, LPN-C came in and checked his pulse but never came back to recheck it. Another time, R33 indicated that his heart was racing [LPN-C] told him he had to wheel himself to her and come and get the medication or hope that the nursing assistant (NA) could come and get him to bring him to the medication cart. After taking the medications that night, he wheeled himself back to the room and she followed him down the hallway and was yelling, telling him that you don't have to be pissed at me. R33 further stated "I told her she is making it worse and to please leave me alone. I did report this to [LPN-D] and the social worker and I have attempted to email corporate regarding her behavior." R33 also said "I went to everyone that would listen and they just let it go. What happens to the people who don't have a voice?" R33 stated no one has followed up on his concerns. When interviewed on 4/23/19, at 3:50 p.m. R36 stated he had a concern with trained medication aide (TMA)-A, regarding putting him on the toilet the wrong way stating, "it hurts me." R36 also stated, "She won't take no for an answer, I have been asking her nicely and she won't listen. I have talked to social services [SS-A] about two to three weeks ago." R36 also voiced concerns	F 585	Policy is being followed. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator/Social Services/DON, or designee.	

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F 585	Continued From page 5	F 585		

about LPN-C and stated she went from, "bad to worse" and he had told SS-A and the director of nursing (DON). R36 stated no one had followed up on any of his concerns.

When interviewed on 4/23/19, at 4:20 p.m. the DON stated that if a resident expresses a verbal concern, they do not always want it written down as a grievance.

When interviewed on 4/23/19, at 4:37 p.m. registered nurse (RN)-A stated she had some grievances that had been turned in to her, but, "I think I left the grievances with the administrator before he left for vacation. I don't have any in my office."

When interviewed on 4/24/19, at 11:25 a.m. the DON stated he did not have other grievances and had looked on the administrators desk, and did not find any there either.

When interviewed on 4/24/19, at 1:28 p.m. the acting administrator stated, and the social worker were unsure if there were any outstanding grievances. They had found four from R68's family and was unable to locate any others. The administrator explained the process was to follow up within five days, and this had not happened for R68. There was no follow up for the verbal concerns of R33 and R36 either. The administrator stated re-education was provided to the social service department, unit managers and the DON.

The facility's Complaint and Grievance procedure, revised 2/2018, indicted any complaints, regardless of how they are received by the facility, will be investigated per the policy. A

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F 585	Continued From page 6 grievance form should be completed when the verbal complain had been voiced to each of the above individuals. This included when a grievance has been resolved right away to show documentation that it was addressed and resolved to the satisfaction of the person voicing the concern. The form should be completed and returned to the administrators office. The administrator or designee shall conduct investigation of the grievance to determine its validity. The administrator shall issue a verbal summary, unless a written summary is required to the complainant no later than five business days after the receipt of the grievance.	F 585		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure resident to resident abuse did not occur and to keep an unknown resident safe from R41's aggressive behaviors.	F 600	Immediate Corrective Action: SBAR review and seen by PCP with medication review completed on 4/29/19. Pending VAMC approval, Resident #41 to	6/4/19

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F 600	Continued From page 7 Findings include: R41's current face sheet included diagnoses of a stroke with right sided hemiplegia (inability to move that side of the body) and traumatic brain injury. R41's quarterly minimum data set (MDS), dated 3/21/19, indicated severe cognitive impairment and verbal behavioral symptoms directed towards others 1-3 days during the reference period. Review of progress notes indicated on 1/7/19, R41 "was in the tv (television) area swearing and yelling at other residents, calling them 'assholes and fuckers,' and struck another resident in the arm." During interview on 4/23/19, at 3:40 p.m. NA-B indicated R41 hits and screams even with the Ativan he gets before his baths and LPN-A stated "He is out of control." During interview on 4/23/19, at 3:48 p.m. NA-B and trained medication aide (TMA)-A indicated they bring up concerns about R41 behaviors but had not had any specialized training to care for him. They further indicated he has attempted to hit other residents for a year now, and the last six months has gotten worse. When they witness him hitting other residents, it is reported to the charge nurse or supervisor. During interview on 4/23/19, at 3:47 p.m. licensed practical nurse (LPN)-A indicated incidents of R41 striking out and hitting residents has been reported to her, the DON, and the administrator. During interview on 4/25/19 at 10:34 a.m., DON stated we first protect the residents and remove the threat, and then report it. His expectation was if a resident hits another resident it would be reported. When reviewing R41 progress note from 1/7/19, DON responded, "I didn't know about that incident and don't know who the other resident was." He further responded "I don't know	F 600	be seen by psychologist on: 5/29/19 for input on aggressive behavior management plan. An OHFC report was filed and investigation completed for the potential Incident of 1/7/2019. Corrective Action as it applies to others: The Abuse Prevention Plan remains current. Immediate re-education on the Abuse Prevention Plan was provided to the DON. Re-education on the Abuse Prevention Plan will be held on 5/30/19 for all staff. The aggressive behavior plan for Resident #41□s care plan was reviewed and remains current. NAR Care cards, and education provided to all nursing staff who provide care to Resident #41 on his individualized plan. Behaviors will continue to be a primary focus to the discussion at morning Quality Conference on an ongoing basis to assure any residents with behaviors which are not being adequately managed are reviewed and interventions are in effect. All incidents will be discussed at morning Quality Conference to assure the process per the Abuse Prevention Plan has been followed. Date of Compliance: 6/4/2019 Recurrence will be prevented by: Audits of all resident to resident incidents will occur weekly x 4 and then monthly x2 to assure the Abuse Prevention Plan has been followed to include protection, reporting, investigation and intervention. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits.	

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F 600	Continued From page 8 what interventions would have been put in place after that incident to protect the other residents." DON confirmed there is a concern with reporting concerns, grievances and incidents. Further, he stated "I am at a loss with R41, he can change on a dime and can require constant redirection." During interview on 4/25/19 at 11:16 a.m., LPN-D identified she would report resident to resident altercations to her supervisor or DON. She would typically fill out an incident report on paper, but was recently told by the DON if there is no injury then there is no need to complete it. LPN-D recalled an incident about two to three months ago of R41 hitting another resident where she started filling out an incident report and reported it to the DON; however, when she looked through the progress notes she could not find the incident report and was unable to recall the date of the incident. LPN-D further indicated there were no specific interventions in place for R41 other than re-directing him. During interview on 4/25/19 at 12:22 p.m., registered nurse (RN)-A indicated when she is informed of resident to resident physical altercation, it is brought to the DON and he makes the decision to notify the state agency. RN-A further indicated if she gets the report, she will call staff and investigate it. RN-A was aware R41 has stuck other residents before and he likes to get in other residents faces. She was unable to recall knowledge of the altercation with the resident that was moved to the dementia unit. During interview on 4/25/19 at 1:23 p.m., the acting administrator indicated a report had not been filed to the state agency related to the incident on 1/7/19. The administrator also verified that any resident to resident physical altercation needed to be reported right away. Furthermore indicated that the DON will be re-educated on	F 600	Corrections will be monitored by: Administrator/DON/ADON/Nurse Managers	

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F 600	Continued From page 9 what needs to be filed and the timeframe it should be filed. Review of the Abuse Prevention Policy, dated 12/2018 indicated this policy was to ensure that residents are not subjected to abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the individual, family member or legal guardian, friends or other individuals. The policy also identified that all staff are responsible for reporting any situation that is considered abuse or neglect. A completed incident report will to routed per facility procedure. The unit nurse will be notified immediately, assess the situation to determine if any emergency treatment or action is required. Staff will take necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated. If this is an injury of unknown origin, the nurse will also attempt to determine the cause of the injury. If it is resident to resident abuse, the abused resident will be removed to a safe environment and all other residents' safety will be ensured. Notification of the facility administrator immediately of any incidents of resident abuse, alleged or suspected abuse, injury or unknown origin, neglect, financial exploitation, or involuntary seclusion will occur immediately. Furthermore, it indicated that resident to resident altercation must be reported to the Minnesota Department of Health. Suspected abuse shall be reported to OHFC no later than 2 hours after forming suspicion of abuse.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 609		6/4/19

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F 609	Continued From page 10 must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report an incident of physical abuse to the administrator and state agency (SA) for 1 of 1 resident (R41) reviewed for resident to resident altercation. Findings include: R41's current face sheet included diagnoses of a stroke with right sided hemiplegia (inability to move that side of the body) and traumatic brain	F 609	Immediate Corrective Action: SBAR review and seen by PCP with medication review completed on week of 4/29/19. Pending VAMC approval, Resident #41 to be seen by psychologist on: 5/29/19 for input on aggressive behavior management plan. An OHFC report was filed and investigation completed for the potential Incident of 1/7/2019. Corrective Action as it applies to others: The Abuse Prevention Plan remains	

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F 609	Continued From page 11 injury. R41's progress note dated 1/7/19, indicated R41 "was in the tv (television) area swearing and yelling at other residents, calling them 'assholes and fuckers,' and struck another resident in the arm." During interview on 4/25/19 at 10:34 a.m., DON stated we first protect the residents and remove the threat, and then report it. His expectation was if a resident hits another resident it would be reported. When reviewing R41 progress note from 1/7/19, DON responded, "I didn't know about that incident and don't know who the other resident was." He further responded "I don't know what interventions would have been put in place after that incident to protect the other residents." DON confirmed that this incident was not reported to the state agency and also confirmed that there is a concern with reporting concerns, grievances and incidents. During interview on 4/25/19 at 11:16 a.m., LPN-D identified she would report resident to resident altercations to her supervisor or DON. She would typically fill out an incident report on paper, but was recently told by the DON if there is no injury then there is no need to complete it. LPN-D recalled an incident about two to three months ago of R41 hitting another resident where she started filling out an incident report and reported it to the DON; however, when she looked through the progress notes she could not find the incident report and was unable to recall the date of the incident. During interview on 4/25/19 at 1:23 p.m., the acting administrator indicated a report had not	F 609	current. Immediate re-education on the Abuse Prevention Plan was provided to the DON. Re-education on the Abuse Prevention Plan will be held on 5/30/19 for all staff. The aggressive behavior plan for Resident #41 care plan was reviewed and remains current. NAR Care cards, and education provided to all nursing staff who provide care to Resident #41 on his individualized plan. Behaviors will continue to be a primary focus to the discussion at morning Quality Conference on an ongoing basis to assure any residents with behaviors which are not being adequately managed are reviewed and interventions are effective. All incidents will be discussed at morning Quality Conference to assure the process per the Abuse Prevention Plan has been followed. Date of Compliance: 6/4/2019 Recurrence will be prevented by: Audits of all resident to resident incidents will occur weekly x 4 and then monthly x2 to assure the Abuse Prevention Plan has been followed to include protection, reporting, investigation and intervention. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator/DON/Nurse Managers	

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F 609	Continued From page 12	F 609		

been filed immediately to the state agency related to the incident on 1/7/19. The administrator also verified that any resident to resident physical altercation needed to be reported to the state agency right away. Furthermore, the administrator indicated that the DON will be re-educated on what needs to be filed and the timeframe it should be filed.

Review of the Abuse Prevention Policy, dated 12/2018 indicated this policy was to ensure that residents are not subjected to abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the individual, family member or legal guardian, friends or other individuals. The policy also identified that all staff are responsible for reporting any situation that is considered abuse or neglect. A completed incident report will to routed per facility procedure. The unit nurse will be notified immediately, assess the situation to determine if any emergency treatment or action is required. Staff will take necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated. If this is an injury of unknown origin, the nurse will also attempt to determine the cause of the injury. If it is resident to resident abuse, the abused resident will be removed to a safe environment and all other residents' safety will be ensured. Notification of the facility administrator immediately of any incidents of resident abuse, alleged or suspected abuse, injury or unknown origin, neglect, financial exploitation, or involuntary seclusion will occur immediately. Furthermore, it indicated that resident to resident altercation must be reported to the Minnesota Department of Health. Suspected abuse shall be reported to OHFC no later than 2 hours after

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F 609	Continued From page 13 forming suspicion of abuse.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to investigate an incident of resident to resident abuse and failed to implement interventions to protect the unknown resident from R41 reviewed for resident to resident abuse. Findings include: R41's current face sheet included diagnoses of a stroke with right sided hemiplegia (inability to move that side of the body) and traumatic brain injury. R41's quarterly minimum data set (MDS), dated	F 610	Immediate Corrective Action: SBAR review and seen by PCP with medication review completed on week of 4/29/19. Pending VAMC approval, Resident #41 to be seen by psychologist on: 5/29/19 for input on aggressive behavior management plan. An OHFC report was filed and investigation completed for the potential Incident of 1/7/2019. Corrective Action as it applies to others: The Abuse Prevention Plan remains current. Immediate re-education on the Abuse Prevention Plan was provided to the DON.	6/4/19

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F 610	Continued From page 14 3/21/19, indicated severe cognitive impairment and verbal behavioral symptoms directed towards others 1-3 days during the reference period. R41's progress note dated 1/7/19, indicated R41 "was in the tv (television) area swearing and yelling at other residents, calling them 'assholes and fuckers,' and struck another resident in the arm." During interview on 4/23/19, at 3:40 p.m. LPN-A stated "He is out of control." During interview on 4/25/19 at 10:34 a.m., DON stated we first protect the residents and remove the threat, and then report it. Expectation was if a resident hits another resident that would be reported. When reviewing R41 progress note from 1/7/19, DON responded, "I didn't know about that incident and don't know who the other resident was." DON further said "I don't know what interventions would have been put in place after that incident to protect the other residents." DON confirmed there was a concern with reporting concerns, grievances and incidents. Further, he stated "I am at a loss with R41, he can change on a dime and can require constant redirection." During interview on 4/25/19 at 12:22 p.m., registered nurse (RN)-A indicated when she was informed of resident to resident physical altercation, that was brought to the DON who makes the decision to notify the state agency. RN-A further indicated if she gets the report, she will call staff and investigate it. RN-A was aware R41 had stuck other residents before and he liked to get in other residents faces. RN-A was unable to recall the incident that took place on	F 610	Re-education on the Abuse Prevention Plan will be held on 5/30/19 for all staff. The aggressive behavior plan for Resident #41 care plan was reviewed and remains current. NAR Care cards, and education provided to all nursing staff who provide care to Resident #41 on his individualized plan. Behaviors will continue to be a primary focus to the discussion at morning Quality Conference on an ongoing basis to assure any residents with behaviors which are not being adequately managed are reviewed and interventions are effective. All incidents will be discussed at morning Quality Conference to assure the process per the Abuse Prevention Plan has been followed. Date of Compliance: 6/4/2019 Recurrence will be prevented by: Audits of all resident to resident incidents will occur weekly x 4 and then monthly x2 to assure the Abuse Prevention Plan has been followed to include protection, reporting, investigation and intervention. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator/DON/Nurse Managers	

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F 610	Continued From page 15	F 610		

1/7/19, and did not know of any interventions that were put in place to protect the other residents at the facility.

During interview on 4/25/19, at 1:23 p.m., the acting administrator indicated a report had not been filed to the state agency related to the incident on 1/7/19. The administrator also verified that any resident to resident physical altercation needed to be reported right away. Furthermore the administrator indicated that the DON will be re-educated on what needs to be filed and the timeframe it should be filed.

Review of the Abuse Prevention Policy, dated 12/2018 indicated this policy was to ensure that residents are not subjected to abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the individual, family member or legal guardian, friends or other individuals. The policy also identified that all staff are responsible for reporting any situation that is considered abuse or neglect. A completed incident report will to routed per facility procedure. The unit nurse will be notified immediately, assess the situation to determine if any emergency treatment or action is required. Staff will take necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated. If this is an injury of unknown origin, the nurse will also attempt to determine the cause of the injury. If it is resident to resident abuse, the abused resident will be removed to a safe environment and all other residents' safety will be ensured. Notification of the facility administrator immediately of any incidents of resident abuse, alleged or suspected abuse, injury or unknown origin, neglect, financial exploitation, or

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F 610	Continued From page 16 involuntary seclusion will occur immediately. Furthermore, it indicated that resident to resident altercation must be reported to the Minnesota Department of Health. Suspected abuse shall be reported to OHFC no later than 2 hours after forming suspicion of abuse.	F 610		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced	F 661		6/4/19

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F 661	Continued From page 17 by: Based on interview and document review, the facility failed to ensure recapitulation of stay was completed at discharge for 1 of 1 (R72) resident reviewed for closed record review. Findings include: R72's closed medical record indicated R72 was admitted to the facility with diagnoses of cerebral infraction, hemiplegia and hemiparesis. R72 discharged from the facility on 1/26/19, with her son. R72's medical record revealed there was no evidence of R72's recapitulation of stay. R72's progress notes dated 1/24/19, indicated a referral was sent to a home health agency to initiate home care for 1/26/19, when R72 was to discharge home with her son. The note dated 1/26/19, indicated R72 was discharged with her daughter going to her son's home with outpatient therapy. R72's discharge Minimum Data Set dated 1/26/19, indicated R72 had discharged from the facility return not anticipated. R72's Discharge/Transfer Summary completed 1/24/19, summarized R72's activities while at the facility, however the discharge summary, reason for discharge/transfer, mental and psychosocial status, vital signs at discharge, physical functioning status, assistive devices needed, treatments for discharge, dental condition, reconciliation of medications, dietary information and therapy after care were left blank. R72's Discharge Instructions dated as completed on 1/24/19, included leisure recommendations,	F 661	Immediate Corrective Action: Resident #72 Discharge Summary was completed. Corrective Action as it applies to others: The Discharge Summary Policy remains current. All residents who have been discharged within the last 30 days will be reviewed to assure all have a completed Discharge Summary which includes a thorough recapitulation of the stay. Re-education on the Discharge Summary Policy was completed with the ID Team. Date of Compliance: 6/4/2019 Recurrence will be prevented by: Audits of all discharged residents will occur weekly x 4 and then monthly x 2 to assure they have a complete and thorough Discharge Summary which includes the recapitulation of the stay. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/ADON/Nurse Managers	

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F 661	Continued From page 18 however medication review, treatments to be continued after discharge, diet instructions, community resources, follow-up appointments and who to contact with questions were left blank. During an interview on 4/25/19, at 10:50 a.m. registered nurse (RN)-C stated she was unable to locate R72's recapitulation of stay at discharge. RN-C stated it should have been completed upon discharge and a copy sent home with the resident. During an interview on 4/25/19, at 2:05 p.m. RN-B confirmed the Discharge/Transfer Summary and Discharge Instructions were not completed at the time of discharge. During an interview on 4/25/19, at 2:57 p.m. the director of nursing stated it was his expectation for a recapitulation of stay to be completed for residents upon discharge. The facility policy Discharge Planning Policy revised date 11/2016, indicated "Discharge information, including transfer form to appropriate home care agency or other nursing facility, must be prepared."	F 661		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		6/4/19

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F 684	Continued From page 19 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a tubi-grip arm sleeve was provided according to physician orders for 1 of 1 resident (R6) reviewed for quality of care services. Findings include: R6's Face Sheet dated 10/16/17, indicated R6 had diagnosis including lymphedema (swelling in an extremity). R6's physician orders dated 3/5/19, indicated R6 was to have tubi-grips to right arm and both lower legs. On in a.m. and off in p.m. every day and evening shift for edema. R6's care plan dated 4/24/19, did not include the application of tubi-grips. On 4/22/19, at 5:00 p.m. R6 was observed sitting in his wheelchair by the medication cart without a tubi-grip on his right arm which appeared to have edema. On 4/23/19, at 2:52 p.m. R6 was observed sitting in his wheelchair without a tubi-grip on his right arm which appeared to have edema. On 4/24/19, at 7:07 a.m. R6 was observed sitting in his wheelchair without a tubi-grip on his right arm which appeared to have edema. On 4/24/19, at 7:24 a.m. R6 stated he did not have tubi-grips on his right arm at this time and had not for a long time. R6 also confirmed he	F 684	Immediate Corrective Action: Resident #6 Tubi grips to right arm and both lower legs will be applied in the AM and removed in PM and any treatment refusals will be documented. MD will be notified of consistent refusals to determine if another treatment should be attempted. Corrective Action as it applies to others: The Policy for following MD orders to include any treatments ordered remains current. Resident #6 care plans/Kardex will be reviewed to assure treatments ordered are indicated. Re-education on providing treatments and documenting refusals will be held on 5/30 for all nursing staff. Date of Compliance: 6/4/2019 Recurrence will be prevented by: Audits of 5 resident treatments will occur weekly x 4 and then monthly x 2 to assure the treatment or refusal has been documented, and consistent refusals are reported to MD. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/ADON/Nurse Managers	

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F 684	Continued From page 20	F 684		

refused the tubi-grip at times but was not offered it for his right arm most days and did need it for his arm swelling.

On 4/24/19, at 9:43 a.m. trained medication aide (TMA)-A stated R6 often refuses things including the tubi-grips and she had not seen them on his arm for a long time. TMA-A also stated any refusals should be charted in the treatment administration record (TAR).

On 4/24/19, at 3:12 p.m. licensed practical nurse (LPN)-A stated there was an area on the TAR for the application of a tubi-grip to his lower extremities and his right arm and refusals should have been noted but had not been. Rebecca confirmed R6 did not have the Tubigrip on his right arm at this time and often did not.

On 4/24/19, at 8:45 a.m. nursing assistant (NA)-A stated R6 is pretty independent and had not ever seen a tubi-grip on his right arm and did not have one on at this time.

On 4/24/19, at 10:14 a.m. the director of nursing (DON) stated he was aware R6 should have had the tubi-grip on his right arm or had a documentation of his refusal in the TAR. The order is for tubi-grips on both lower extremities and his right arm and the orders should have been separated so we would know if he refused any of the three which would have allowed us to track him better. It also should have been on the care plan but was not at this time. The DON confirmed the TAR indicated the Tubi-grip was on his right arm on days when it was probably not.

A policy on edema and tubi-grips was requested but not provided.

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F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate assistance to prevent an accident 1 of 1 resident (R26) observed during a transfer using a device. Findings Include: R26's quarterly Minimum Data Set (MDS) dated 2/16/19 included diagnoses of hemiplegia/hemiparesis (paralysis or weakness on one side) and dementia without behavior disturbances. R26's Miss-Fall Risk Assessment Welcov HC, dated 12/5/18, indicated R26 was at risk for falls and directed two staff to assist with all Hoyer lift (mechanical lift used to lift and move a patient with a minimal amount of effort from an assistant or helper) transfers. R26's NA (nursing assistant) guide dated 4/23/19, directed staff to use assist of two staff with Hoyer lift for transfers. R26's current care plan, revised 2/22/19, indicated R26 required extensive assistance of one staff to complete transfers but failed to direct	F 689	Immediate Corrective Action: Nursing Assistant D was counseled on the failure to follow the Lift Policy and Procedure for transferring Resident #26 on 4/23/19 with a Hoyer lift without a trained second person to assist. 2 assistants needed for a Hoyer lift transfer was confirmed on Resident #26 care plan/Kardex. Corrective Action as it applies to others: The Lift Policy and Procedure remains current. All resident care plans/Kardex will be reviewed to assure any resident to be transferred with a Hoyer lift have 2 assistants indicated. Re-education on the Lift Policy and Procedure will be held on 5/30/19 for all nursing staff. Date of Compliance: 6/4/2019 Recurrence will be prevented by: Audits of 5 residents transferred with a Hoyer lift will occur weekly x 4 and then monthly x 2 to assure the proper assistance of 2 staff is provided. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the	6/4/19

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F 689	Continued From page 22 staff to use a Hoyer lift and two staff members to complete the task. On 4/23/19, at 11:22 a.m., nursing assistant (NA)-D was observed transporting R26 into her room. A student nurse (SN-A) also entered R26's room. NA-D began to connect the sling to the Hoyer lift. SN-A turned to NA-D and stated, "I cannot assist with Hoyer Lift transfers, I have not been trained." NA-D nodded and continued with the Hoyer lift transfer without assistance from SN-A. After R26's transfer and cares were complete, NA-D stated R26 stayed in bed until the, "evening shift gets her up." NA-D and SN-A left the room. On 4/23/19, at 11:30 a.m., NA-D stated when using a Hoyer lift, two staff members were needed, "for standby, just in case someone pushes the button and moves the Hoyer." NA-D stated she was aware SN-A was not able to assist with the transfer of R26 using a Hoyer lift. NA-D stated she should have not completed the transfer without another trained staff available to assist. On 4/25/19, at 1:40 p.m., two staff were observed transferring R26 via Hoyer lift from a wheelchair to a bed. NA-E stated, "We always use two staff to transfer a resident when using a mechanical lift." NA-D stated both staff members need to be trained and able to assist. NA-E further explained that it was not beneficial if staff was only available as, "a standby." On 4/25/19, at 1:47 p.m., a licensed practical nurse (LPN-B) stated the facility's protocol was to use two staff members to assist in transfers with a Hoyer lift. LPN-B further explained if a staff or a student nurse was not trained to use an electric	F 689	audits. Corrections will be monitored by: DON/ADON/Nurse Managers	

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F 689	Continued From page 23 lift to transfer a resident, another staff member would need to be sought out to assist in the transfer. LPN-B stated staff was directed to always use two staff who were trained and knowledgeable regarding a Hoyer lift transfer. On 4/25/19, at 2:04 p.m. the administrator stated she expected anyone who assisted a resident in a Hoyer lift transfer would be trained, including student nurses who were doing a clinical in the facility. The administrator further stated staff should seek out help even if it meant "taking a nurse off the cart to help." The administrator further stated NA-D was aware the nursing student was not trained in the area of Hoyer lift transfers and, "therefore was unable to assist in any way." The facility's Lift Policy and Procedure, revised July 2017, indicated a portable lift was to be used by two nursing assistants to perform the procedure.	F 689		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete annual performance evaluations (PE) for 5 of 5 nursing assistants (NA-E, NA-F, NA-G, NA-H, NA-I) who worked at	F 730	Immediate Corrective Action: Annual Performance Reviews were completed on NAR: E, F, G, H and I. Required Annual Education was assigned to NAR: E, F and	6/4/19

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F 730	Continued From page 24 the facility for over a year. In addition, the facility failed to ensure required annual education was completed for 3 of 5 NA's (NA-E, NA-F, NA-I). Findings include: Review of NA and TMA personnel files on 4/25/19, revealed the following: -NA-E's date of hire (DOH) 7/31/15, NA-E's personnel file lacked evidence of completed PE and/ or 12 hours of completed education; -NA-F's DOH 2/26/16, NA-F's file lacked evidence of completed PE and/ or 12 hours of completed education; -NA-G's DOH 1/19/16, NA-G's file lacked evidence of completed PE; -NA-H's DOH 11/7/18, NA-H's file lacked evidence of completed PE; -NA-I's DOH: 8/30/16, NA-I's file lacked evidence of completed PE and/ or 12 hours of completed education. During an interview on 4/25/19, at 1:42 p.m. human resources and the acting administrator confirmed there were no current PE's on file. The administrator stated it was her expectation for PE to be completed annually. During a subsequent interview at 4:10 p.m. the administrator stated it was her expectation for required education to be completed timely. The facility policies regarding PE and education were requested, but not provided.	F 730	I with a date of completion. Corrective Action as it applies to others: The Policy for required Performance Reviews and Education remains current. HR Director and DON have developed a rolling calendar plan for required NAR Performance Reviews to include assurance of required annual education. All Nursing Assistants will be reviewed to assure a schedule to get current with required education and Performance Reviews has been set. Re-education on the Requirements for 12 hours of education per rolling calendar year and required education will be held on 5/30/19 for all nursing staff. Date of Compliance: 6/4/2019 Recurrence will be prevented by: Audits of 5 NAR□s assigned required annual education and Performance Reviews due will occur weekly x 4 and then monthly x 2 to assure they are completed. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: HR/DON/ADON	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency	F 755		6/4/19

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F 755	Continued From page 25 drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure Fentanyl (narcotic pain patches) were destroyed according to manufactures guidelines to prevent inappropriate storage of used medication, potential diversion, and accidental contact by staff through handling for 1 of 1 resident (R34) reviewed for medication storage who had Fentanyl patches ordered.	F 755	Immediate Corrective Action: The practice of flushing used Fentanyl patches into sewer was confirmed as soon as the incorrect destruction method was discovered. Corrective Action as it applies to others: The Policy for Fentanyl Patch destruction remains current.	

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	245067	A. BUILDING _____ B. WING _____	C 04/25/2019

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F 755	Continued From page 26 Findings include: R34's physician orders from the electronic medical record (EMR), dated 4/6/19 included: Fentanyl Patch 72 hour 25 micrograms(MCG)/hour(Hr). Apply 1 patch transdermally one time a day every 3rd day for chronic pain syndrome. The director of nursing (DON) was interviewed on 4/24/19 at 1:20 p.m. and stated used Fentanyl patches were folded in half and disposed of in a sharps container. The disposal of the used patch was to be performed by a licensed nurse and witnessed by a second staff member. The DON also requested to check with additional staff who applied and removed the patches as wasn't certain if this was the process being utilized. On 4/24/19, at 1:25 p.m. licensed practical nurse (LPN)- A was interviewed about application and removal of Fentanyl patches and confirmed she would remove the used patch, fold it up and dispose of into a sharps container as she was witnessed by a second staff member. LPN- B was interviewed on 4/24/19, at 1:33 p.m. and stated the process she would follow for a used Fentanyl patch would be to remove from the patient, apply the new patch and then fold the used patch and dispose of with a witness into a sharps container. LPN- hesitated and stated she wanted to verify the process for disposal with the assistant (A) DON. LPN-B returned after 5 minutes and said she had confirmed it with the ADON and used Fentanyl patches were to be disposed on in a sharps container witnessed by a second staff member.	F 755	Education on the correct method for destroying Fentanyl patches into sewer with 2 witnesses per Policy will be held on 5/30/19 with all licensed nurses. All future policy changes will be communicated to staff as dictated by local municipalities or the MN Dept of Health or the State Operations Manual. Date of Compliance: 6/4/2019 Recurrence will be prevented by: Audits of the process for destruction of Fentanyl patches will occur 5x weekly x 4 weeks and then monthly x 2 months to assure it is correctly completed per Policy. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/ADON/Nurse Managers	

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F 755	Continued From page 27 On 4/24/19 at 1:40 p.m. the DON stated he was not aware of the regulation change with regard to the recommended disposal of used Fentanyl patches into the sewer witnessed by a second person. The DON further confirmed he was not aware of any city ordinance prohibiting disposal of used Fentanyl patches into the sewer. A facility Policy and Procedure Fentanyl Removal, Application and Destruction, dated October 2013, listed the policy as: To address safe and secure medication handling and storage, limit access and reconciliation of controlled substances in order to minimize loss or diversion and provide safe handling, delivery and disposal of the fentanyl patch. The policy interpretation and implementation included Remove fentanyl patch and fold the adhesive sides together so there are no exposed medication. Take the used patch to the locked medication room (without touching adhesive sides), complete Fentanyl destruction log or Medication Disposal Form. With two licensed nurses wrapping the used fentanyl patch in toilet paper and flushing down the sewer. Two licensed nurses must verify destruction and sign the proper form for proof of destruction.	F 755		
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.	F 880		6/4/19

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F 880	Continued From page 28 §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 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	F 880		

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F 880	Continued From page 29 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. §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 record review the facility failed to follow infection control practices during a dressing change for 1 of 1 resident (R52). In addition, the facility failed to ensure infection control practices were followed while assisting a resident with eating for 1 of 1 resident (R34). Findings include: R52's physician orders dated 4/18/19, identified Santyl (ointment used to promote healing of skin ulcers and wounds) to slough, calcium to alginate over the wound, secure with Kerlix to wound on left lower leg and change every day shift. Registered nurse (RN)-A was observed on 4/24/19, at 8:26 a.m. during a dressing change for R52 to a wound on the left lower leg. RN-A applied gloves, but did not wash her hands before	F 880	Immediate Corrective Action: RN-A was re-educated on the Dressing change Policy to include washing hands before and after donning gloves. NA-C was re-educated on the need to wash hands, apply gloves or use silverware to touch any food to handle any finger foods. Corrective Action as it applies to others: The Policy for Handwashing and Dressing Change remain current. All nursing and Culinary staff will be re-educated on the use of PPE and Handwashing Policy of handling finger foods on 5/30/19. All licensed nurses will be re-educated on the Dressing Change Policy on 5/30/19. Date of Compliance: 6/4/2019 Recurrence will be prevented by: Audits of 5 meals and 5 dressing changes will occur weekly x 4 weeks and then monthly	

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F 880	Continued From page 30 the dressing change. RN-A then went out of the room and touched the door frame with her gloved hands looking for another staff member. Then proceeded to take off the soiled gauze dressing that had a minimal amount of serosanguinous drainage for the left lower leg with the same pair of gloves. After removing the soiled gauze dressing RN-A did not change gloves or wash hands before applying the new dressing. During interview on 4/25/19, at 9:49 a.m. the nurse practitioner (NP) stated expectation would be that staff would wash hands before a dressing change and staff should would take off gloves, and wash hands after removing the old dressing. During interview on 4/25/19, at 12:30 p.m. with RN-A stated "I know I messed up once, I did not wash my hands before I put my gloves on to start." RN-A also indicated that she was aware that she should change gloves and wash hands after removing a soiled dressing. During interview on 4/25/19, at 12:57 p.m. the assistant director of nurses (ADON) stated "my expectation is that staff change gloves and wash their hands after removing a soiled dressing." The Dressing change policy, updated on August 2018, identified that you should wash hands before beginning a dressing change and put on clean gloves. After removing the soiled dressing remove gloves and discard in plastic or biohazard bag. Then wash hands or use alcohol gel. Then staff should apply new gloves. The supper meal was observed on 4/22/19, at 6:20 p.m.. The nursing aide (NA)-C picked up a bun with an ungloved hand and gave it to the R34	F 880	x 2 months to assure they are completed correctly per Policy. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Culinary Director/ADON/Nurse Managers	

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F 880	Continued From page 31 to eat. NA-C then touched R43's oxygen tubing by her ear and then straightened out her blanket. NA-C again picked up her bun with the same ungloved hand and attempted to give R34 a bite of food. NA-C place both her hands on the top of her thighs, then picked up a potato wedge and gave it to R34. During interview on 4/25/19, at 11:00 a.m. the director of nursing (DON) stated staff should always wear gloves if they were touching foods directly. During interview on 4/25/19, at 11:14 a.m. the assistant director of nursing (ADON) indicated staff were not supposed to pick food up with bare hands. During interview on 4/25/19, at 12:37 p.m. the dietary manager (DM) confirmed staff should not be touching food ready to eat with their bare hands. Review of the Handwashing policy dated July 2017, makes no mention that staff should not touch food with ungloved hands.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 883		6/4/19

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F 883	Continued From page 32	F 883		

immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal

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F 883	Continued From page 33 immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 resident (R21) reviewed for immunizations, were offered and provided pneumococcal polysaccharide vaccine (PPSV23). Findings include: The current guidelines by the Center for Disease Control and Prevention (CDC) (2019) recommended the PPSV23 and pneumococcal conjugate vaccine (PCV13) for all adults 65 years or older. It recommended, for those age 65 or older administer PPSV23 at least 1 year after PCV13. R21's Admission Record dated 4/25/19, indicated R21 was 67 years old and was admitted to the facility on 2/7/17. R21's allergies included Cialis and Penicillin. The Immunization Report indicated PCV13 date given 1/30/15, and PPSV23 "not eligible." During an interview 4/25/19, at 1:48 p.m. the assistant director of nursing (DON) reviewed R21's medical record and identified R21's medical record indicated to administer PPSV23 on 9/1/2017, however "it was not done." the DON stated it was her expectation to administer vaccines per recommended guidelines. The facility Pneumococcal Policy revised	F 883	Immediate Corrective Action: Resident #21 was administered the PPSV23 vaccine. Corrective Action as it applies to others: The Pneumococcal Policy remains current. Whole House audits completed by 4/25 to assure their Pneumococcal immunizations are current. All licensed nurses will be re-educated on the Pneumococcal Policy on 5/30/19. Date of Compliance: 6/4/2019 Recurrence will be prevented by: Back up staff members to the ADON have been established and educated to ensure this process is followed through. An ongoing spreadsheet will be maintained to assure all resident vaccines are offered and administered per resident wishes to assure no eligible vaccines are missed. The ADON/Designee will share with the facility QAPI Committee on an ongoing basis the number of vaccinations and refusals for the month prior for input on any negative trends. Corrections will be monitored by: DON/ADON/Designee	

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F 883	Continued From page 34 11/2017, identified Pneumococcal vaccination will be administered to resident, per physician order and CDC recommendations, and will be documented in the resident's medical record.	F 883		

Electronically delivered
May 14, 2019

Administrator
The Emeralds At Faribault Llc
500 Southeast First Street
Faribault, MN 55021

Re: State Nursing Home Licensing Orders - Project Number S5067031, H5067019C, and H5067020C

Dear Administrator:

The above facility was surveyed on April 22, 2019 through April 25, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5067019C and H5067020C that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Eva Loch, Unit Supervisor
Metro D Survey Team
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: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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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: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 4/22/19, through 4/25/19, a survey was conducted to determine compliance for state licensure. The following correction orders are issued. Please indicate your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected. In addition, complaint investigations were also completed at the time of the licensing survey. The following complaints were found to be not substantiated: H5067019C and H5067020C. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 285	MN Rule 4658.0100 Subp. 2 Employee Orientation and In-Service Education Subp. 2. In-service education. A nursing home must provide in-service education. The in-service education must be sufficient to ensure the continuing competence of employees, must address areas identified by the quality assessment and assurance committee, and must address the special needs of residents as	2 285		6/4/19

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	00571	A. BUILDING: _____ B. WING _____	C 04/25/2019

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2 285	Continued From page 2 determined by the nursing home staff. A nursing home must provide an in-service training program in rehabilitation for all nursing personnel to promote ambulation; aid in activities of daily living; assist in activities, self-help, maintenance of range of motion, and proper chair and bed positioning; and in the prevention or reduction of incontinence. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete annual performance evaluations (PE) for 5 of 5 nursing assistants (NA-E, NA-F, NA-G, NA-H, NA-I) who worked at the facility for over a year. In addition, the facility failed to ensure required annual education was completed for 3 of 5 NA's (NA-E, NA-F, NA-I). Findings include: Review of NA and TMA personnel files on 4/25/19, revealed the following: -NA-E's date of hire (DOH) 7/31/15, NA-E's personnel file lacked evidence of completed PE and/ or 12 hours of completed education; -NA-F's DOH 2/26/16, NA-F's file lacked evidence of completed PE and/ or 12 hours of completed education; -NA-G's DOH 1/19/16, NA-G's file lacked evidence of completed PE; -NA-H's DOH 11/7/18, NA-H's file lacked evidence of completed PE; -NA-I's DOH: 8/30/16, NA-I's file lacked evidence of completed PE and/ or 12 hours of completed education. During an interview on 4/25/19, at 1:42 p.m. human resources and the acting administrator confirmed there were no current PE's on file. The	2 285	Corrected	

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2 285	Continued From page 3 administrator stated it was her expectation for PE to be completed annually. During a subsequent interview at 4:10 p.m. the administrator stated it was her expectation for required education to be completed timely. The facility policies regarding PE and education were requested, but not provided. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures regarding performance evaluation and ongoing education hours. The DON or designee could develop monitoring systems to ensure ongoing compliance and report the results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 285		
2 685	MN Rule 4658.0465 Subp. 2 Transfer, Discharge, and Death Subp. 2. Other discharge. When a resident is transferred or discharged for any reason other than death, the nursing home must compile a discharge summary that includes the date and time of transfer or discharge, reason for transfer or discharge, transfer or discharge diagnoses, and condition. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure recapitulation of stay was completed at discharge for 1 of 1 (R72) resident reviewed for closed record review.	2 685	corrected	6/4/19

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2 685	Continued From page 4 Findings include: R72's closed medical record indicated R72 was admitted to the facility with diagnoses of cerebral infraction, hemiplegia and hemiparesis. R72 discharged from the facility on 1/26/19, with her son. R72's medical record revealed there was no evidence of R72's recapitulation of stay. R72's progress notes dated 1/24/19, indicated a referral was sent to a home health agency to initiate home care for 1/26/19, when R72 was to discharge home with her son. The note dated 1/26/19, indicated R72 was discharged with her daughter going to her son's home with outpatient therapy. R72's discharge Minimum Data Set dated 1/26/19, indicated R72 had discharged from the facility return not anticipated. R72's Discharge/Transfer Summary completed 1/24/19, summarized R72's activities while at the facility, however the discharge summary, reason for discharge/transfer, mental and psychosocial status, vital signs at discharge, physical functioning status, assistive devices needed, treatments for discharge, dental condition, reconciliation of medications, dietary information and therapy after care were left blank. R72's Discharge Instructions dated as completed on 1/24/19, included leisure recommendations, however medication review, treatments to be continued after discharge, diet instructions, community resources, follow-up appointments and who to contact with questions were left blank. During an interview on 4/25/19, at 10:50 a.m.	2 685		

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2 685	Continued From page 5 registered nurse (RN)-C stated she was unable to locate R72's recapitulation of stay at discharge. RN-C stated it should have been completed upon discharge and a copy sent home with the resident. During an interview on 4/25/19, at 2:05 p.m. RN-B confirmed the Discharge/Transfer Summary and Discharge Instructions were not completed at the time of discharge. During an interview on 4/25/19, at 2:57 p.m. the director of nursing stated it was his expectation for a recapitulation of stay to be completed for residents upon discharge. The facility policy Discharge Planning Policy revised date 11/2016, indicated "Discharge information, including transfer form to appropriate home care agency or other nursing facility, must be prepared." SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures regarding discharge summary. The DON or designee could develop monitoring systems to ensure ongoing compliance and report the results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 685		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and	2 830		6/4/19

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2 830	Continued From page 6 custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a tubi-grip arm sleeve was provided according to physician orders for 1 of 1 resident (R6) reviewed for quality of care services. In addition the facility failed to provide adequate assistance to prevent an accident 1 of 1 resident (R26) observed during a transfer using a device. Findings include: R6's Face Sheet dated 10/16/17, indicated R6 had diagnosis including lymphedema (swelling in an extremity). R6's physician orders dated 3/5/19, indicated R6 was to have tubi-grips to right arm and both lower legs. On in a.m. and off in p.m. every day and evening shift for edema. R6's care plan dated 4/24/19, did not include the application of tubi-grips. On 4/22/19, at 5:00 p.m. R6 was observed sitting in his wheelchair by the medication cart without a	2 830	corrected	

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2 830	Continued From page 7 tubi-grip on his right arm which appeared to have edema. On 4/23/19, at 2:52 p.m. R6 was observed sitting in his wheelchair without a tubi-grip on his right arm which appeared to have edema. On 4/24/19, at 7:07 a.m. R6 was observed sitting in his wheelchair without a tubi-grip on his right arm which appeared to have edema. On 4/24/19, at 7:24 a.m. R6 stated he did not have tubi-grips on his right arm at this time and had not for a long time. R6 also confirmed he refused the tubi-grip at times but was not offered it for his right arm most days and did need it for his arm swelling. On 4/24/19, at 9:43 a.m. trained medication aide (TMA)-A stated R6 often refuses things including the tubi-grips and she had not seen them on his arm for a long time. TMA-A also stated any refusals should be charted in the treatment administration record (TAR). On 4/24/19, at 3:12 p.m. licensed practical nurse (LPN)-A stated there was an area on the TAR for the application of a tubi-grip to his lower extremities and his right arm and refusals should have been noted but had not been. Rebecca confirmed R6 did not have the Tubigrip on his right arm at this time and often did not. On 4/24/19, at 8:45 a.m. nursing assistant (NA)-A stated R6 is pretty independent and had not ever seen a tubi-grip on his right arm and did not have one on at this time. On 4/24/19, at 10:14 a.m. the director of nursing (DON) stated he was aware R6 should have had	2 830		

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2 830	Continued From page 8	2 830		

the tubi-grip on his right arm or had a documentation of his refusal in the TAR. The order is for tubi-grips on both lower extremities and his right arm and the orders should have been separated so we would know if he refused any of the three which would have allowed us to track him better. It also should have been on the care plan but was not at this time. The DON confirmed the TAR indicated the Tubi-grip was on his right arm on days when it was probably not.

A policy on edema and tubi-grips was requested but not provided.

R26's diagnosis included: Left side Hemiplegia/ Hemiparesis and Dementia without behavior disturbances.

The Miss-Fall Risk Assessment Welcov HC, dated 12/5/18, indicated R26 was at risk for falls and directed two staff to assist with all Hoyer lift transfers.

The quarterly Minimum Data Set (MDS), dated 2/26/19 noted R26 required extensive assistance of two staff for transfers.

The Care Are Assessment (CAA) was requested, but was not provided.

R26's NA sheet dated 4/23/19, directed staff assist of two with Hoyer lift transfers.

The current care plan, revised 2/22/19, indicated R26 required extensive assistance of one staff to complete transfers but failed to direct staff to use a Hoyer lift to complete the task.

On 4/23/19, at 11:22 a.m., a nursing assistant

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2 830	Continued From page 9	2 830		

(NA)-D was observed transporting R26 into her room. A student nurse (SN-A) also entered R26's room. NA-D began to connect the sling to the Hoyer lift (mechanical lift used to lift and move a patient with a minimal amount of effort from an assistant or helper). SN-A turned to NA-D and stated, "I cannot assist with Hoyer Lift transfers, I have not been trained." NA-D nodded and continued with the Hoyer lift transfer without assistance from SN-A. After R26's transfer and cares were complete, NA-D stated R26 stayed in bed until the "evening shift gets her up." NA-D and SN-A left the room.

On 4/23/19, at 11:30 a.m., NA-D stated when using a Hoyer lift, two staff members were needed "for standby, just in case someone pushes the button and moves the Hoyer." NA-D stated she was aware SN-A was not able to assist with the transfer of R26 using a Hoyer lift. NA-D stated she should have not completed the transfer without another trained staff available to assist.

On 4/25/19, at 1:40 p.m., two staff were observed transferring R26 via Hoyer lift from a wheelchair to a bed. NA-E stated, "We always use two staff to transfer a resident when using a mechanical lift." NA-D stated both staff members need to be trained and able to assist. NA-E further explained that it was not beneficial if staff was only available as "a standby."

On 4/25/19, at 1:47 p.m., a licensed practical nurse (LPN-B) stated the facility's protocol was to use two staff members to assist in transfers with a Hoyer lift. LPN-B further explained if a staff or a student nurse was not trained to use an electric lift to transfer a resident, another staff member would need to be sought out to assist in the

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2 830	Continued From page 10 transfer. LPN-B stated staff was directed to always use two staff who were trained and knowledgeable regarding a Hoyer lift transfer. On 4/25/19, at 2:04 p.m. the administrator stated she expected anyone who assisted a resident in a Hoyer lift transfer would be trained, including student nurses who were doing a clinical in the facility. The administrator further stated staff should seek out help even if it meant "taking a nurse off the cart to help." The administrator further stated NA-D was aware the nursing student was not trained in the area of Hoyer lift transfers and "therefore was unable to assist in any way." The Mechanical Lift Policy and Procedure, revised July 2017, indicated a portable lift was to be used by two nursing assistants to perform the procedure. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure the facility properly assessed residents with edema, and interventions were implemented and monitored per physician orders. In addition the facility could review and /or revise policies and procedures and provide staff training to ensure resident safety during transfers with a mechanical lift. The DON or designee could develop care plans and monitoring systems to ensure ongoing compliance and report the results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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21390	Continued From page 11	21390		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to follow infection control practices during a dressing change for 1 of 1 resident (R52). In addition, the facility failed to ensure infection control practices were followed	21390	corrected	6/4/19

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while assisting a resident with eating for 1 of 1 resident (R34). In addition the facility failed to ensure 1 of 5 resident (R21) reviewed for immunizations, were offered and provided pneumococcal polysaccharide vaccine (PPSV23).

Findings include:

R52's physician orders dated 4/18/19, identified Santyl (ointment used to promote healing of skin ulcers and wounds) to slough, calcium to alginate over the wound, secure with Kerlix to wound on left lower leg and change every day shift.

Registered nurse (RN)-A was observed on 4/24/19, at 8:26 a.m. during a dressing change for R52 to a wound on the left lower leg. RN-A applied gloves, but did not wash her hands before the dressing change. RN-A then went out of the room and touched the door frame with her gloved hands looking for another staff member. Then proceeded to take off the soiled gauze dressing that had a minimal amount of serosanguinous drainage for the left lower leg with the same pair of gloves. After removing the soiled gauze dressing RN-A did not change gloves or wash hands before applying the new dressing.

During interview on 4/25/19, at 9:49 a.m. the nurse practitioner (NP) stated expectation would be that staff would wash hands before a dressing change and staff should would take off gloves, and wash hands after removing the old dressing.

During interview on 4/25/19, at 12:30 p.m. with RN-A stated "I know I messed up once, I did not wash my hands before I put my gloves on to start." RN-A also indicated that she was aware that she should change gloves and wash hands after removing a soiled dressing.

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21390	Continued From page 13 During interview on 4/25/19, at 12:57 p.m. the assistant director of nurses (ADON) stated "my expectation is that staff change gloves and wash their hands after removing a soiled dressing." The Dressing change policy, updated on August 2018, identified that you should wash hands before beginning a dressing change and put on clean gloves. After removing the soiled dressing remove gloves and discard in plastic or biohazard bag. Then wash hands or use alcohol gel. Then staff should apply new gloves. R34 The supper meal was observed on 4/22/19, at 6:20 p.m.. The nursing aide (NA)-C picked up a bun with an ungloved hand and gave it to the R34 to eat. NA-C then touched R43's oxygen tubing by her ear and then straightened out her blanket. NA-C again picked up her bun with the same ungloved hand and attempted to give R34 a bite of food. NA-C place both her hands on the top of her thighs, then picked up a potato wedge and gave it to R34. During interview on 4/25/19, at 11:00 a.m. the director of nursing (DON) stated staff should always wear gloves if they were touching foods directly. During interview on 4/25/19, at 11:14 a.m. the assistant director of nursing (ADON) indicated staff were not supposed to pick food up with bare hands. During interview on 4/25/19, at 12:37 p.m. the dietary manager (DM) confirmed staff should not be touching food ready to eat with their bare hands.	21390		

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21390	Continued From page 14 Review of the Handwashing policy dated July 2017, makes no mention that staff should not touch food with ungloved hands. The current guidelines by the Center for Disease Control and Prevention (CDC) (2019) recommended the PPSV23 and pneumococcal conjugate vaccine (PCV13) for all adults 65 years or older. It recommended, for those age 65 or older administer PPSV23 at least 1 year after PCV13. R21's Admission Record dated 4/25/19, indicated R21 was 67 years old and was admitted to the facility on 2/7/17. R21's allergies included Cialis and Penicillin. The Immunization Report indicated PCV13 date given 1/30/15, and PPSV23 "not eligible." During an interview 4/25/19, at 1:48 p.m. the assistant director of nursing (DON) reviewed R21's medical record and identified R21's medical record indicated to administer PPSV23 on 9/1/2017, however "it was not done." the DON stated it was her expectation to administer vaccines per recommended guidelines. The facility Pneumococcal Policy revised 11/2017, identified Pneumococcal vaccination will be administered to resident, per physician order and CDC recommendations, and will be documented in the resident's medical record. SUGGESTED METHOD OF CORRECTION: The DON or designee could educate staff on pneumococcal vaccine administration guidelines. The DON or designee could complete audits of new admissions and current residents to ensure	21390		

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21390	Continued From page 15 proper pneumococcal vaccine administration. In addition the DON and/or designee could educate responsible staff related to hand hygiene and infection control practices. The DON or designee could conduct audits of resident cares to ensure hand hygiene and infection control measures are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by:	21426		6/4/19

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21426	Continued From page 16 Based on interview and document review, the facility failed to provide tuberculosis (TB) sign and symptoms assessment in accordance with state guidelines for 3 of 5 residents (R48, R21, R59) who immunization records were reviewed. In addition, the facility failed to implement current Centers for Disease Control (CDC) guidelines for preventing the transmission of Tuberculosis (TB) for 1 of 5 employees (E-A) as directed by State Tuberculosis Guidelines. Findings include: R48 was admitted on 12/21/15. The Medication Administration Record (MAR) revealed the first step TB skin test was administered on 12/22/15, however the TB sign and symptom assessment was not completed. R21 was admitted on 2/7/17. The Immunization Record revealed the first step TB skin test was administered on 2/8/17, however the TB sign and symptoms assessment was not completed. R59 was admitted on 9/30/11. The Immunization Record revealed the first step TB skin test was administered on 11/9/11, however the TB sign and symptom assessment was not completed. E-A's record indicated E-A was hired on 1/23/19, however E-A's sign and symptom assessment and 1st step Tuberculin Skin Test (TST) were not completed until 4/8/19. During an interview on 4/25/19, at 1:48 p.m. assistant director of nursing (ADON) confirmed R48, R21 and R59 did not have TB sign and symptom assessments completed. ADON stated it was her expectation for all residents and employees to have had their TB sign and	21426	corrected	

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21426	Continued From page 17 symptom assessment and their TST initiated within 24 hours of admission. During an interview on 4/25/19, at 2:54 p.m. human resources director explained they were unable to locate E-A's completed TB sign and symptom assessment and/ or TST "so we started over" in 4/2019. Regulation for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, Screening Health Care Workers (HCWs) directed "... Serial TB screening Serial TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a one-step TST or single IGRA (Interferon Gamma Release Assay)..." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could develop policies and procedures for a tuberculosis screening program in the facility. The director of nursing or designee, could conduct random audits to ensure that this tuberculosis screening program has been implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home	21550		6/4/19

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21550	Continued From page 18 must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure Fentanyl (narcotic pain patches) were destroyed according to manufactures guidelines to prevent inappropriate storage of used medication, potential diversion, and accidental contact by staff through handling for 1 of 1 resident (R34) reviewed for medication storage who had Fentanyl patches ordered. Findings include: R34's physician orders from the electronic medical record (EMR), dated 4/6/19 included: Fentanyl Patch 72 hour 25 micrograms(MCG)/hour(Hr). Apply 1 patch transdermally one time a day every 3rd day for chronic pain syndrome. The director of nursing (DON) was interviewed on 4/24/19 at 1:20 p.m. and stated used Fentanyl patches were folded in half and disposed of in a sharps container. The disposal of the used patch was to be performed by a licensed nurse and witnessed by a second staff member. The DON also requested to check with additional staff who applied and removed the patches as wasn't certain if this was the process being utilized. On 4/24/19, at 1:25 p.m. licensed practical nurse (LPN)- A was interviewed about application and removal of Fentanyl patches and confirmed she would remove the used patch, fold it up and dispose of into a sharps container as she was	21550	corrected	

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21550	Continued From page 19 witnessed by a second staff member. LPN- B was interviewed on 4/24/19, at 1:33 p.m. and stated the process she would follow for a used Fentanyl patch would be to remove from the patient, apply the new patch and then fold the used patch and dispose of with a witness into a sharps container. LPN- hesitated and stated she wanted to verify the process for disposal with the assistant (A) DON. LPN-B returned after 5 minutes and said she had confirmed it with the ADON and used Fentanyl patches were to be disposed on in a sharps container witnessed by a second staff member. On 4/24/19 at 1:40 p.m. the DON stated he was not aware of the regulation change with regard to the recommended disposal of used Fentanyl patches into the sewer witnessed by a second person. The DON further confirmed he was not aware of any city ordinance prohibiting disposal of used Fentanyl patches into the sewer. A facility Policy and Procedure Fentanyl Removal, Application and Destruction, dated October 2013, listed the policy as: To address safe and secure medication handling and storage, limit access and reconciliation of controlled substances in order to minimize loss or diversion and provide safe handling, delivery and disposal of the fentanyl patch. The policy interpretation and implementation included Remove fentanyl patch and fold the adhesive sides together so there are no exposed medication. Take the used patch to the locked medication room (without touching adhesive sides), complete Fentanyl destruction log or Medication Disposal Form. With two licensed nurses wrapping the used fentanyl patch in toilet paper and flushing down the sewer. Two licensed nurses must verify destruction and sign	21550		

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21550	Continued From page 20 the proper form for proof of destruction. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures for residents' Fentanyl patch destruction. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21550		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that	21880		6/4/19

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21880	Continued From page 21 provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure grievances were documented, investigated and corrective actions taken for 3 of 3 (R68, R33, and R36) residents reviewed who had grievances. Findings include: When interviewed on 4/22/19, at 6:30 p.m. R68, along with family members (FM)-D and FM-E stated they have filed many official grievances with the facility and have not received any response. "If we talk to the administrator it gets us nowhere. We have written multiple grievances regarding licensed practical nurse (LPN)-C. We have not heard a response from anybody	21880	corrected	

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regarding any of them." FM-A brought in copies of the 10 grievances they had given to social services. Grievances were filled out on 4/15/19, 4/11/19, 4/6/19, 4/1/19, 3/15/19,1/20/19, 1/15/19, and 3 separate grievances for 10/1/18. The grievance dated 3/15/19 was followed up on by the facility. None of the others had any facility response. The majority of the grievances brought in by the family had to do with LPN-C or other staff that cared for their mother.

When interviewed on 4/22/19, at 1:58 p.m. R33 stated he had over heard LPN-C talk about another resident, "I gave him morphine maybe that will shut him up." R33 also stated, "I don't want this to keep happening to me or anyone else." R33 also had concerns that when he was not feeling well and his heart was racing, LPN-C came in and checked his pulse but never came back to recheck it. Another time, R33 indicated that his heart was racing [LPN-C] told him he had to wheel himself to her and come and get the medication or hope that the nursing assistant (NA) could come and get him to bring him to the medication cart. After taking the medications that night, he wheeled himself back to the room and she followed him down the hallway and was yelling, telling him that you don't have to be pissed at me. R33 further stated "I told her she is making it worse and to please leave me alone. I did report this to [LPN-D] and the social worker and I have attempted to email corporate regarding her behavior." R33 also said "I went to everyone that would listen and they just let it go. What happens to the people who don't have a voice?" R33 stated no one has followed up on his concerns.

When interviewed on 4/23/19, at 3:50 p.m. R36

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stated he had a concern with trained medication aide (TMA)-A, regarding putting him on the toilet the wrong way stating, "it hurts me." R36 also stated, "She won't take no for an answer, I have been asking her nicely and she won't listen. I have talked to social services [SS-A] about two to three weeks ago." R36 also voiced concerns about LPN-C and stated she went from, "bad to worse" and he had told SS-A and the director of nursing (DON). R36 stated no one had followed up on any of his concerns.

When interviewed on 4/23/19, at 4:20 p.m. the DON stated that if a resident expresses a verbal concern, they do not always want it written down as a grievance.

When interviewed on 4/23/19, at 4:37 p.m. registered nurse (RN)-A stated she had some grievances that had been turned in to her, but, "I think I left the grievances with the administrator before he left for vacation. I don't have any in my office."

When interviewed on 4/24/19, at 11:25 a.m. the DON stated he did not have other grievances and had looked on the administrators desk, and did not find any there either.

When interviewed on 4/24/19, at 1:28 p.m. the acting administrator stated, and the social worker were unsure if there were any outstanding grievances. They had found four from R68's family and was unable to locate any others. The administrator explained the process was to follow up within five days, and this had not happened for R68. There was no follow up for the verbal concerns of R33 and R36 either. The administrator stated re-education was provided to the social service department, unit managers and

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21880	Continued From page 24 the DON. The facility's Complaint and Grievance procedure, revised 2/2018, indicted any complaints, regardless of how they are received by the facility, will be investigated per the policy. A grievance form should be completed when the verbal complain had been voiced to each of the above individuals. This included when a grievance has been resolved right away to show documentation that it was addressed and resolved to the satisfaction of the person voicing the concern. The form should be completed and returned to the administrators office. The administrator or designee shall conduct investigation of the grievance to determine its validity. The administrator shall issue a verbal summary, unless a written summary is required to the complainant no later than five business days after the receipt of the grievance. SUGGESTED METHOD OF CORRECTION: Staff should be trained to report all resident concerns to the appropriate administrative staff. Administrative staff could develop or revise policy and procedures related to resident grievances. Nursing and administrative staff could randomly ask residents if they have any grievances/concerns and immediately follow-up on the grievance/concern. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment.	21995		6/4/19

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21995	Continued From page 25 (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report an incident of physical abuse to the administrator and state agency (SA) for 1 of 1 resident (R41) reviewed for resident to resident altercation. Findings include: R41's current face sheet included diagnoses of a stroke with right sided hemiplegia (inability to move that side of the body) and traumatic brain injury. R41's progress note dated 1/7/19, indicated R41 "was in the tv (television) area swearing and yelling at other residents, calling them 'assholes and fuckers,' and struck another resident in the arm." During interview on 4/25/19 at 10:34 a.m., DON stated we first protect the residents and remove the threat, and then report it. His expectation was if a resident hits another resident it would be reported. When reviewing R41 progress note from 1/7/19, DON responded, "I didn't know about that incident and don't know who the other resident was." He further responded "I don't know	21995	corrected	

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what interventions would have been put in place after that incident to protect the other residents." DON confirmed that this incident was not reported to the state agency and also confirmed that there is a concern with reporting concerns, grievances and incidents.

During interview on 4/25/19 at 11:16 a.m., LPN-D identified she would report resident to resident altercations to her supervisor or DON. She would typically fill out an incident report on paper, but was recently told by the DON if there is no injury then there is no need to complete it. LPN-D recalled an incident about two to three months ago of R41 hitting another resident where she started filling out an incident report and reported it to the DON; however, when she looked through the progress notes she could not find the incident report and was unable to recall the date of the incident.

During interview on 4/25/19 at 1:23 p.m., the acting administrator indicated a report had not been filed immediately to the state agency related to the incident on 1/7/19. The administrator also verified that any resident to resident physical altercation needed to be reported to the state agency right away. Furthermore, the administrator indicated that the DON will be re-educated on what needs to be filed and the timeframe it should be filed.

Review of the Abuse Prevention Policy, dated 12/2018 indicated this policy was to ensure that residents are not subjected to abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the individual, family member or legal guardian, friends or other individuals. The policy also identified that all staff are responsible

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for reporting any situation that is considered abuse or neglect. A completed incident report will to routed per facility procedure. The unit nurse will be notified immediately, assess the situation to determine if any emergency treatment or action is required. Staff will take necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated. If this is an injury of unknown origin, the nurse will also attempt to determine the cause of the injury. If it is resident to resident abuse, the abused resident will be removed to a safe environment and all other residents' safety will be ensured. Notification of the facility administrator immediately of any incidents of resident abuse, alleged or suspected abuse, injury or unknown origin, neglect, financial exploitation, or involuntary seclusion will occur immediately. Furthermore, it indicated that resident to resident altercation must be reported to the Minnesota Department of Health. Suspected abuse shall be reported to OHFC no later than 2 hours after forming suspicion of abuse.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee could review and revise the abuse policies, educate staff on the facility's abuse and neglect policies and procedures to ensure staff immediately report any allegation of resident abuse. The director of nursing or designee could randomly audit reports to ensure compliance. The results of the audits could be reported to the facility's quality assurance committee.

TIME PERIOD FOR CORRECTION: Seven (7) days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00571	A. BUILDING: _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT FARIBAULT LLC	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

(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) COMPLETE DATE
22000	Continued From page 28	22000		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if	22000		6/4/19

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22000	Continued From page 29 unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to investigate an incident of resident to resident abuse and failed to implement interventions to protect the unknown resident from R41 reviewed for resident to resident abuse. Findings include: R41's current face sheet included diagnoses of a stroke with right sided hemiplegia (inability to move that side of the body) and traumatic brain injury. R41's quarterly minimum data set (MDS), dated 3/21/19, indicated severe cognitive impairment and verbal behavioral symptoms directed towards others 1-3 days during the reference period. R41's progress note dated 1/7/19, indicated R41 "was in the tv (television) area swearing and yelling at other residents, calling them 'assholes and fuckers,' and struck another resident in the arm." During interview on 4/23/19, at 3:40 p.m. LPN-A	22000	corrected	

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22000	Continued From page 30 stated "He is out of control." During interview on 4/25/19 at 10:34 a.m., DON stated we first protect the residents and remove the threat, and then report it. Expectation was if a resident hits another resident that would be reported. When reviewing R41 progress note from 1/7/19, DON responded, "I didn't know about that incident and don't know who the other resident was." DON further said "I don't know what interventions would have been put in place after that incident to protect the other residents." DON confirmed there was a concern with reporting concerns, grievances and incidents. Further, he stated "I am at a loss with R41, he can change on a dime and can require constant redirection." During interview on 4/25/19 at 12:22 p.m., registered nurse (RN)-A indicated when she was informed of resident to resident physical altercation, that was brought to the DON who makes the decision to notify the state agency. RN-A further indicated if she gets the report, she will call staff and investigate it. RN-A was aware R41 had stuck other residents before and he liked to get in other residents faces. RN-A was unable to recall the incident that took place on 1/7/19, and did not know of any interventions that were put in place to protect the other residents at the facility. During interview on 4/25/19, at 1:23 p.m., the acting administrator indicated a report had not been filed to the state agency related to the incident on 1/7/19. The administrator also verified that any resident to resident physical altercation needed to be reported right away. Furthermore the administrator indicated that the DON will be re-educated on what needs to be filed and the	22000		

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22000	Continued From page 31 timeframe it should be filed. Review of the Abuse Prevention Policy, dated 12/2018 indicated this policy was to ensure that residents are not subjected to abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the individual, family member or legal guardian, friends or other individuals. The policy also identified that all staff are responsible for reporting any situation that is considered abuse or neglect. A completed incident report will to routed per facility procedure. The unit nurse will be notified immediately, assess the situation to determine if any emergency treatment or action is required. Staff will take necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated. If this is an injury of unknown origin, the nurse will also attempt to determine the cause of the injury. If it is resident to resident abuse, the abused resident will be removed to a safe environment and all other residents' safety will be ensured. Notification of the facility administrator immediately of any incidents of resident abuse, alleged or suspected abuse, injury or unknown origin, neglect, financial exploitation, or involuntary seclusion will occur immediately. Furthermore, it indicated that resident to resident altercation must be reported to the Minnesota Department of Health. Suspected abuse shall be reported to OHFC no later than 2 hours after forming suspicion of abuse. SUGGESTED METHOD OF CORRECTION: The administrator could review policies and procedures regarding reporting and investigating all alleged abuse/neglect/mistreatment. The administrator and or designee, could re-educate all staff on the policies and procedures. The	22000		

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22000	Continued From page 32 administrator could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/24/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT FARIBAULT LLC	**500 SOUTHEAST FIRST STREET** **FARIBAULT, MN 55021**

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K 000	INITIAL COMMENTS 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (The Emeralds of Faribault) 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care 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	K 000	EPOC	

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

Electronically Signed | 05/23/2019

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 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Emeralds at Faribault, previously St Lucas Care Center, was constructed at 5 different times.. The original building is a 4-story building with no basement. It was constructed in 1908 and was determined to be of Type I (332) construction, (the 1st and 2nd floor are used for health care). In 1960 a 1-story addition was constructed and was determined to be of Type II (111) construction, with no basement. In 1971 a 1-story addition was constructed and was determined to be of Type II (111) construction, with a full basement. In 1990 a 1-story addition was constructed and was determined to be of Type II (111) construction, with no basement. In 1991 an addition was constructed and was determined to be of Type II (111) construction, with no basement. Because the original building and the 4 additions and meet the construction type allowed for existing buildings, the facility was surveyed as one building. 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	K 000		

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K 000	Continued From page 2 department notification. The facility has a capacity of 90 beds and had a census of 77 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.2.2.2.7, 19.2.2.2.8) This deficient practice could affect the safety of all (77) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 04/24/2019, observations and staff interview revealed the following:	K 223	Immediate corrective action: Maintenance director repaired the exit door in dining room on the first floor to self close and properly latch. This repair was also completed on the exit door adjacent to the kitchen. Action as it applies to others: All exit doors were checked to ensure they close and latch properly. Date of completion: __6/4/2019_____. Recurrence will be prevented by:	6/4/19

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	245067	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/24/2019**

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K 223	Continued From page 3 During the walk-through inspection of the facility observed the following: (1) Exit door in the Dining Room (1st FL) did not self-close and latch properly upon testing (2) Exit door set in the corridor adjacent to the Kitchen did not self-close and latch properly upon testing This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 223	Maintenance director will enter into Tel□s program to check qtrly. All exit doors to ensure they close and latch properly. The correction will be monitored by: Maintenance director, Adm., or designee will monitor for compliance.	
K 324 SS=F	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		6/4/19

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K 324	Continued From page 4 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2) This deficient practice could affect the safety of all (77) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 04/24/2019, observations and staff interview revealed the following: During the walk-through inspection of the facility observed the training stove in the Therapy Rm was not connected to a secured (keyed lock-out) electrical power source This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 324	Immediate corrective action: Maintenance director has disconnected the training stove in therapy dept. and keyed lock out at the electrical panel Action as it applies to others: Training stove has a sticker affixed to the stove indicating it is non-operational Date of completion: __6/4/2019_____. Recurrence will be prevented by: Maintenance director will enter into Tel□s program to check qtrly. To make sure it is still non-operational The correction will be monitored by: Maintenance director, Adm., or designee will monitor for compliance.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked	K 353		6/4/19

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K 353	Continued From page 5 b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (9.7.5, 9.7.7, 9.7.8, and NFPA 25) This deficient practice could affect the safety of all (77) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 04/24/2019, observations, documnetation review and staff interview revealed the following: During the walk-through inspection of the facility observed that the gauges on the sprinkler riser were identified as last being changed in 2011. Documentation review also identified that the last 5 yr sprinkler system inspection was completed in 2011 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 353	Immediate corrective action: The gauges on the sprinkler riser will be changed along with the 5 year sprinkler system being inspected. Action as it applies to others: Sprinkler system inspection will be scheduled to be inspected every 5 years and gauges replaced Date of completion: __6/4/2019_____. Recurrence will be prevented by: Maintenance director will enter into Tel□s program to check annually. The correction will be monitored by: Maintenance director, Adm., or designee will monitor for compliance.	