#### CENTERS FOR MEDICARE & MEDICAID SERVICES

	CARE/MEDICAID CERTIFICATI - TO BE COMPLETED BY THE		ID: EZXR Facility ID: 00571
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245067  2.STATE VENDOR OR MEDICAID NO.     (L2) 470618800	3. NAME AND ADDRESS OF FACILITY (L3) THE EMERALDS AT FARIBAU (L4) 500 SOUTHEAST FIRST STREET (L5) FARIBAULT, MN	ULT LLC ET (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
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 06/04/2019 (L34)			8. Full Survey After Complaint
6. DATE OF SURVEY <b>06/04/2019</b> (L34)  8. ACCREDITATION STATUS: (L10)  0 Unaccredited	03 SNF/NF/Distinct 07 X-Ray 11 I	NF 14 CORF ICF/IID 15 ASC RHC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
11. LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12. Total Facility Beds 13. Total Certified Beds 90 (L18)  14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 90 (L37) (L38) (L39)  16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE)	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:  ICF IID  (L42) (L43)  E SHOW LTC CANCELLATION DATE):	And/Or Approved Waivers Of TI  2. Technical Personnel  3. 24 Hour RN  4. 7-Day RN (Rural SNI  5. Life Safety Code  * Code: A  15. FACILITY MEETS  1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director
17. SURVEYOR SIGNATURE  Susanne Reuss, Unit Supervis		18. STATE SURVEY AGENCY  Douglas Larson, Enf	
PART II - TO BI	E COMPLETED BY HCFA REGIO	ONAL OFFICE OR SINGLE ST	ATE AGENCY
19. DETERMINATION OF ELIGIBILITY  _X 1. Facility is Eligible to Participate  2. Facility is not Eligible  (L21)	20. COMPLIANCE WITH CIVII RIGHTS ACT:		ncial Solvency (HCFA-2572)  ol Interest Disclosure Stmt (HCFA-1513)  :
22. ORIGINAL DATE  OF PARTICIPATION  01/01/1967  (L24)  (L41)  23. LTC AGREEM  BEGINNING  (L41)		26. TERMINATION ACTION:  VOLUNTARY  01-Merger, Closure  02-Dissatisfaction W/ Reimbursem	05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: 27. ALTERNATI	VE SANCTIONS n of Admissions: (L44)	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE: 29	O. INTERMEDIARY/CARRIER NO.	30. REMARKS	
(L28)	<b>03001</b> (I	.31)	

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

06/28/2019

(L32)

31. RO RECEIPT OF CMS-1539



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

1 Jovens Stappon

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File



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 guestions.

Sincerely,

Towers Stapeon

Douglas Larson, Enforcement Specialist

The Emeralds At Faribault Llc July 10, 2019 Page 2

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

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

#### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	ICARE/MEDICAID CERTIFICATION I - TO BE COMPLETED BY THE ST		ID: EZXR
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 FARIBAUL (L4) 500 SOUTHEAST FIRST STREET (L5) FARIBAULT, MN	T LLC	Facility ID: 00571  4. TYPE OF ACTION: 2 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
<ul> <li>5. EFFECTIVE DATE CHANGE OF OWNERSHIP         (L9)</li> <li>6. DATE OF SURVEY 04/25/2019 (L34)</li> </ul>	7. PROVIDER/SUPPLIER CATEGORY  01 Hospital 05 HHA 09 ESB  02 SNF/NF/Dual 06 PRTF 10 NF	02 (L7) D 13 PTIP 22 CLIA 14 CORF	8. Full Survey After Complaint
8. ACCREDITATION STATUS: (L10)  0 Unaccredited	03 SNF/NF/Distinct 07 X-Ray 11 ICF 04 SNF 08 OPT/SP 12 RHe	TIID 15 ASC	FISCAL YEAR ENDING DATE: (L35)  12/31
11. LTC PERIOD OF CERTIFICATION         From (a):       (a):         To (b):       (b):         12. Total Facility Beds       90 (L18)         13. Total Certified Beds       90 (L17)	A. In Compliance With  Program Requirements  Compliance Based On:	And/Or Approved Waivers Of Th  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
14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF 19 SN  90  (L37) (L38) (L39)		* Code: <b>B</b> *  15. FACILITY MEETS  1861 (e) (1) or 1861 (j) (1):	(L12) (L15)
16. STATE SURVEY AGENCY REMARKS (IF APPLICA  17. SURVEYOR SIGNATURE	Date:	18. STATE SURVEY AGENCY A	
Thomas O'Brien, HFE NE II	05/28/2019 (L19	<u> </u>	00/28/2017 (L20
PART II - TO	BE COMPLETED BY HCFA REGION	AL OFFICE OR SINGLE ST.	ATE AGENCY
DETERMINATION OF ELIGIBILITY  _X1. Facility is Eligible to Participate2. Facility is not Eligible  (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:		acial Solvency (HCFA-2572)  I Interest Disclosure Stmt (HCFA-1513) :
22. ORIGINAL DATE 23. LTC AGRE  OF PARTICIPATION BEGINNIN  01/01/1967  (L24) (L41)		26. TERMINATION ACTION:  VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	05-Fail to Meet Health/Safety nt 06-Fail to Meet Agreement
A. Suspen	TIVE SANCTIONS  ion of Admissions:  (L44)  Suspension Date:  (L45)	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS	
/I 20\	03001		
(L28)	(L31	<u>'</u>	

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of All Minnesotans

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.

The Emeralds At Faribault Llc May 14, 2019 Page 2

- 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.

The Emeralds At Faribault Llc May 14, 2019 Page 3

#### **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:

The Emeralds At Faribault Llc May 14, 2019 Page 4

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,

Towards Stapson

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

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 05/28/2019 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
					С	
		245067	B. WING_		04/25/2019	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE EME	RALDS AT FARIBAU	ILT LLC		500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
	CLIMANA DV CTA	TEMENT OF DEFICIENCIES			1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION	
E 000	Initial Comments		E 00	00		
F 000	Emergency Prepare conducted on 4/22/ recertification surve	iance with CMS Appendix Z edness Requirements, was 19 through 4/25/19, during a ey. The facility is in compliance Z Emergency Preparedness	F 00	00		
	On 4/22/29 through was completed at y Department of Hea was in compliance	n 4/25/19, a standard survey our facility by the Minnesota Ith to determine if your facility with the requirements of 42 part B, and Requirements for				
	In addition, complai completed at the tir	int investigations were also ne of the survey.				
		laints were found to be not 67019C and H5067020C.				
	as your allegation of Department's acception enrolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will tion of compliance.				
E 505	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility will be conducted to ntial compliance with the attained in accordance with	F		0440	
F 585 SS=D		)-(4)	F 58	35	6/4/19	
LABORATOR`	Y D <b>I</b> RECTOR'S OR PROV <b>I</b> E	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE	
Electron	ically Signed				05/23/2019	

(X2) MULTIPLE CONSTRUCTION

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		245067	B. WING		04	C //25/2019
	NAME OF PROVIDER OR SUPPLIER  THE EMERALDS AT FARIBAULT LLC			STREET ADDRESS, CITY, STATE, ZIP COE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	•	
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CTATEMENT OF DEFICIENCIES (VA) PROVIDED (CURRILIER) (CURRILIER)					(VO) DATE CUDVEV		
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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		245067	B. WING			04/	25/2019
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		decision regarding his or her					
		contact information of					
		s with whom grievances may					
		pertinent State agency,					
		nt Organization, State Survey					
		ong-Term Care Ombudsman					
		on and advocacy system;					
		evance Official who is					
		rseeing the grievance process,					
		ing grievances through to their					
		g any necessary investigations					
		taining the confidentiality of all					
		ated with grievances, for					
		ty of the resident for those					
		ed anonymously, issuing					
		ecisions to the resident; and					
		tate and federal agencies as					
		f specific allegations;					
		aking immediate action to					
		ential violations of any resident					
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	investigated;	0.400.407.747.					
		§483.12(c)(1), immediately					
		d violations involving neglect,					
		uries of unknown source,					
		ation of resident property, by					
		services on behalf of the					
		ninistrator of the provider; and					
	as required by Stat						
		I written grievance decisions					
		e grievance was received, a					
		it of the resident's grievance,					
		nvestigate the grievance, a					
		rtinent findings or conclusions					
		ent's concerns(s), a statement					
		rievance was confirmed or not					
		rective action taken or to be					
	∣ taken by the facility	as a result of the grievance,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 \ /	, ,	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245067	B. WING			C <b>/25/2019</b>	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•	20/2010	
T				500 SOUTHEAST FIRST STREET			
THE EME	ERALDS AT FARIBAL	JLT LLC		FARIBAULT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		SHOULD BE	(X5) COMPLETION DATE	
F 585	and the date the wi (vi) Taking appropriaccordance with St of the residents' rig or if an outside entithe State Survey A Organization, or loc confirms a violation rights within its area (vii) Maintaining eversult of all grievandayears from the ist decision.  This REQUIREMED by: Based on interview failed to ensure grie investigated and conditional states of the second states of the sec	ritten decision was issued; iate corrective action in ate law if the alleged violation hts is confirmed by the facility ty having jurisdiction, such as gency, Quality Improvement cal law enforcement agency in for any of these residents and of responsibility; and idence demonstrating the ces for a period of no less than suance of the grievance.  NT is not met as evidenced and record review the facility evances were documented, prective actions taken for 3 of 236) residents reviewed who such a demonstration it gets have not received any lik to the administrator it gets are written multiple grievances practical nurse (LPN)-C. We esponse from anybody em." FM-A brought in copies as they had given to social es were filled out on 4/15/19, 1/19, 3/15/19, 1/20/19, 1/15/19, evances for 10/1/18. The 15/19 was followed up on by the others had any facility ority of the grievances brought	F 5	Immediate Corrective Action #68, #33 and #36 were interested assure any concerns were in addressed. Family member were also interviewed to assure any concerns were immediately Corrective Action as it applied The Grievance Policy remain Immediate re-education on process was provided to the Services and Nurse Manage Re-education on the Grievance and Nurse Manage Re-education on the Grievance will be held on 5/30 for all of Grievance review will be admorning Quality Conference ongoing to assure any concern documented on a Grievance timely investigation and followed the complainant occur.  Date of Compliance: 6/4/20 Recurrence will be prevented fall grievances will occur wonthly x 2 to assure the Grievance in the grievances will occur wonthly x 2 to assure the Grievance in the grievances will occur wonthly x 2 to assure the Grievance in the grievances will occur wonthly x 2 to assure the Grievance in the grievances will occur wonthly x 2 to assure the Grievance in the grievance will occur wonthly x 2 to assure the Grievance in the grievance will occur wonthly x 2 to assure the Grievance in the grievance will occur wonthly x 2 to assure the Grievance in the grievance will occur wonthly x 2 to assure the Grievance in the grievance will occur wonthly x 2 to assure the Grievance in the grievance will be prevented to the grievance will be grievance will occur wonthly x 2 to assure the Grievance will be	rviewed to mmediately rs D and E sure any addressed. es to others: ins current. the grievance e DON, Social ers. nce Policy adership and ther staff. ded to e meeting erns are e Form and ow-up with the 19 ed by: Audits weekly x 4 and		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C		
		245067	B. WING			1	_ 25/2019
	PROVIDER OR SUPPLIER ERALDS AT FARIBAL	ULT LLC		50	REET ADDRESS, CITY, STATE, ZIP CODE NO SOUTHEAST FIRST STREET ARIBAULT, MN 55021	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 585	in by the family had staff that cared for the staff that cared he had over another resident, "I that will shut him up want this to keep had else." R33 also had not feeling well and came in and check back to recheck it. I that his heart was not owneed himself to medication or hope (NA) could come as medication cart. Affinight, he wheeled she followed him do yelling, telling him to pissed at me. R33 making it worse and did report this to [LI and I have attempted regarding her behad everyone that would what happens to the voice?" R33 stated concerns.  When interviewed of stated he had a condide (TMA)-A, regarthe wrong way stati	to do with LPN-C or other their mother.  on 4/22/19, at 1:58 p.m. R33 heard LPN-C talk about gave him morphine maybe o." R33 also stated, "I don't appening to me or anyone I concerns that when he was his heart was racing, LPN-C ed his pulse but never came Another time, R33 indicated acing [LPN-C] told him he had her and come and get the that the nursing assistant and get him to bring him to the ter taking the medications that himself back to the room and own the hallway and was hat you don't have to be further stated "I told her she is d to please leave me alone. I PN-D] and the social worker ed to email corporate vior." R33 also said "I went to d listen and they just let it go. he people who don't have a no one has followed up on his on 4/23/19, at 3:50 p.m. R36 incern with trained medication rding putting him on the toilet ng, "it hurts me." R36 also	F 5	885	Policy is being followed. The resul these audits will be shared with the QAPI committee for input on the ne increase, decrease or discontinue audits.  Corrections will be monitored by: Administrator/Social Services/DON designee.	e facility eed to the	
	stated, "She won't t been asking her nic have talked to social	ng, "it hurts me." R36 also ake no for an answer, I have cely and she won't listen. I al services [SS-A] about two ." R36 also voiced concerns					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
		245067	B. WING		04	/25/2019
	PROVIDER OR SUPPLIER ERALDS AT FARIBAL	ULT LLC		STREET ADDRESS, CITY, STATE, ZIP COE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 585	worse" and he had nursing (DON). R3 up on any of his co.  When interviewed of DON stated that if a concern, they do not as a grievance.  When interviewed or registered nurse (Rigrievances that had think I left the grievance he left for varioffice."  When interviewed of DON stated he did had looked on the anot find any there exists were unsure if there grievances. They he family and was una administrator explain up within five days, R68. There was no concerns of R33 are administrator stated the social service of the DON.  The facility's Comp	tated she went from, "bad to told SS-A and the director of 5 stated no one had followed incerns.  on 4/23/19, at 4:20 p.m. the a resident expresses a verbal of always want it written down on 4/23/19, at 4:37 p.m.  N)-A stated she had some if been turned in to her, but, "I ances with the administrator incation. I don't have any in my on 4/24/19, at 11:25 a.m. the not have other grievances and administrators desk, and did ither.  on 4/24/19, at 1:28 p.m. the instated, and the social worker is were any outstanding ad found four from R68's ble to locate any others. The ined the process was to follow and this had not happened for follow up for the verbal and R36 either. The dire-education was provided to epartment, unit managers and laint and Grievance	F 5	85		
	procedure, revised complaints, regardl	2/2018, indicted any ess of how they are received e investigated per the policy. A				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  NG	СОМ	E SURVEY PLETED
		245067	B. WING_			C <b>25/2019</b>
	PROVIDER OR SUPPLIER ERALDS AT FARIBAL	ULT LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 585 F 600 SS=D	grievance form sho verbal complain ha above individuals. grievance has beer documentation that resolved to the sati the concern. The for returned to the adm administrator or de- investigation of the validity. The admini summary, unless a to the complainant days after the recei Free from Abuse an	build be completed when the d been voiced to each of the This included when a resolved right away to show it was addressed and sfaction of the person voicing orm should be completed and ninistrators office. The signee shall conduct grievance to determine its strator shall issue a verbal written summary is required no later than five business pt of the grievance.	F 58			6/4/19
33-0	§483.12 Freedom f Exploitation The resident has the neglect, misapproper and exploitation as includes but is not lead to corporal punishment any physical or cheater the resident's §483.12(a) The fact fact shall be shall	rom Abuse, Neglect, and re right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from nt, involuntary seclusion and mical restraint not required to medical symptoms.  ility must- use verbal, mental, sexual, or reporal punishment, or		Immediate Corrective Action: SE review and seen by PCP with med review completed on 4/29/19. Pending VAMC approval, Resider	dication	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION		E SURVEY PLETED
						С	
		245067	B. WING			04/2	25/2019
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TUE EME	ERALDS AT FARIBAL	штис		50	00 SOUTHEAST FIRST STREET		
I HE EIVIE	KALDS AT FARIDAL	JLT LLC		F.	ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	Continued From para Findings include: R41's current face stroke with right side move that side of the injury. R41's quarterly mindicated sand verbal behavior others 1-3 days durent Review of progress R41 "was in the two yelling at other resisand fuckers," and sarm." During interview or indicated R41 hits and Ativan he gets before "He is out of controls."	sheet included diagnoses of a led hemiplegia (inability to ne body) and traumatic brain simum data set (MDS), dated severe cognitive impairment ral symptoms directed towards ring the reference period. In the inclusion of the resident in the least of the severe cognitive impairment ral symptoms directed towards ring the reference period. It is notes indicated on 1/7/19, (television) area swearing and dents, calling them 'assholes truck another resident in the least of t	F 6		be seen by psychologist on: 5/29/19 input on aggressive behavior management plan. An OHFC repo filed and investigation completed for potential Incident of 1/7/2019. Corrective Action as it applies to oth The Abuse Prevention Plan remain current. Immediate re-education on the Abuse Prevention Plan was provided to the Re-education on the Abuse Preven Plan will be held on 5/30/19 for all so The aggressive behavior plan for Resident #41 scare plan was reviewed and remains current.  NAR Care cards, and education proto all nursing staff who provide care Resident #41 on his individualized processive provided to the provide care Resident #41 on his individualized provided to the provide care Resident #41 on his individualized provided to the provide care Resident #41 on his individualized provided to the provid	9 for rt was or the hers: s use e DON. tion staff. ewed ovided e to olan.	DATE
	and trained medicathey bring up concerned had not had any sphim. They further in hit other residents in months has gotten hitting other residents or supervisor During interview or practical nurse (LP R41 striking out an reported to her, the During interview or stated we first prote the threat, and ther if a resident hits an reported. When rev from 1/7/19, DON rethat incident and do	14/23/19, at 3:48 p.m. NA-B ation aide (TMA)-A indicated terns about R41 behaviors but ecialized training to care for adicated he has attempted to for a year now, and the last six worse. When they witness him ats, it is reported to the charge of the char			Behaviors will continue to be a prim focus to the discussion at morning Conference on an ongoing basis to assure any residents with behaviors are not being adequately managed reviewed and interventions are in etall incidents will be discussed at more Quality Conference to assure the proper the Abuse Prevention Plan has followed.  Date of Compliance: 6/4/2019  Recurrence will be prevented by: Audits of all resident to resident incuring will occur weekly x 4 and then mone to assure the Abuse Prevention Plan been followed to include protection, reporting, investigation and interver The results of these audits will be swith the facility QAPI Committee for on the need to increase, decrease discontinue the audits.	Quality s which are ffect. orning rocess been idents thly x2 an has ntion. chared r input	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED
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		245067	B. WING			04/2	25/2019
	NAME OF PROVIDER OR SUPPLIER  THE EMERALDS AT FARIBAULT LLC			50	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTHEAST FIRST STREET ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	what interventions after that incident to DON confirmed the concerns, grievand stated "I am at a load ime and can reconcerns and can reconcern and can reconcern and can incident ago of R41 hitting a started filling out and to the DON; however the progress notes report and was una incident. LPN-D fur specific intervention re-directing him. During interview or registered nurse (Finformed of resider altercation, it is brown and the progress in the decision RN-A further indicated will call staff and in R41 has stuck other to get in other resider that was in During interview or acting administrated been filed to the strincident on 1/7/19, that any resident to needed to be reported.	would have been put in place or protect the other residents." ere is a concern with reporting res and incidents. Further, he say with R41, he can change on quire constant redirection." a 4/25/19 at 11:16 a.m., LPN-D of report resident to resident supervisor or DON. She would incident report on paper, but by the DON if there is no injury red to complete it. LPN-D at about two to three months another resident where she in incident report and reported it rer, when she looked through she could not find the incident able to recall the date of the ather indicated there were no must in place for R41 other than at 4/25/19 at 12:22 p.m., RN)-A indicated when she is not to resident physical regidents before and he likes that to resident physical residents before and he likes that the attention with the residents before and he likes that a treatment at 1:23 p.m., the resident physical altercation with the moved to the dementia unit. A 4/25/19 at 1:23 p.m., the resident physical altercation that agency related to the The administrator also verified or resident physical altercation that agency related to the The administrator also verified or resident physical altercation that resident physical physical physical physical physical phys	F 6	;00	Corrections will be monitored by: Administrator/DON/ADON/Nurse Managers		

245067 B. WING CO 4/29  NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	25/2019
THE EMERALDS AT FARIBAULT LLC  500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 CHC no later than 2 hours after forming suspicion of abuse.  F 609  Reporting of Alleged Violations  F 609  SS=D  Figure 2011 response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	6/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVE COMPLETED		
		245067	B. WING				25/2019
	PROVIDER OR SUPPLIER ERALDS AT FARIBA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021				
(X4) ID PREF <b>I</b> X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	must:  §483.12(c)(1) Ensinvolving abuse, no mistreatment, inclusions after the allest that cause the allest that cause the allest that cause the allest that cause that cause and do not the administrator of the administr	ure that all alleged violations eglect, exploitation or uding injuries of unknown propriation of resident property, ediately, but not later than 2 egation is made, if the events gation involve abuse or result in ry, or not later than 24 hours if use the allegation do not involve result in serious bodily injury, to of the facility and to other to the State Survey Agency re services where state law action in long-term care dance with State law through dures.  For the results of all the administrator or his or her entative and to other officials in state law, including to the State alleged violation is verified ative action must be taken.  ENT is not met as evidenced we and document review, the mediately report an incident of the administrator and state of 1 resident (R41) reviewed for	F6	609	Immediate Corrective Action: SBA review and seen by PCP with media review completed on week of 4/29/Pending VAMC approval, Resident be seen by psychologist on: 5/29/19 input on aggressive behavior management plan. An OHFC repofiled and investigation completed for potential Incident of 1/7/2019. Corrective Action as it applies to oth The Abuse Prevention Plan remain	cation 19. #41 to for rt was r the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245067	B. WING			25/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		20/2010	
(X4) ID PREF <b>I</b> X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 609	injury.  R41's progress no "was in the tv (tele yelling at other resand fuckers," and sarm."  During interview o stated we first protect the threat, and the if a resident hits arreported. When refrom 1/7/19, DON that incident and cresident was." He what interventions after that incident DON confirmed th reported to the stath there is a congrievances and incomplete the progress and incomplete the progress notes are port and was un incident.  During interview of the progress notes are port and was un incident.	te dated 1/7/19, indicated R41 vision) area swearing and idents, calling them 'assholes struck another resident in the n 4/25/19 at 10:34 a.m., DON teet the residents and remove in report it. His expectation was nother resident it would be viewing R41 progress note responded, "I didn't know about lon't know who the other further responded "I don't know would have been put in place to protect the other residents." at this incident was not te agency and also confirmed cern with reporting concerns,	F 609	current. Immediate re-education on the Prevention Plan was provided Re-education on the Abuse Prevention Plan will be held on 5/30/19 for The aggressive behavior plant Resident #41 care plan was retremains current.  NAR Care cards, and education to all nursing staff who provide Resident #41 on his individuali Behaviors will continue to be a focus to the discussion at more Conference on an ongoing bas assure any residents with behaviors are not being adequately manareviewed and interventions are All incidents will be discussed Quality Conference to assure the per the Abuse Prevention Plant followed.  Date of Compliance: 6/4/2019 Recurrence will be prevented the all resident to resident incident weekly x 4 and then monthly x the Abuse Prevention Plant has followed to include protection, investigation and intervention. Of these audits will be shared we facility QAPI Committee for inpineed to increase, decrease or the audits.  Corrections will be monitored to Administrator/DON/Nurse Management of the second of th	to the DON. evention all staff. for viewed and on provided care to zed plan. primary ning Quality sis to aviors which aged are effective. at morning he process has been by: Audits of s will occur to assure s been reporting, The results with the out on the discontinue		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		245067	B. WING		04	C <b>/25/2019</b>		
	PROVIDER OR SUPPLIER ERALDS AT FARIBAL	ILT LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE		
F 609	been filed immedia to the incident on 1 verified that any resaltercation needed agency right away. administrator indicare-educated on what timeframe it should Review of the Abus 12/2018 indicated to residents are not strincluding, but not limited the residents, consultared agencies serving the legal guardian, frier policy also identified for reporting any sittle abuse or neglect. At the routed per facility be notified immediated the residents from possimisconduct or injurinvestigated. If this the nurse will also a of the injury. If it is a bused resident will environment and all ensured. Notification immediately of any alleged or suspected origin, neglect, final involuntary seclusion Furthermore, it indicattercation must be Department of Heal	tely to the state agency related /7/19. The administrator also sident to resident physical to be reported to the state Furthermore, the state that the DON will be at needs to be filed and the	F6	609				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245067	B. WING_			C <b>25/2019</b>
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	20/2013
				500 SOUTHEAST FIRST STREET		
THE EME	ERALDS AT FARIBAU	JLT LLC		FARIBAULT, MN 55021		
(X4) <b>I</b> D	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	 NC	(X5)
PREF <b>I</b> X TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF <b>I</b> X TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLETION DATE
F 609	Continued From pa	age 13	F 60	09		
	forming suspicion of	~				
		t/Correct Alleged Violation	F 61	0		6/4/19
00-0	0111(0): 100:12(0)(	_/ ( '/				
		onse to allegations of abuse, n, or mistreatment, the facility				
	§483.12(c)(2) Have violations are thoro	e evidence that all alleged ughly investigated.				
		ent further potential abuse, n, or mistreatment while the rogress.				
	designated represe accordance with St Survey Agency, wit incident, and if the appropriate correct	ort the results of all e administrator or his or her entative and to other officials in rate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced				
	Based on interview facility failed to inveto resident abuse a interventions to pro	v and document review, the estigate an incident of resident and failed to implement attect the unknown resident for resident to resident abuse.		Immediate Corrective Action: SB review and seen by PCP with med review completed on week of 4/29 Pending VAMC approval, Resider be seen by psychologist on: 5/29/input on aggressive behavior	dication 9/19. nt #41 to	
	Findings include:			management plan. An OHFC rep		
	stroke with right sid move that side of th injury.	sheet included diagnoses of a led hemiplegia (inability to ne body) and traumatic brain himum data set (MDS), dated		potential Incident of 1/7/2019. Corrective Action as it applies to contract the Abuse Prevention Plan remains current. Immediate re-education on the Abuse Prevention Plan was provided to the Prevention Plan was p	others: ns ouse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L. IDENTIFICATION NUMBER: L.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245067	B. WING			04/2	25/2019	
	PROVIDER OR SUPPLIEF ERALDS AT FARIBA			5	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTHEAST FIRST STREET ARIBAULT, MN 55021	<u>, , , , , , , , , , , , , , , , , , , </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH SHOU		) BE	(X5) COMPLETION DATE	
F 610	3/21/19, indicated and verbal behavior others 1-3 days do R41's progress no "was in the tv (tele yelling at other resand fuckers," and arm."  During interview of stated "He is out of the threat, and the resident hits another reported. When refrom 1/7/19, DON that incident and of resident was." DO what interventions after that incident DON confirmed the reporting concerns Further, he stated can change on a concerning concerns. The stated can change on a concerning concerning concerns that incident incident polynomial concerns that incident incident polynomial concerns that incident incident polynomial concerns that incident incident incident polynomial concerns that incident inci	severe cognitive impairment oral symptoms directed towards uring the reference period.  Set edated 1/7/19, indicated R41 evision) area swearing and sidents, calling them 'assholes struck another resident in the	F6	310	Re-education on the Abuse Prever Plan will be held on 5/30/19 for all some The aggressive behavior plan for Resident #41 care plan was review remains current.  NAR Care cards, and education proto all nursing staff who provide care Resident #41 on his individualized Behaviors will continue to be a prin focus to the discussion at morning Conference on an ongoing basis to assure any residents with behavior are not being adequately managed reviewed and interventions are effected. Incidents will be discussed at magnetic quality Conference to assure the paper the Abuse Prevention Plan has followed.  Date of Compliance: 6/4/2019  Recurrence will be prevented by: A all resident to resident incidents will weekly x 4 and then monthly x2 to the Abuse Prevention Plan has been followed to include protection, repositivestigation and intervention. The of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discount to the sum of the second to the second	staff.  yed and  ovided e to plan. nary Quality os which I are ective. orning process s been  audits of II occur assure en orting, e results the n the ontinue		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION		E SURVEY PLETED	
		245067	B. WING			1	C <b>25/2019</b>	
	PROVIDER OR SUPPLIER	LT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021			,		
(X4) ID PREF <b>I</b> X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 610	1/7/19, and did not were put in place to the facility.  During interview on acting administrator been filed to the staincident on 1/7/19, that any resident to needed to be report the administrator in re-educated on what timeframe it should.  Review of the Abus 12/2018 indicated the residents are not suincluding, but not lir residents, consultar agencies serving the legal guardian, frier policy also identified for reporting any sit abuse or neglect. At to routed per facility be notified immediate determine if any emrequired. Staff will the residents from possimisconduct or injurinvestigated. If this the nurse will also a of the injury. If it is rabused resident will environment and all ensured. Notificatio immediately of any alleged or suspected.	know of any interventions that protect the other residents at 4/25/19, at 1:23 p.m., the indicated a report had not the agency related to the The administrator also verified resident physical altercation the right away. Furthermore dicated that the DON will be at needs to be filed and the		310				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMF	COMPLETED	
		245067	B. WING_		04/2	; 25/2019	
	PROVIDER OR SUPPLIER	ULT LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021			
(X4) ID PREF <b>I</b> X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 610	involuntary seclusic Furthermore, it indi- altercation must be Department of Hea reported to OHFC I forming suspicion of	on will occur immediately. cated that resident to resident reported to the Minnesota Ith. Suspected abuse shall be no later than 2 hours after of abuse.	F 62			CIAIAO	
F 661 SS=D	§483.21(c)(2) Disclet When the facility armust have a dischart but is not limited to (i) A recapitulation of includes, but is not of illness/treatment radiology, and consection of illness/treatment radiology, and consection of the disconsection of the disconsection of the consent of the consent of the representative.  (iii) Reconciliation of medications with the medications (both pover-the-counter).  (iv) A post-dischart developed with the and, with the resider representative(s), wadjust to his or her post-discharge plart the individual plans that have been marked and any post-non-medical service.	narge Summary nticipates discharge, a resident arge summary that includes, the following: of the resident's stay that limited to, diagnoses, course or therapy, and pertinent lab, sultation results. of the resident's status to ragraph (b)(1) of §483.20, at harge that is available for ed persons and agencies, with resident or resident's of all pre-discharge e resident's post-discharge orescribed and ge plan of care that is participation of the resident ent's consent, the resident which will assist the resident to new living environment. The n of care must indicate where to reside, any arrangements de for the resident's follow up discharge medical and	F 66	51		6/4/19	

1 ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A BUILDI			COM	DATE SURVEY COMPLETED	
		245067	B. WING				25/2019	
	PROVIDER OR SUPPLIER ERALDS AT FARIBAL	ULT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021			<u> </u>		
(X4) <b>I</b> D PREF <b>I</b> X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 661	facility failed to ens completed at dischareviewed for closed Findings include:  R72's closed medical admitted to the faci infraction, hemipled discharged from the son. R72's medical evidence of R72's referral was sent to initiate home care for discharge home with 1/26/19, indicated for discharge home with 1/26/19, indicated for discharge/transistatus, vital signs a functioning status, at treatments for discharge in the reconciliation of meand therapy after care.	and document review, the ure recapitulation of stay was arge for 1 of 1 (R72) resident I record review.  Cal record indicated R72 was lity with diagnoses of cerebral gia and hemiparesis. R72 as facility on 1/26/19, with her record revealed there was no recapitulation of stay.  Les dated 1/24/19, indicated a standard home health agency to for 1/26/19, when R72 was to the her son. The note dated R72 was discharged with her rereson's home with outpatient liminum Data Set dated R72 had discharged from the atticipated.  Leansfer Summary completed and R72's activities while at the decided R72's activities while at the discharge summary, reason fer, mental and psychosocial that discharge, physical assistive devices needed, marge, dental condition, adications, dietary information	F 6	61	Immediate Corrective Action: Resi #72 Discharge Summary was comp Corrective Action as it applies to off The Discharge Summary Policy rencurrent.  All residents who have been dischawithin the last 30 days will be review assure all have a completed Discha Summary which includes a thorough recapitulation of the stay.  Re-education on the Discharge Sum Policy was completed with the ID Todate of Compliance: 6/4/2019  Recurrence will be prevented by: An all discharged residents will occur with a viction of the stay. The result have a complete and thorough Discontinues and thorough Discontinues and the prevented with the QAPI Committee for input on the neincrease, decrease or discontinue thaudits.  Corrections will be monitored by: DON/ADON/Nurse Managers	oleted. hers: hains rged ved to arge h mmary eam. udits of veekly they charge Its of facility eed to		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BU <b>I</b> LDI	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		245067	B. WING			C <b>25/2019</b>
	PROVIDER OR SUPPLIER ERALDS AT FARIBAU	ILT LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	<del> </del>	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684 SS=D	continued after discommunity resource and who to contact During an interview registered nurse (R locate R72's recapir RN-C stated it should discharge and a corresident.  During an interview RN-B confirmed the Summary and Discompleted at the time During an interview director of nursing sfor a recapitulation residents upon discompleted at the time During an interview director of nursing sfor a recapitulation residents upon discompleted at 11/201 information, including home care agency be prepared."  Quality of Care CFR(s): 483.25  § 483.25 Quality of Quality of care is a	n review, treatments to be charge, diet instructions, es, follow-up appointments with questions were left blank.  on 4/25/19, at 10:50 a.m.  N)-C stated she was unable to tulation of stay at discharge. In the state of discharge at 2:05 p.m.  Discharge/Transfer harge Instructions were not the of discharge.  on 4/25/19, at 2:57 p.m. the stated it was his expectation of stay to be completed for harge.  ischarge Planning Policy ischarge Planning Policy ischarge form to appropriate or other nursing facility, must	F 6			6/4/19
	facility residents. Ba assessment of a re that residents received accordance with pro-	ent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245067	B. WING			04/2	25/2019	
	PROVIDER OR SUPPLIER ERALDS AT FARIBA			50	REET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTHEAST FIRST STREET ARIBAULT, MN 55021	0-112	.0,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 684	care plan, and the This REQUIREME by: Based on observareview, the facility sleeve was provide orders for 1 of 1 re of care services.  Findings include: R6's Face Sheet of had diagnosis include an extremity). R6's physician ord was to have tubi-glegs. On in a.m. are evening shift for each of the control of	residents' choices. ENT is not met as evidenced ation, interview, and document failed to ensure a tubi-grip armed according to physician esident (R6) reviewed for quality atted 10/16/17, indicated R6 ading lymphedema (swelling in ers dated 3/5/19, indicated R6 rips to right arm and both lower and off in p.m. every day and dema.  ed 4/24/19, did not include the grips.  D p.m. R6 was observed sitting by the medication cart without a not arm which appeared to have a price of the price	F 6	884	Immediate Corrective Action: Res #6 Tubi grips to right arm and both legs will be applied in the AM and removed in PM and any treatment refusals will be documented. MD was notified of consistent refusals to determine if another treatment shou attempted.  Corrective Action as it applies to other treatments ordered remourant.  Resident #6 care plans/Kardex will reviewed to assure treatments ordered are indicated.  Reseducation on providing treatment documenting refusals will be held off all nursing staff.  Date of Compliance: 6/4/2019  Recurrence will be prevented by: A5 resident treatments will occur were and then monthly x 2 to assure the treatment or refusal has been documented, and consistent refusal reported to MD. The results of the audits will be shared with the facility Committee for input on the need to increase, decrease or discontinue the audits.  Corrections will be monitored by: DON/ADON/Nurse Managers	lower  vill be  uld be hers: to hains be ered hts and n 5/30  udits of ekly x 4  Is are se v QAPI		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) M A. BUI			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245067	B. WING				2 <b>5/2019</b>	
	PROVIDER OR SUPPLIER ERALDS AT FARIBAU	ILT LLC		5	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	, , , , , ,		
(X4) ID PREF <b>I</b> X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE	
F 684	refused the tubi-grip it for his right arm in his arm swelling.  On 4/24/19, at 9:43 (TMA)-A stated R6 the tubi-grips and sarm for a long time refusals should be administration reco  On 4/24/19, at 3:12 (LPN)-A stated ther the application of a extremities and his have been noted by confirmed R6 did noright arm at this time.  On 4/24/19, at 8:45 stated R6 is pretty i seen a tubi-grip on one on at this time.  On 4/24/19, at 10:1 (DON) stated he was the tubi-grip on his documentation of horder is for tubi-grip and his right arm ar been separated so any of the three who track him better. It a care plan but was nonfirmed the TAR his right arm on day	a.m. trained medication aide often refuses things including he had not seen them on his TMA-A also stated any charted in the treatment rd (TAR).  p.m. licensed practical nurse was an area on the TAR for tubi-grip to his lower right arm and refusals should ut had not been. Rebecca ot have the Tubigrip on his e and often did not.  a.m. nursing assistant (NA)-A ndependent and had not ever his right arm and did not have  4 a.m. the director of nursing as aware R6 should have had	F6	i84				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		LE CONSTRUCTION (X3	(X3) DATE SURVEY COMPLETED	
		245067	B. WING	_			C 25/2019
	PROVIDER OR SUPPLIER ERALDS AT FARIBA			5	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
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F 689 SS=D	S483.25(d) Accide The facility must e §483.25(d)(1) The as free of accident §483.25(d)(2)Each supervision and as accidents. This REQUIREME by: Based on observareview, the facility assistance to prevent (R26) observed du Findings Include: R26's quarterly Min 2/16/19 included dhemiplegia/hemiplegia	nts. nsure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent  NT is not met as evidenced tion, interview, and document failed to provide adequate ent an accident 1 of 1 resident ring a transfer using a device.  nimum Data Set (MDS) dated tagnoses of tresis (paralysis or weakness ementia without behavior  sk Assessment Welcov HC, cated R26 was at risk for falls taff to assist with all Hoyer lift ed to lift and move a patient ount of effort from an assistant	F6	689	Immediate Corrective Action: Nursing Assistant D was counseled on the failt to follow the Lift Policy and Procedure transferring Resident #26 on 4/23/19 va Hoyer lift without a trained second person to assist. 2 assistants needed a Hoyer lift transfer was confirmed on Resident #26 care plan/Kardex. Corrective Action as it applies to other 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 a nursing staff.  Date of Compliance: 6/4/2019  Recurrence will be prevented by: Audi 5 residents transferred with a Hoyer lift occur weekly x 4 and then monthly x 2 assure the proper assistance of 2 staf provided. The results of these audits v be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the	g ure for with for rs: sits of ft will to ff is will	6/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245067	B. WING		04	C /25/2019	
	PROVIDER OR SUPPLIER ERALDS AT FARIBA	ULT LLC		STREET ADDRESS, CITY, STATE, ZIP CO 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	•		
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F 689	staff to use a Hoye complete the task.  On 4/23/19, at 11:2-D was observed to the student nurse (SNA-D began to cortise SN-A turned to NA with Hoyer Lift transfer without as R26's transfer and stated R26 stayed gets her up." NA-D On 4/23/19, at 11:3 using a Hoyer lift, the needed, "for stand pushes the button stated she was awassist with the transfer without an assist.  On 4/25/19, at 1:40 transferring R26 vito a bed. NA-E state to transfer a reside lift." NA-D stated between the transfer a reside lift. "NA-D stated between the transfer a reside lift." NA-D stated between the transfer a reside lift. "NA-D stated between the transfer a reside lift." NA-D stated between the transfer and able to that it was not beneas, "a standby."  On 4/25/19, at 1:47 nurse (LPN-B) statuse two staff mem a Hoyer lift. LPN-B	age 22 a.m., nursing assistant (NA) ransporting R26 into her room. N-A) also entered R26's room. nect the sling to the Hoyer liftD and stated, "I cannot assist sfers, I have not been trained." continued with the Hoyer lift sistance from SN-A. After cares were complete, NA-D in bed until the, "evening shift and SN-A left the room.  30 a.m., NA-D stated when wo staff members were by, just in case someone and moves the Hoyer." NA-D are SN-A was not able to sfer of R26 using a Hoyer lift. hould have not completed the other trained staff available to D p.m., two staff were observed a Hoyer lift from a wheelchair ated, "We always use two staff that when using a mechanical oth staff members need to be assist. NA-E further explained efficial if staff was only available.  7 p.m., a licensed practical and the facility's protocol was to bers to assist in transfers with further explained if a staff or a not trained to use an electric.	F 689	audits. Corrections will be monitored DON/ADON/Nurse Managers			

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		245067	B. WING_			C <b>25/2019</b>	
	PROVIDER OR SUPPLIER ERALDS AT FARIBAL	JLT LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021			
(X4) ID PREF <b>I</b> X TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 689	lift to transfer a resi would need to be s transfer. LPN-B sta always use two star knowledgeable reg. On 4/25/19, at 2:04 she expected anyo Hoyer lift transfer w student nurses who facility. The administration off the cart to further stated NA-E student was not transfers and, "ther any way."  The facility's Lift Poduly 2017, indicated	ident, another staff member ought out to assist in the sted staff was directed to ff who were trained and arding a Hoyer lift transfer.  p.m. the administrator stated ne who assisted a resident in a would be trained, including a were doing a clinical in the strator further stated staff lip even if it meant "taking a behelp." The administrator was aware the nursing ined in the area of Hoyer lift refore was unable to assist in solicy and Procedure, revised dia portable lift was to be used stants to perform the	F 68	99			
	Nurse Aide Peform CFR(s): 483.35(d)( §483.35(d)(7) Regulation The facility must confevery nurse aide months, and must reducation based or reviews. In-service requirements of §4 This REQUIREMED by:  Based on interview facility failed to come evaluations (PE) for the service of	ular in-service education. Emplete a performance review at least once every 12 provide regular in-service the outcome of these training must comply with the	F 73	Immediate Corrective Action: Ar Performance Reviews were compared Education was assigned to NAR:	oleted on Annual		

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		245067	B. WING_			C <b>25/2019</b>
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		20/2010
THE EMERALDS AT FARIBAULT LLC			500 SOUTHEAST FIRST STREET			
I HE EIVIE	RALDS AT FARIBAU	LI LLC		FARIBAULT, MN 55021		
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F 730	Continued From pa	ge 24	F 73	30		
	failed to ensure req	a year. In addition, the facility uired annual education was 5 NA's (NA-E, NA-F, NA-I).		I with a date of completion. Corrective Action as it applie The Policy for required Perf Reviews and Education rem HR Director and DON have	ormance nains current.	
	Review of NA and 74/25/19, revealed the NA-E's date of hire personnel file lacker and/or 12 hours of NA-F's DOH 2/26/2 evidence of completed education NA-G's DOH 1/19/2 evidence of complete NA-H's DOH 11/7/2 evidence of complete NA-I's DOH: 8/30/2 of completed PE are education.	e (DOH) 7/31/15, NA-E's d evidence of completed PE completed education; 16, NA-F's file lacked ted PE and/ or 12 hours of on; 16, NA-G's file lacked ted PE; 18, NA-H's file lacked		rolling calendar plan for required performance Reviews to incomplete assurance of required annual All Nursing Assistants will be assure a schedule to get curequired education and Performance as the Reviews has been set.  Re-education on the Required hours of education per rolling year and required education on 5/30/19 for all nursing standard performance will be prevented to assure they are completed of these audits will be share facility QAPI Committee for need to increase, decrease	uired NAR clude al education. e reviewed to irrent with formance rements for 12 ng calendar n will be held aff. 19 ed by: Audits of d annual e Reviews due en monthly x 2 ed. The results ed with the input on the	
	administrator stated to be completed an interview at 4:10 p.r was her expectation completed timely.	d it was her expectation for PE nually. During a subsequent m. the administrator stated it n for required education to be regarding PE and education		the audits. Corrections will be monitore HR/DON/ADON		
	were requested, bu Pharmacy Srvcs/Pr CFR(s): 483.45(a)(l	t not provided. ocedures/Pharmacist/Records o)(1)-(3)	F 75	55		6/4/19
	§483.45 Pharmacy The facility must pro	Services ovide routine and emergency				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				STREET ADDRESS, CITY, STATE, ZIP C 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	•	1 04/20/2010	
PRÉF <b>I</b> X	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 755	•	~	F 75	55			
	them under an agr §483.70(g). The fa personnel to admir permits, but only u	eement described in acility may permit unlicensed nister drugs if State law					
	pharmaceutical se that assure the acc dispensing, and ac	rvices (including procedures curate acquiring, receiving, Iministering of all drugs and					
		e Consultation. The facility tain the services of a licensed					
		rides consultation on all rision of pharmacy services in					
		blishes a system of records of ition of all controlled drugs in enable an accurate					
	order and that an a is maintained and	ermines that drug records are in account of all controlled drugs periodically reconciled. NT is not met as evidenced					
	Based on interview facility failed to ensign patches) were design manufactures guid storage of used meand accidental confor 1 of 1 resident	w and document review, the sure Fentanyl (narcotic pain troyed according to elines to prevent inappropriate edication, potential diversion, tact by staff through handling (R34) reviewed for medication entanyl patches ordered.		Immediate Corrective Action practice of flushing used Feinto sewer was confirmed a incorrect destruction methodiscovered.  Corrective Action as it appliated The Policy for Fentanyl Pateremains current.	ntanyl patches s soon as the d was es to others:		

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		245067	B. WING		04/2	; 25/2019
	PROVIDER OR SUPPLIER	ULT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE  500 SOUTHEAST FIRST STREET  FARIBAULT, MN 55021			10/2010
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F 755	Findings include:  R34's physician ord medical record (EN Fentanyl Patch 72 micrograms(MCG) transdermally one chronic pain syndromatic patches were folder sharps container. It was to be performed witnessed by a second second patch and removation of the patch and syndromatic patch and dissipatch and said sharps container. It wanted to verify the assistant (A) DON minutes and said shapon and used Fernand said shapon said said said said said said said said	ders from the electronic MR), dated 4/6/19 included: hour 25 /hour(Hr). Apply 1 patch time a day every 3rd day for ome.  sing (DON) was interviewed on an and stated used Fentanyled in half and disposed of in a The disposal of the used patched by a licensed nurse and cond staff member. The DON check with additional staff who ed the patches as wasn't he process being utilized.  5 p.m. licensed practical nurse viewed about application and yl patches and confirmed she used patch, fold it up and harps container as she was cond staff member.  ewed on 4/24/19, at 1:33 p.m. cleases she would follow for a ch would be to remove from the new patch and then fold the spose of with a witness into a LPN- hesitated and stated she as process for disposal with the changle patches were to be harps container witnessed by a	F 758	Education on the correct method destroying Fentanyl patches into with 2 witnesses per Policy will b 5/30/19 with all licensed nurses. policy changes will be communic staff as dictated by local municip the MN Dept of Health or the Sta Operations Manual.  Date of Compliance: 6/4/2019  Recurrence will be prevented by: the process for destruction of Fe patches will occur 5x weekly x 4 and then monthly x 2 months to a is correctly completed per Policy. results of these audits will be shathe facility QAPI Committee for in the need to increase, decrease of discontinue the audits.  Corrections will be monitored by: DON/ADON/Nurse Managers	sewer e held on All future cated to alities or ite  Audits of intanyl weeks assure it The ared with input on or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ILT LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 755	not aware of the receive the recommended of patches into the serperson. The DON from aware of any city or used Fentanyl patch.  A facility Policy and Application and Deslisted the policy as: medication handling and reconciliation or order to minimize to safe handling, deliving fentanyl patch. The implementation inclient and fold the adhesimo exposed medicate the locked medicate adhesive sides), collog or Medication Delicensed nurses was in toilet paper and folicensed nurses must the proper form for Infection Prevention CFR(s): 483.80 (a)(s) §483.80 Infection CFR(s): 483.80 (a)(s) §483.80 Infection prevention designed to provide comfortable environ	p.m. the DON stated he was gulation change with regard to disposal of used Fentanyl wer witnessed by a second urther confirmed he was not dinance prohibiting disposal of hes into the sewer.  Procedure Fentanyl Removal, struction, dated October 2013, To address safe and secure g and storage, limit access f controlled substances in loss or diversion and provide ery and disposal of the expolicy interpretation and uded Remove fentanyl patch we sides together so there are ation. Take the used patch to on room (without touching mplete Fentanyl destruction isposal Form. With two apping the used fentanyl patch lushing down the sewer. Two lest verify destruction and sign proof of destruction.  A Control 1)(2)(4)(e)(f)  Control tablish and maintain an and control program as asfe, sanitary and ment and to help prevent the ansmission of communicable	F 7			6/4/19

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	СОМ	E SURVEY PLETED
		245067	B. WING				C <b>25/2019</b>
	PROVIDER OR SUPPLIER ERALDS AT FARIBAL	ULT LLC		500	EET ADDRESS, CITY, STATE, ZIP CODE SOUTHEAST FIRST STREET RIBAULT, MN 55021	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	§483.80(a) Infection program. The facility must estand control program a minimum, the following states of the stat	tablish an infection prevention (IPCP) that must include, at owing elements:  stem for preventing, g, investigating, and controlling municable diseases for all unteers, visitors, and other g services under a contractual upon the facility assessment to §483.70(e) and following standards;  en standards, policies, and program, which must include, or eillance designed to identify able diseases or ey can spread to other ty; nom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a	F8	80			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	` ´com	E SURVEY PLETED
		245067	B. WING_			C <b>25/2019</b>
	PROVIDER OR SUPPLIER ERALDS AT FARIBA	JLT LLC		STREET ADDRESS, CITY, STATE, ZIP CO 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	•	
(X4) <b>I</b> D PREF <b>I</b> X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	contact will transm (vi)The hand hygie by staff involved in §483.80(a)(4) A sy identified under the corrective actions §483.80(e) Linens. Personnel must hat transport linens so infection.  §483.80(f) Annual The facility will con IPCP and update to This REQUIREME by: Based on observative with facility fipractices during a resident (R52). In a censure infection con while assisting a resident (R34).  Findings include:  R52's physician on Santyl (ointment usulcers and wounds over the wound, see left lower leg and control of Registered nurse (4/24/19, at 8:26 a.1 for R52 to a wounds	nts or their food, if direct it the disease; and ne procedures to be followed direct resident contact.  stem for recording incidents a facility's IPCP and the taken by the facility.	F 88	Immediate Corrective Action re-educated on the Dressing Policy to include washing han and after donning gloves. Note-educated on the need to wapply gloves or use silverward any food to handle any finger Corrective Action as it applies. The Policy for Handwashing and Culinary staff re-educated on the use of PP Handwashing Policy of handle foods on 5/30/19. All licenses be re-educated on the Dressi Policy on 5/30/19. Date of Compliance: 6/4/2015 Recurrence will be prevented 5 meals and 5 dressing changoccur weekly x 4 weeks and the contraction of the processing changoccur weekly x 4 weeks and the contraction of the processing changoccur weekly x 4 weeks and the contraction of the processing changoccur weekly x 4 weeks and the processing changos are processing changos and the processing changos and the processing changos are processing changos are processing changos and the proce	change ids before A-C was rash hands, e to touch foods. s to others: and Dressing will be E and ing finger ed nurses will ng Change by: Audits of ges will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION  NG	COM	E SURVEY IPLETED	
		245067	B. WING_			C <b>25/2019</b>
	PROVIDER OR SUPPLIER ERALDS AT FARIBAL	JLT LLC		STREET ADDRESS, CITY, STATE, ZIP 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPR <b>I</b> ATE	(X5) COMPLETION DATE
F 880	the dressing changeroom and touched hands looking for a proceeded to take that had a minimal drainage for the lef of gloves. After rendressing RN-A did hands before apply During interview or nurse practitioner (be that staff would change and staff stand wash hands af During interview or RN-A stated "I knowash my hands be start." RN-A also in that she should charafter removing a score During interview or assistant director of expectation is that their hands after remove gloves. After remove gloves. After remove gloves and bag. Then wash has staff should apply round the supper meal we 6:20 p.m The nurse of the composition of the supper meal we 6:20 p.m The nurse round to the composition of the supper meal we 6:20 p.m The nurse round to the composition of the supper meal we 6:20 p.m The nurse round to the composition of the supper meal we 6:20 p.m The nurse round to take the composition of the composition	the RN-A then went out of the the door frame with her gloved another staff member. Then off the soiled gauze dressing amount of serosanguinous it lower leg with the same pair noving the soiled gauze not change gloves or wash ving the new dressing.  1. 4/25/19, at 9:49 a.m. the NP) stated expectation would wash hands before a dressing hould would take off gloves, iter removing the old dressing.  1. 4/25/19, at 12:30 p.m. with we I messed up once, I did not before I put my gloves on to adicated that she was aware ange gloves and wash hands biled dressing.  1. 4/25/19, at 12:57 p.m. the of nurses (ADON) stated "my staff change gloves and wash emoving a soiled dressing."  1. 4/25/19, at 12:57 p.m. the of nurses (ADON) stated "my staff change gloves and wash emoving a soiled dressing."  1. 4/25/19, at 12:57 p.m. the of nurses (ADON) stated "my staff change gloves and wash emoving a soiled dressing."  1. 4/25/19, at 12:57 p.m. the of nurses (ADON) stated "my staff change gloves and wash emoving a soiled dressing."  1. 4/25/19, at 12:57 p.m. the of nurses (ADON) stated "my staff change gloves and wash emoving a soiled dressing."  1. 4/25/19, at 12:57 p.m. the of nurses (ADON) stated "my staff change gloves and wash emoving a soiled dressing."	F8	x 2 months to assure they correctly per Policy. The audits will be shared with the Committee for input on the increase, decrease or discussional disconnections will be monitor Director/ADON/Nurse Market Market Policy (ADON/Nurse Market) and the shared with the committee for input on the increase, decrease or disconnections will be monitor Director/ADON/Nurse Market Market Policy (ADON/Nurse Market) and the shared with the committee for input on the increase, decrease or disconnections will be monitored by the committee for input on the increase, decrease or disconnections will be monitored by the committee for input on the increase, decrease or disconnections will be monitored by the committee for input on the increase, decrease or disconnections will be monitored by the committee for input on the increase, decrease or disconnections will be monitored by the committee for input on the increase of the committee for input on the committee for input o	results of these the facility QAPI e need to continue the red by: Culinary	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245067	B. WING				C <b>25/2019</b>
	PROVIDER OR SUPPLIER	ULT LLC		50	REET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTHEAST FIRST STREET ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 883	by her ear and then NA-C again picked ungloved hand and of food. NA-C place her thighs, then pic gave it to R34.  During interview on director of nursing (always wear gloves directly.  During interview on assistant director of staff were not supphands.  During interview on dietary manager (D be touching food rehands.  Review of the Hand 2017, makes no metouch food with unguingluenza and Pneu CFR(s): 483.80(d) (1) [S483.80(d) (1) Influenza immunizations S483.80(d) (1) Influenza and procedure in the same policies and procedure in the same place in the same procedure in the same place	buched R43's oxygen tubing a straightened out her blanket. up her bun with the same attempted to give R34 a bite both her hands on the top of ked up a potato wedge and 4/25/19, at 11:00 a.m. the (DON) stated staff should if they were touching foods 4/25/19, at 11:14 a.m. the finursing (ADON) indicated osed to pick food up with bare 4/25/19, at 12:37 p.m. the M) confirmed staff should not ady to eat with their bare dwashing policy dated July ention that staff should not gloved hands.	F 8				6/4/19
	each resident or the receives education potential side effect	e resident's representative regarding the benefits and is of the immunization; offered an influenza					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245067		B. WING		C <b>04/25/2019</b>	
	PROVIDER OR SUPPLIER ERALDS AT FARIBAL	ULT LLC		5	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTHEAST FIRST STREET ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 883	annually, unless the contraindicated or to immunized during to (iii) The resident or has the opportunity (iv) The resident's indocumentation that following:  (A) That the resident was provided educt and potential side of immunization; and (B) That the resident immunization or dictimunization or dictimunization due to refusal.  §483.80(d)(2) Pneumust develop policit that—  (i) Before offering to immunization, each representative receive benefits and potent immunization;  (ii) Each resident is immunization, unleadically contrained already been immunization or has the opportunity (iv) The resident's indocumentation that following:  (A) That the reside was provided eductions.	ber 1 through March 31 e immunization is medically the resident has already been his time period; the resident's representative to refuse immunization; and hedical record includes indicates, at a minimum, the ht or resident's representative ation regarding the benefits effects of influenza ht either received the influenza ht not receive the influenza h not receive the influenza h mococcal disease. The facility hes and procedures to ensure he pneumococcal h resident or the resident's hives education regarding the hial side effects of the hoffered a pneumococcal his sthe immunization is hicated or the resident has	F	883			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION  NG	СОМ	E SURVEY IPLETED
		245067	B. WING_			C <b>25/2019</b>
	PROVIDER OR SUPPLIER ERALDS AT FARIBAI	JLT LLC		STREET ADDRESS, CITY, STATE, ZIP C 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 883	immunization; and (B) That the reside pneumococcal immunization or This REQUIREME by: Based on interview facility failed to ensure viewed for immunication or This REQUIREME by: Based on interview facility failed to ensure viewed for immunication of the construction of the current guidelic Control and Prever recommended the conjugate vaccine or older. It recommolder administer PIPCV13.  R21's Admission RR21 was 67 years facility on 2/7/17. Rand Penicillin. The PCV13 date given eligible."  During an interview assistant director of R21's medical recommedical re	nt either received the nunization or did not receive immunization due to medical refusal.  NT is not met as evidenced w and document review, the sure 1 of 5 resident (R21) nizations, were offered and occal polysaccharide vaccine	F8	Immediate Corrective Actio #21 was administered the P vaccine. Corrective Action as it applies The Pneumococcal Policy recurrent. Whole House audits comples assure their Pneumococcal immunizations are current. All licensed nurses will be rethe Pneumococcal Policy or Date of Compliance: 6/4/20° Recurrence will be prevente staff members to the ADON established and educated to process is followed through. spreadsheet will be maintain all resident vaccines are offeadministered per resident wassure no eligible vaccines. The ADON/Designee will she facility QAPI Committee on a basis the number of vaccinarefusals for the month prior any negative trends. Corrections will be monitore DON/ADON/Designee	es to others: emains  eted by 4/25 to  e-educated on n 5/30/19. 19 ed by: Back up I have been o ensure this . An ongoing ned to assure ered and rishes to are missed. hare with the an ongoing ations and for input on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245067	B. WING			C / <b>25/2019</b>
	PROVIDER OR SUPPLIER	JLT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE  500 SOUTHEAST FIRST STREET  FARIBAULT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 883	11/2017, identified be administered to and CDC recomme	ge 34 Pneumococcal vaccination will resident, per physician order endations, and will be resident's medical record.	F 8			



Protecting, Maintaining and Improving the Health of All Minnesotans

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 <u>only a suggestion</u> 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

The Emeralds At Faribault Llc May 14, 2019 Page 2

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

The Emeralds At Faribault Llc May 14, 2019 Page 3

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT <b>I</b> PL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00571	B. WING		04/2	; 5/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EM	ERALDS AT FARIBAU	JI T I I C	HEAST FIRS			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING CORRECTION ORDER					
	144A.10, this corre pursuant to a surve found that the defic herein are not corre not corrected shall	Minnesota Statute, section ction order has been issued by. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment 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.					
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s	o participate in the electronic nsure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE Electronically Signed 05/23/19

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00571	B. WING		04/2	5/2019
NAME OF I	PROV <b>I</b> DER OR SUPPL <b>I</b> ER			STATE, ZIP CODE		
THE EM	ERALDS AT FARIBAU	Л I I I G:	HEAST FIRS LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ige 1	2 000			
	you electronically. is necessary for State enter the word "correct text. You must then State licensure processing to the state licensure processing the state in	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.				
	conducted to detern licensure. The followissued. Please indicorrection that you	h 4/25/19, a survey was mine compliance for state wing correction orders are icate your electronic plan of have reviewed these order, e when they will be corrected.				
		int investigations were also me of the licensing survey.				
		plaints were found to be not 67019C and H5067020C.				
	signature is not req page of state form. is required, it is req	ed in ePOC and therefore a uired at the bottom of the first Although no plan of correction uired that the facility pt of the electronic documents.				
2 285	MN Rule 4658.0100 Orientation and In-S		2 285			6/4/19
	must provide in-ser education must be continuing compete address areas iden assessment and as	e education. A nursing home rvice education. The in-service sufficient to ensure the ence of employees, must tified by the quality ssurance committee, and pecial needs of residents as				

Minnesota Department of Health

STATE FORM 6899 EZXR11 If continuation sheet 2 of 33

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:	: <u></u>		
		00571	B. WING		04/2	<i>;</i> 5/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
THE EM	ERALDS AT FARIBAU	)          C:	THEAST FIRE			
(VA) ID	STAMMADV STA	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTI	ON.	/VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG			(X5) COMPLETE DATE
2 285	Continued From pa	age 2	2 285			
	home must provide program in rehabilit to promote ambula living; assist in activ of range of motion, positioning; and in incontinence.	nursing home staff. A nursing e an in-service training tation for all nursing personnel tion; aid in activities of daily vities, self-help, maintenance and proper chair and bed the prevention or reduction of ent is not met as evidenced				
	by: Based on interview facility failed to com evaluations (PE) fo (NA-E, NA-F, NA-G the facility for over failed to ensure rec	and document review, the applete annual performance r 5 of 5 nursing assistants G, NA-H, NA-I) who worked at a year. In addition, the facility puired annual education was 5 NA's (NA-E, NA-F, NA-I).		Corrected		
	Findings include:					
	4/25/19, revealed the NA-E's date of hire personnel file lacked and/ or 12 hours of NA-F's DOH 2/26/ evidence of completed education NA-G's DOH 1/19/ evidence of completed education NA-H's DOH 11/7/ evidence of completed nA-H's DOH: 8/30/	e (DOH) 7/31/15, NA-E's ed evidence of completed PE completed education; 16, NA-F's file lacked eted PE and/ or 12 hours of on; /16, NA-G's file lacked eted PE; /18, NA-H's file lacked				
	human resources a	on 4/25/19, at 1:42 p.m. and the acting administrator are no current PE's on file. The				

Minnesota Department of Health

STATE FORM EZXR11 If continuation sheet 3 of 33

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00571	B. WING		C <b>04/25/2019</b>	
	PROVIDER OR SUPPLIER ERALDS AT FARIBAU	UTILC 500 SOUT	DRESS, CITY, STHEAST FIRS			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE
2 285	administrator stated to be completed an interview at 4:10 p.r was her expectation completed timely.  The facility policies were requested, bu SUGGESTED MET The director of nurs develop, review, an procedures regardinand ongoing educates designee could devensure ongoing corto the quality assurate recommendations.	d it was her expectation for PE nually. During a subsequent m. the administrator stated it n for required education to be regarding PE and education	2 285			
2 685	and Death  Subp. 2. Other disc transferred or disch than death, the nurs discharge summary time of transfer or c or discharge, transf and condition.  This MN Requirement by: Based on interview facility failed to ense	charge. When a resident is larged for any reason other sing home must compile a y that includes the date and discharge, reason for transfer for or discharge diagnoses, ent is not met as evidenced and document review, the large for 1 of 1 (R72) resident is record review.	2 685	corrected		6/4/19

Minnesota Department of Health

STATE FORM 6899 EZXR11 If continuation sheet 4 of 33

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT <b>I</b> PL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
			D WING			
		00571	B. WING		04/2	5/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EMI	ERALDS AT FARIBAL	H I I I G	THEAST FIRS LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 685	Continued From pa	age 4	2 685			
	admitted to the faci infraction, hemiples discharged from the son. R72's medical evidence of R72's referral was sent to initiate home care f discharge home with 1/26/19, indicated f daughter going to he therapy.	cal record indicated R72 was lity with diagnoses of cerebral gia and hemiparesis. R72 e facility on 1/26/19, with her record revealed there was no recapitulation of stay.  es dated 1/24/19, indicated a pa home health agency to for 1/26/19, when R72 was to the her son. The note dated R72 was discharged with her her son's home with outpatient sinimum Data Set dated R72 had discharged from the				
	1/24/19, summarize facility, however the for discharge/transs status, vital signs a functioning status, treatments for discharge for conciliation of me and therapy after conciliation of me and the continued after discommunity resource and who to contact	ransfer Summary completed ed R72's activities while at the ed discharge summary, reason fer, mental and psychosocial transcription discharge, physical assistive devices needed, harge, dental condition, edications, dietary information				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
		00571	1		04/2	5/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EM	ERALDS AT FARIBAU	HTIIC	HEAST FIR			
	CLIMMADY CTA		LT, MN 550		ON!	0.450
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 685	Continued From pa	ge 5	2 685			
	locate R72's recapi RN-C stated it shou	N)-C stated she was unable to tulation of stay at discharge. Ild have been completed upon py sent home with the				
	RN-B confirmed the	on 4/25/19, at 2:05 p.m. e Discharge/Transfer harge Instructions were not ne of discharge.				
	director of nursing s	on 4/25/19, at 2:57 p.m. the stated it was his expectation of stay to be completed for harge.				
	revised date 11/201 information, including	ischarge Planning Policy 6, indicated "Discharge ng transfer form to appropriate or other nursing facility, must				
	The director of nurs develop, review, an procedures regardin DON or designee c systems to ensure of report the results to	HODS OF CORRECTION: sing (DON) or designee could d /or revise policies and ng discharge summary. The ould develop monitoring ongoing compliance and the quality assurance er recommendations.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	Subp. 1 Adequate and e; General	2 830			6/4/19
		general. A resident must e and treatment, personal and				

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STATE FORM 6899 EZXR11 If continuation sheet 6 of 33

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	SURVEY LETED		
						;
		00571	B. WING		04/2	5/2019
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE EMI	ERALDS AT FARIBAL	H I I I C:	THEAST FIR: LT, MN 550:			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830			
	by: Based on observati review, the facility f sleeve was provide orders for 1 of 1 res of care services. In provide adequate a	ent is not met as evidenced ion, interview, and document ailed to ensure a tubi-grip arm d according to physician sident (R6) reviewed for quality addition the facility failed to issistance to prevent an dent (R26) observed during a vice.		corrected		
		ated 10/16/17, indicated R6 ding lymphedema (swelling in				
	was to have tubi-gr	ers dated 3/5/19, indicated R6 ips to right arm and both lower d off in p.m. every day and ema.				
	R6's care plan date application of tubi-g	ed 4/24/19, did not include the prips.				
		p.m. R6 was observed sitting the medication cart without a				

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STATE FORM 6899 EZXR11 If continuation sheet 7 of 33

NAME OF PROVIDER OR SUPPLIER  THE EMERALDS AT FARIBAULT LLC  SON SOUTHEAST FIRST STREET FARIBAULT, MN 55021    CAPITED   PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l \ /			E SURVEY PLETED
THE EMERALDS AT FARIBAULT LLC  (X4) ID PREFIX FARIBAULT, MN 55021  (X4) ID RECOLATORY OR LSC IDENTIFYING INFORMATION)  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).			00571	B. WING			_
(X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (EACH DEFICIENCY)  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).			UTILC 500 SOUT	HEAST FIRS	ST STREET		
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).	PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	HOULD BE	COMPLETE
(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	2 830	tubi-grip on his righ edema.  On 4/23/19, at 2:52 in his wheelchair wi arm which appeare  On 4/24/19, at 7:07 in his wheelchair wi arm which appeare  On 4/24/19, at 7:24 have tubi-grips on had not for a long tirefused the tubi-grip it for his right arm nhis arm swelling.  On 4/24/19, at 9:43 (TMA)-A stated R6 the tubi-grips and sarm for a long time refusals should be administration reco  On 4/24/19, at 3:12 (LPN)-A stated ther the application of a extremities and his have been noted by confirmed R6 did noright arm at this tim  On 4/24/19, at 8:45 stated R6 is pretty i seen a tubi-grip on one on at this time.	t arm which appeared to have  p.m. R6 was observed sitting ithout a tubi-grip on his right of to have edema.  a.m. R6 was observed sitting ithout a tubi-grip on his right of to have edema.  a.m. R6 stated he did not his right arm at this time and ime. R6 also confirmed he pat times but was not offered nost days and did need it for  a.m. trained medication aide often refuses things including the had not seen them on his. TMA-A also stated any charted in the treatment rd (TAR).  p.m. licensed practical nurse re was an area on the TAR for tubi-grip to his lower right arm and refusals should but had not been. Rebecca of have the Tubigrip on his is and often did not.  a.m. nursing assistant (NA)-A independent and had not ever his right arm and did not have	2 830			

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NAME OF PROVIDER OR SUPPLIER  THE EMERALDS AT FARIBAULT LLC  SUMMARY STATEMENT OF DEFICIENCIES FARIBAULT, MN 55021  PRETTY FACING PROVIDER ON THE PROPERTY HIGH TOP PROPERTY FOR THE PROVIDER OF THE PROPERTY HIGH TOP PROPERTY HIGH	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   PROVIDER'S PLAN OF CORRECTION   PREFIX   PREVIX   PROVIDER'S PLAN OF CORRECTION   PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX   TAG   PREFIX   PREVIX   P			00571	B. WING			-
SUMMARY STATEMENT OF DERICISCIES   10   PROMOSET'S PLAN OF CORRECTION   CARCH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   TAG   CROSS-REFERENCED TO THE APPROPRIATE   DATE			UTLIC 500 SOU	THEAST FIRS	ST STREET		
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	PRÉFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	ON SHOULD BE HE APPROPR <b>I</b> ATE	COMPLETE
On 4/23/19, at 11:22 a.m., a nursing assistant	2 830	the tubi-grip on his documentation of horder is for tubi-grip and his right arm arbeen separated so any of the three wh track him better. It a care plan but was not confirmed the TAR his right arm on day.  A policy on edema but not provided.  R26's diagnosis inchemiparesis and D disturbances.  The Miss-Fall Risk dated 12/5/18, indicand directed two statransfers.  The quarterly Minim 2/26/19 noted R26 of two staff for transfers.  The Care Are Asse but was not provided.  R26's NA sheet datassist of two with Horder extent care plans and plete transfers a Hoyer lift to compare the required extent complete transfers a Hoyer lift to compare the required extent complete transfers a Hoyer lift to compare the required extent complete transfers a Hoyer lift to compare the required extent complete transfers a Hoyer lift to compare the required extent complete transfers a Hoyer lift to compare the required extent complete transfers a Hoyer lift to compare the required extent complete transfers and the required extent complete transfers a Hoyer lift to compare the required extent complete transfers and the required extent complete transfe	right arm or had a is refusal in the TAR. The is on both lower extremities and the orders should have we would know if he refused ich would have allowed us to also should have been on the not at this time. The DON indicated the Tubi-grip was only swhen it was probably not.  and tubi-grips was requested alluded: Left side Hemiplegia/ementia without behavior  Assessment Welcov HC, cated R26 was at risk for falls aff to assist with all Hoyer lift that the properties of the properties assistance and the cate of the properties of the				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	COMP	(3) DATE SURVEY COMPLETED	
00571 B. WING		C 2 <b>5/2019</b>	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  500 SOUTHEAST FIRST STREET  FARIBAULT, MN 55021			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COMPANY OF LICENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPR <b>I</b> ATE	(X5) COMPLETE DATE	
(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			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	1 ` ′	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
74401 1544	or connection	IDENTIFICATION NONBERG	A. BUILDING:			
		00571	B. WING		04/2	2 <b>5/2019</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EMI	ERALDS AT FARIBAL	)          C:	THEAST FIRS			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	transfer. LPN-B sta always use two star knowledgeable reg On 4/25/19, at 2:04 she expected anyo Hoyer lift transfer with student nurses who facility. The administ should seek out he nurse off the cart to further stated NA-E student was not trainsfers and "there any way."  The Mechanical Lift revised July 2017, is be used by two nurprocedure.  SUGGESTED MET The director of nurse develop, review, and procedures to ensurassessed residents interventions were per physician order review and /or revisit provide staff training during transfers with or designee could of monitoring systems compliance and repassurance committing recommendations.	atted staff was directed to ff who were trained and arding a Hoyer lift transfer.  In p.m. the administrator stated the who assisted a resident in a rould be trained, including to were doing a clinical in the strator further stated staff the even if it meant "taking a to help." The administrator to was aware the nursing the indicated a portable lift was to sing assistants to perform the the facility properly to with edema, and the facility properly to with edema, and the facility could the policies and procedures and the facility encycles the machanical lift. The DON develop care plans and to ensure ongoing toort the results to the quality	2 830			
	(21) days.	CONTRACTION. I WORLY-ONE				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY DMPLETED		
00571		00571	B. WING			5/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
THE EME	ERALDS AT FARIBAU	1 1 1 1 ( :	HEAST FIRS LT, MN 550				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21390	0 Continued From page 11		21390				
21390	MN Rule 4658.0800	Subp. 4 A-I Infection Control	21390			6/4/19	
	control program muprocedures which pare collection to identify residents;  B. a system for control of outbreaks.  C. isolation and reduce risk of trans.  D. in-service exprevention and content of control of outbreaks.  E. a resident has immunization program defined in part 465 procedures of resident the prevention and formulation program procedures of resident procedures of resident procedures, including defined in part 4658.  G. a system for products which affeed disinfectants, antised incontinence products.	ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; ment and implementation of dicies and infection control a tuberculosis program as 8.0815; reviewing antibiotic use; review and evaluation of ct infection control, such as eptics, gloves, and					
	by: Based on observati review the facility fa practices during a c resident (R52). In a	ent is not met as evidenced on, interview and record illed to follow infection control lressing change for 1 of 1 ddition, the facility failed to ntrol practices were followed		corrected			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		00571	B. WING			C <b>25/2019</b>
	PROVIDER OR SUPPLIER ERALDS AT FARIBAU	UTILC 500 SOU	DDRESS, CITY, S THEAST FIRS ILT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21390	resident (R34). In a ensure 1 of 5 reside immunizations, wer pneumococcal poly  Findings include:  R52's physician ord Santyl (ointment us ulcers and wounds) over the wound, see left lower leg and change and staff shands looking for a proceeded to take of that had a minimal drainage for the left of gloves. After rem dressing RN-A did hands before apply  During interview on nurse practitioner (I be that staff would change and staff shand wash hands after the staff wash my hands be start." RN-A also in the staff shands in the staff would wash my hands be start." RN-A also in the staff would wash my hands be start." RN-A also in the staff would wash my hands be start." RN-A also in the staff would wash my hands be start." RN-A also in the staff would wash my hands be start." RN-A also in the staff would wash my hands be start." RN-A also in the staff would wash my hands be start." RN-A also in the staff wash wash my hands be start." RN-A also in the staff wash wash my hands be start." RN-A also in the staff wash my hands be start."	sident with eating for 1 of 1 ddition the facility failed to ent (R21) reviewed for the offered and provided saccharide vaccine (PPSV23).  Hers dated 4/18/19, identified ed to promote healing of sking to slough, calcium to alginate cure with Kerlix to wound on mange every day shift.  RN)-A was observed on the left lower leg. RN-A did not wash her hands before end to rame with her gloved nother staff member. Then off the soiled gauze dressing amount of serosanguinous is lower leg with the same pair noving the soiled gauze not change gloves or wash ing the new dressing.  4/25/19, at 9:49 a.m. the NP) stated expectation would wash hands before a dressing nould would take off gloves, ther removing the old dressing.  4/25/19, at 12:30 p.m. with we I messed up once, I did not fore I put my gloves on to dicated that she was aware ange gloves and wash hands				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00571 B. WING 04/2		5/2019		
	PROVIDER OR SUPPLIER ERALDS AT FARIBAU	UTILC 500 SOUT	DRESS, CITY, S HEAST FIRS LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 13	21390			
	assistant director of expectation is that stheir hands after reference. The Dressing changes 2018, identified that before beginning a clean gloves. After remove gloves and bag. Then wash ha staff should apply negatives.	4/25/19, at 12:57 p.m. the fourses (ADON) stated "my staff change gloves and wash moving a soiled dressing."  ge policy, updated on August to you should wash hands dressing change and put on removing the soiled dressing discard in plastic or biohazard ands or use alcohol gel. Then ew gloves.				
	6:20 p.m The nurse bun with an unglove to eat. NA-C then to by her ear and then NA-C again picked ungloved hand and of food. NA-C place	as observed on 4/22/19, at sing aide (NA)-C picked up a sed hand and gave it to the R34 buched R43's oxygen tubing straightened out her blanket. up her bun with the same attempted to give R34 a bite both her hands on the top of ked up a potato wedge and				
	director of nursing (	4/25/19, at 11:00 a.m. the DON) stated staff should if they were touching foods				
	assistant director of	4/25/19, at 11:14 a.m. the f nursing (ADON) indicated osed to pick food up with bare				
	dietary manager (D	4/25/19, at 12:37 p.m. the M) confirmed staff should not ady to eat with their bare				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00571 B. WING			C <b>04/25/2019</b>		
	PROVIDER OR SUPPLIER ERALDS AT FARIBAU	UTILC 500 SOUT	DRESS, CITY, S THEAST FIRS LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 14	21390			
		lwashing policy dated July ention that staff should not lloved hands.				
	Control and Preven recommended the loonjugate vaccine (or older. It recomme	nes by the Center for Disease tion (CDC) (2019) PPSV23 and pneumococcal PCV13) for all adults 65 years ended, for those age 65 or PSV23 at least 1 year after				
	R21 was 67 years of facility on 2/7/17. Rand Penicillin. The	ecord dated 4/25/19, indicated old and was admitted to the 21's allergies included Cialis Immunization Report indicated 1/30/15, and PPSV23 "not				
	assistant director of R21's medical reco medical record indi- on 9/1/2017, howev stated it was her ex	4/25/19, at 1:48 p.m. the f nursing (DON) reviewed rd and identified R21's cated to administer PPSV23 rer "it was not done." the DON pectation to administer amended guidelines.				
	11/2017, identified be administered to and CDC recomme	ococcal Policy revised Pneumococcal vaccination will resident, per physician order endations, and will be resident's medical record.				
	The DON or design pneumococcal vaccording The DON or design	HOD OF CORRECTION: ee could educate staff on cine administration guidelines. ee could complete audits of d current residents to ensure				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		С		
		00571	B. WING			5/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE EMI	ERALDS AT FARIBAU	HTIIC	HEAST FIRS LT, MN 5502				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21390	'		21390				
	addition the DON a responsible staff reinfection control pracould conduct audit	cal vaccine administration. In nd/or designee could educate lated to hand hygiene and actices. The DON or designee is of resident cares to ensure infection control measures are					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one					
21426	MN St. Statute 144 Prevention And Cor	A.04 Subd. 3 Tuberculosis ntrol	21426			6/4/19	
	maintain a comprehinfection control procurrent tuberculosis issued by the United Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control plaunpaid employees, residents, and volumed the shall provide regarding implements.	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines distates Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of extechnical assistance intation of the guidelines.					
	This MN Requirement	ent is not met as evidenced					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA				DATE SURVEY COMPLETED	
20574			B. WING		C		
		00571	B. WING		04/2	5/2019	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
THE EMI	ERALDS AT FARIBAU	H T I I C	HEAST FIRS LT, MN 5502				
(X4) ID PREFIX TAG	(4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
21426	Continued From pa	ge 16	21426				
	facility failed to prove symptoms assessing guidelines for 3 of 5 who immunization raddition, the facility Centers for Disease preventing the trans	and document review, the vide tuberculosis (TB) sign and nent in accordance with state is residents (R48, R21, R59) records were reviewed. In failed to implement current a Control (CDC) guidelines for smission of Tuberculosis (TB) is (E-A) as directed by State elines.		corrected			
	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.						
	Record revealed th administered on 11	on 9/30/11. The Immunization e first step TB skin test was /9/11, however the TB sign ssment was not completed.					
	however E-A's sign	ted E-A was hired on 1/23/19, and symptom assessment culin Skin Test (TST) were not /19.					
	assistant director of R48, R21 and R59 symptom assessment it was her expectati	on 4/25/19, at 1:48 p.m. f nursing (ADON) confirmed did not have TB sign and ents completed. ADON stated on for all residents and had their TB sign and					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					) DATE SURVEY COMPLETED	
00571		B. WING		04/2	5/2019	
					04/2	312019
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S THEAST FIRS	STATE, ZIP CODE		
THE EM	ERALDS AT FARIBAU	H T I I C	LT, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 17	21426			
	symptom assessme within 24 hours of a	ent and their TST initiated admission.				
	human resources dunable to locate E-/	on 4/25/19, at 2:54 p.m. irector explained they were A's completed TB sign and ent and/ or TST "so we started				
	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)"					
	The director of nurs develop policies an tuberculosis screen The director of nurs conduct random au	THOD OF CORRECTION: sing or designee, could d procedures for a ing program in the facility. sing or designee, could dits to ensure that this ing program has been				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21550	MN Rule 4658.1329 Medications; Pharm	5 Subp. 1 Adminiatration of nacy Serv.	21550			6/4/19
	Subpart 1. Pharma	cy services. A nursing home				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:			
		00571	B. WING		04/2	5/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EMI	ERALDS AT FARIBAU	II T I I C	HEAST FIRS LT, MN 550			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG			(X5) COMPLETE DATE
21550	Continued From pa	ge 18	21550			
	must arrange for th services.	e provision of pharmacy				
	by: Based on interview facility failed to ensipatches) were dest manufactures guide storage of used me and accidental cont for 1 of 1 resident (I storage who had Fe Findings include: R34's physician ord medical record (EM Fentanyl Patch 72 h micrograms(MCG)/ transdermally one t	elines to prevent inappropriate dication, potential diversion, eact by staff through handling R34) reviewed for medication entanyl patches ordered.  Hers from the electronic IR), dated 4/6/19 included: hour 25 hour(Hr). Apply 1 patch ime a day every 3rd day for		corrected		
	4/24/19 at 1:20 p.m patches were folder sharps container. Twas to be performe witnessed by a secondary and remove certain if this was the On 4/24/19, at 1:25 (LPN)- A was intervenently and removal of Fentany	sing (DON) was interviewed on and stated used Fentanyl din half and disposed of in a she disposal of the used patch diby a licensed nurse and condistaff member. The DON heck with additional staff who ed the patches as wasn't he process being utilized.  p.m. licensed practical nurse riewed about application and I patches and confirmed she used patch, fold it up and				

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00571	B. WING			5/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		500 SOUT	HEAST FIRS	ST STREET		
THE EMI	ERALDS AT FARIBAL	)	LT, MN 5502			
(X4) <b>I</b> D	SUMMARY STA		, ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	COMPLETE DATE
21550	Continued From pa	ige 19	21550			
	·					
	witnessed by a sec	ond starr member.				
	I DNI P was intervie	ewed on 4/24/19, at 1:33 p.m.				
		ess she would follow for a				
		h would be to remove from the				
		ew patch and then fold the				
	, , , ,	pose of with a witness into a				
		PN- hesitated and stated she				
	wanted to verify the	process for disposal with the				
	assistant (A) DON. LPN-B returned after 5					
		he had confirmed it with the				
		entanyl patches were to be				
		arps container witnessed by a				
	second staff memb	er.				
	On 4/24/19 at 1:40	p.m. the DON stated he was				
		gulation change with regard to				
		disposal of used Fentanyl				
		wer witnessed by a second				
		urther confirmed he was not				
		dinance prohibiting disposal of				
	used Fentanyl patc	hes into the sewer.				
	A 6 1111 5 11					
		Procedure Fentanyl Removal,				
		struction, dated October 2013,				
		To address safe and secure g and storage, limit access				
	1	of controlled substances in				
		oss or diversion and provide				
		ery and disposal of the				
		e policy interpretation and				
		luded Remove fentanyl patch				
		ve sides together so there are				
		ation. Take the used patch to				
		ion room (without touching				
		mplete Fentanyl destruction				
		isposal Form. With two				
		apping the used fentanyl patch				
		lushing down the sewer. Two				
	licensed nurses mu	ist verify destruction and sign				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			,
		00571	B. WING		1	5/2019
NAME OF I	PROV <b>I</b> DER OR SUPPL <b>I</b> ER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EMI	ERALDS AT FARIBAU	II TII C	HEAST FIRS LT, MN 5502			
(X4) <b>I</b> D PREF <b>I</b> X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21550	Continued From pa	ge 20	21550			
	the proper form for	proof of destruction.				
	The Director of Nur develop, review, an procedures for residustruction. The DC all appropriate staff procedures. The D monitoring systems compliance.	ON or designee could develop				
21880	(21) days	651 Subd. 20 Patients &	21880			6/4/19
	Residents of HC Fasubd. 20. Grievar shall be encouraged their stay in a facility to understand and expatients, residents, residents, residents may voice changes in policies and others of their content of their content of their content of the cont	ac.Bill of Rights  aces. Patients and residents and assisted, throughout or their course of treatment, exercise their rights as and citizens. Patients and a grievances and recommend and services to facility staff choice, free from restraint, on, discrimination, or reprisal, lischarge. Notice of the e of the facility or program, as and telephone numbers for the cility Complaints and the area adsman pursuant to the Older tion 307(a)(12) shall be				

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00571	B. WING		04/2	5/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EMI	ERALDS AT FARIBAL	11 1 1 1 C	HEAST FIRS			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21880	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.		21880			
	by: Based on interview failed to ensure grid investigated and co 3 (R68, R33, and R had grievances.  Findings include:  When interviewed of along with family m stated they have fill with the facility and response. "If we tal us nowhere. We have	and record review the facility evances were documented, prective actions taken for 3 of (36) residents reviewed who con 4/22/19, at 6:30 p.m. R68, embers (FM)-D and FM-E and many official grievances have not received any k to the administrator it gets are written multiple grievances practical nurse (LPN)-C. We esponse from anybody		corrected		

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MILLIFOR	na Department of Tie	ailli				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
		00571	B. WING		1	5/2019
					<u>, , , , , , , , , , , , , , , , , , , </u>	
NAME OF	PROV <b>I</b> DER OR SUPPL <b>I</b> ER			STATE, ZIP CODE		
THE EMI	ERALDS AT FARIBAL	HTIIC	THEAST FIRS			
		FARIBAU	LT, MN 5502	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21880	Continued From pa	ae 22	21880			
21880	regarding any of the of the 10 grievance services. Grievance 4/11/19, 4/6/19, 4/1 and 3 separate grie grievance dated 3/1 the facility. None of response. The major in by the family had staff that cared for When interviewed of stated he had over another resident, "I that will shut him up want this to keep he else." R33 also had not feeling well and came in and check back to recheck it. I that his heart was not wheel himself to medication or hope (NA) could come and medication cart. Affinight, he wheeled she followed him do yelling, telling him to pissed at me. R33 making it worse and did report this to [LI and I have attempted that would what happens to the services."	em." FM-A brought in copies s they had given to social es were filled out on 4/15/19, /19, 3/15/19,1/20/19, 1/15/19, evances for 10/1/18. The 15/19 was followed up on by the others had any facility ority of the grievances brought to do with LPN-C or other	21880			
	When interviewed	on 4/23/19, at 3:50 p.m. R36				

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STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						C
		00571	B. WING			25/2019
NAME OF	PROV <b>I</b> DER OR SUPPL <b>I</b> ER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EM	ERALDS AT FARIBAL	)          C:	THEAST FIRS LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21880	stated he had a coraide (TMA)-A, regathe wrong way statistated, "She won't is been asking her nich have talked to socioto three weeks ago about LPN-C and sworse" and he had nursing (DON). R3 up on any of his co.  When interviewed a concern, they do not as a grievance.  When interviewed registered nurse (R grievances that had think I left the griev before he left for valoffice."  When interviewed a concern had looked on the anot find any there expressed to the property of th	ncern with trained medication arding putting him on the toilet ing, "it hurts me." R36 also take no for an answer, I have cely and she won't listen. I al services [SS-A] about two o." R36 also voiced concerns stated she went from, "bad to told SS-A and the director of 6 stated no one had followed ncerns.  on 4/23/19, at 4:20 p.m. the a resident expresses a verbal of always want it written down on 4/23/19, at 4:37 p.m.  RN)-A stated she had some dibeen turned in to her, but, "I rances with the administrator acation. I don't have any in my on 4/24/19, at 11:25 a.m. the not have other grievances and administrators desk, and dideither.  on 4/24/19, at 1:28 p.m. the restated, and the social worker ewere any outstanding and found four from R68's able to locate any others. The nined the process was to follow and this had not happened for follow up for the verbal	21880			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED	
		00571	B. WING		04/2	5/2019
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 0412	5/2015
THE EME	ERALDS AT FARIBAU	JLT LLC	HEAST FIR			
()()()	SHIMMADV STA	TEMENT OF DEFICIENCIES	LT, MN 550	PROVIDER'S PLAN OF CORRECTION	N.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21880	Continued From pa	ge 24	21880			
	the DON.					
	complaints, regardl by the facility, will be grievance form showerbal complain has above individuals. If grievance has been documentation that resolved to the satistic the concern. The foreturned to the admadministrator or desinvestigation of the validity. The administratory unless a	2/2018, indicted any ess of how they are received e investigated per the policy. A uld be completed when the d been voiced to each of the This included when a resolved right away to show it was addressed and sfaction of the person voicing orm should be completed and ninistrators office. The signee shall conduct grievance to determine its strator shall issue a verbal written summary is required no later than five business				
	Staff should be train concerns to the app Administrative staff and procedures relative nursing and administrative ask residents if they grievances/concern on the grievance/co	ns and immediately follow-up oncern.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21995	MN St. Statute 626. Maltreatment of Vu	.557 Subd. 4a Reporting - Inerable Adults	21995			6/4/19
	Subd. 4a. Interna	I reporting of maltreatment.				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00571	B. WING		04/2	; 5/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	•	
THE EM	ERALDS AT FARIBAU	H T I I C	HEAST FIRS LT, MN 550			
(X4) ID PREF <b>I</b> X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21995	(a) Each facility shongoing written proapplicable licensing of suspected maltre facility has an intermandated reporter requirements of this internally. However responsible for comporting requirements of this internally. However responsible for comporting requirements of this MN Requirements of this MN Requirements of the second of the s	all establish and enforce an ocedure in compliance with a rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting section by reporting r, the facility remains aplying with the immediate ents of this section.  The procedure is not met as evidenced and document review, the necliately report an incident of the administrator and state of 1 resident (R41) reviewed for	21995	corrected		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BOILDING.			
		00571	B. WING			25/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EMI	ERALDS AT FARIBAU	H I I I C:	HEAST FIRS			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21995	what interventions after that incident to DON confirmed that reported to the statt that there is a concerning interview on identified she would altercations to here typically fill out an inwas recently told by then there is no new recalled an incident ago of R41 hitting a started filling out art to the DON; however the progress notes report and was una incident.  During interview on acting administrato been filed immediated to the incident on 1 verified that any resultercation needed agency right away, administrator indicated.	would have been put in place of protect the other residents." at this incident was not be agency and also confirmed ern with reporting concerns, idents.  4/25/19 at 11:16 a.m., LPN-D direport resident to resident supervisor or DON. She would incident report on paper, but by the DON if there is no injury ed to complete it. LPN-D at about two to three months another resident where she incident report and reported it er, when she looked through she could not find the incident able to recall the date of the  4/25/19 at 1:23 p.m., the resident where she incident are ported in the date of the could not find the incident able to recall the date of the resident physical to be reported to the state	21995			
	12/2018 indicated the residents are not sure including, but not linguage residents, consultated agencies serving the legal guardian, frier	be filed.  se Prevention Policy, dated his policy was to ensure that ubjected to abuse by anyone mited to, facility staff, other nts, volunteers, staff of other he individual, family member or nds or other individuals. The d that all staff are responsible				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	E CONSTRUCTION (X3) DATE : COMPL		
00571 B. WING	<b>I</b>	2 <b>5/2019</b>	
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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLA PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIV TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIATE CIENCY)	(X5) COMPLETE DATE	
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.			

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		DISTRICTATION NUMBER:    00571		C <b>/25/2019</b>		
NAME OF I	PROV <b>I</b> DER OR SUPPL <b>I</b> ER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EMI	ERALDS AT FARIBAU	H				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 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		22000			6/4/19
	personal care atten establish and enforprevention plan. The assessment of the environment, and it factors which may earn a statement of to minimize the risk comply with any rulpromulgated by the (b) Each facility, agency and personproviders, shall devertion plan for residing there or reacting there or reacting there or reacting the plan shall contassessment of: (1) abuse by other indivulnerable adults; (1) other vulnerable adults; (2) other vulnerable adults; (3) other vulnerable adults. For the puriterm "abuse" includes	dant services providers, shall ce an ongoing written abuse he plan shall contain an physical plant, its is population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan licensing agency. Including a home health care all care attendant services relop an individual abuse each vulnerable adult ceiving services from them. In an individualized the person's susceptibility to viduals, including other (2) the person's risk of abusing ults; and (3) statements of the to be taken to minimize the to person and other vulnerable poses of this paragraph, the les self-abuse.				
	and personal care a knows that the vuln violent crime or an toward others, the i plan must detail the minimize the risk th reasonably be expe	attendant services providers, erable adult has committed a				

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STATE FORM 6899 EZXR11 If continuation sheet 29 of 33

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	
		00571	B. WING		04/2	5/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE	<u>,                                      </u>	
		500 SOUT	HEAST FIRS			
THE EMI	ERALDS AT FARIBAU	FARIBAUI	LT, MN 5502	21		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 29	22000			
	unsupervised. Und of a vulnerable adu misconduct or phys such information from authority or through another facility, and	er this section, a facility knows It's history of criminal sical aggression if it receives om a law enforcement a medical record prepared by ther health care provider, or g assessments of the				
	by: Based on interview facility failed to inve to resident abuse a interventions to pro from R41 reviewed	and document review, the stigate an incident of resident nd failed to implement tect the unknown resident abuse.		corrected		
	stroke with right sid	sheet included diagnoses of a ed hemiplegia (inability to ne body) and traumatic brain				
	3/21/19, indicated s and verbal behavior	imum data set (MDS), dated severe cognitive impairment ral symptoms directed towards ing the reference period.				
	"was in the tv (telev yelling at other resid	e dated 1/7/19, indicated R41 ision) area swearing and dents, calling them 'assholes truck another resident in the				
	During interview on	4/23/19, at 3:40 p.m. LPN-A				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT <b>I</b> PL	E CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		DOST1  DENTIFICATION NUMBER  DOST1  B. WING  DOST1  STREET ADDRESS, CITY, STATE, ZIP CODE  SOUTHEAST FIRST STREET FARIBAULT, MN 55021  PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Intinued From page 30  Lited "He is out of control."  Irring interview on 4/25/19 at 10:34 a.m., DON leted we first protect the residents and remove threat, and then report it. Expectation was if a sident hits another resident that would be sorted. When reviewing R41 progress note m 17/719, DON responded, "I didn't know about tincident and don't know who the other sident was." DON further said "I don't know at interventions would have been put in place er that incident to protect the other residents." DN confirmed there was a concern with sorting concerns, grievances and incidents. There, he stated "I am at a loss with R41, he n change on a dime and can require constant direction."  Irring interview on 4/25/19 at 12:22 p.m., gistered nurse (RN)-A indicated when she was ormed of resident to resident by the state agency, I-A further indicated if she gets the report, she icall staff and investigate it. RN-A was aware 1 had stuck other residents faces. RN-A was able to recall the incident that took place on 1/19, and did not know of any interventions that		25/2019		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EM	ERALDS AT FARIBAL	HTIIC				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	JLD BE	(X5) COMPLETE DATE
22000	stated "He is out of During interview on stated we first prote the threat, and ther resident hits another reported. When reversident was." DON what incident and do resident was." DON what interventions after that incident to DON confirmed the reporting concerns. Further, he stated "can change on a diredirection."  During interview on registered nurse (Rinformed of resider altercation, that wa makes the decision RN-A further indicated will call staff and in R41 had stuck other liked to get in other unable to recall the 1/7/19, and did not were put in place to the facility.  During interview on acting administrato been filed to the staincident on 1/7/19. that any resident to needed to be reported.	dect the residents and remove a report it. Expectation was if a resident that would be riewing R41 progress note responded, "I didn't know about on't know who the other of the vertice of the other residents." I don't know would have been put in place of protect the other residents." I am at a loss with R41, he me and can require constant of the resident physical is brought to the DON who in to notify the state agency. It is the residents before and he residents faces. RN-A was incident that took place on				

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Wilnnesc	<u>ita Department of He</u>	alth	_			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
				<del></del>	ے ا	
		00574	B. WING		04/0	
		00571	B. WIIVO	_	04/2	5/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		500 SOUT	HEAST FIRS	ST STREET		
THE EMI	ERALDS AT FARIBAU	JI I I I C:	LT, MN 5502			
			LI, WIN 550			
(X4) <b>I</b> D		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL	ON D.BE	(X5) COMPLETE
PREF <b>I</b> X TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF <b>I</b> X TAG	CROSS-REFERENCED TO THE APPRO		DATE
170			IAO	DEFICIENCY)		
22000	Continued From pa	ge 31	22000			
	timeframe it should	ho filed				
	limename it snould	be filed.				
	Dovious of the Abus	e Prevention Policy, dated				
		his policy was to ensure that				
		ubjected to abuse by anyone				
		mited to, facility staff, other				
		nts, volunteers, staff of other				
		e individual, family member or				
		nds or other individuals. The				
		d that all staff are responsible				
		uation that is considered				
		completed incident report will				
		procedure. The unit nurse will				
		ately, assess the situation to				
		nergency treatment or action is				
	required. Staff will t	ake necessary steps to protect				
	residents from poss	sible subsequent incidents of				
	misconduct or injur	y while the matter is being				
	investigated. If this	is an injury of unknown origin,				
	the nurse will also a	attempt to determine the cause				
	of the injury. If it is i	resident to resident abuse, the				
		I be removed to a safe				
		I other residents' safety will be				
		n of the facility administrator				
		incidents of resident abuse,				
		ed abuse, injury or unknown				
		ncial exploitation, or				
		on will occur immediately.				
		cated that resident to resident				
		reported to the Minnesota				
		Ith. Suspected abuse shall be				
		no later than 2 hours after				
	forming suspicion of					
	Torring suspicion of	n abuse.				
	CHOOSESTED MET	HOD OF CORRECTION:				
		HOD OF CORRECTION:				
		could review policies and				
		ng reporting and investigating				
		eglect/mistreatment. The				
		r designee, could re-educate				
	all staff on the polic	ies and procedures. The				

STATE FORM 6899 If continuation sheet 32 of 33 EZXR11

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00571	B. WING			C <b>25/2019</b>
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
THE EMI	ERALDS AT FARIBAU	11 1 1 1 (*	LT, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 32	22000			
	administrator could to ensure ongoing of	develop a monitoring system compliance.				
	TIME PERIOD FOF (14) days.	R CORRECTION: Fourteen				

Minnesota Department of Health

F5067028

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(X4) ID PREFIX		045007				
(X4) ID PREFIX		245067	B. WING		04	/24/2019
PREFIX	ROVIDER OR SUPPLIER  RALDS AT FARIBAU	LT LLC	0.000 -000	STREET ADDRESS, CITY, STATE, ZIP COD 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	E	
TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ADAGO DEFERENCED TO THE AD	HOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	тѕ	K	000		
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT T	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS F COMPLIANCE.				
141	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS H	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN VITH YOUR VERIFICATION.				
	Minnesota Departi Fire Marshal Divis The Emeralds of F compliance with the in Medicare/Medic 483.70(a), Life Sa edition of National	e Survey was conducted by the ment of Public Safety - State ion. At the time of this survey, (Faribault) was found not in the requirements for participation aid at 42 CFR, Subpart fety from Fire, and the 2012 Fire Protection Association 101, Life Safety Code (LSC), and Health Care.				
	PLEASE RETURI CORRECTION FO DEFICIENCIES (K-TAGS) TO:	N THE PLAN OF OR THE FIRE SAFETY		EPO	C	
	Health Care Fire State Fire Marsha 445 Minnesota St St Paul, MN 5510	al Division ., Suite 145				
	By email to: fm.hc.Inspections	@state.mn.us		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.

PRINTED: 06/04/2019 FORM APPROVED OMB NO. 0938-0391

	F CORRECTION	IDENTIFICATION NUMBER:	V D commonweal	IG 01 - MAIN BUILDING 01	COMPLETED
		245067	B. WING _		04/24/2019
	PROVIDER OR SUPPLIER	LT LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
K 000		RRECTION FOR EACH ST INCLUDE ALL OF THE	K 00	00	
	A description of to correct the deficite.     The actual, or property.     The name and/oresponsible for correct.	what has been, or will be, done iency.  roposed, completion date.  or title of the person rection and monitoring to			
	The Emeralds at F. Care Center, was of times The original with no basement. and was determined construction, (the 1 health care). In 19 constructed and was (111) constructed and was determined to be owith a full basement was constructed at Type II (111) constructed at Type I	aribault, previously St Lucas constructed at 5 different I building is a 4-story building It was constructed in 1908 at to be of Type I (332) let and 2nd floor are used for 60 a 1-story addition was as determined to be of Type II with no basement. In 1971 at as constructed and was af Type II (111) construction, and In 1990 a 1-story addition and was determined to be of the ruction, with no basement. In a vas constructed and was af Type II (111) construction, and was determined to be of the ruction, with no basement. In the vas constructed and was af Type II (111) construction, Because the original building and meet the construction tisting buildings, the facility was uilding.			
	system. The facility full corridor smoke	tected by a full fire sprinkler y has a fire alarm system with detection and spaces open to s monitored for automatic fire			

Event ID: EZXR21

PRINTED: 06/04/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(1.5)		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		245067	B. WING		P	04/2	24/2019
	PROVIDER OR SUPPLIER	LT LLC		50	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTHEAST FIRST STREET ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	2000	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000			K	000	e e e e e e e e e e e e e e e e e e e		a a
	The requirement at NOT MET as evide Doors with Self-Clo CFR(s): NFPA 101		K	223			6/4/19
	or horizontal exit, sarea enclosure are closed position, un device complying victoses all such doccompartment or er * Required manual * Local smoke detection strong through the smoke passing through the smoke detection strong	ssageway, stairway enclosure, moke barrier, or hazardous self-closing and kept in the less held open by a release with 7.2.1.8.2 that automatically ors throughout the smoke attre facility upon activation of: fire alarm system; and ectors designed to detect ough the opening or a required system; and ler system, if installed; and 2.8, 19.2.2.2.7, 19.2.2.2.8 NT is not met as evidenced as comply with Life Safety Code 2.2.8)  Itice could affect the safety of all s, staff and visitors within the ent/ Facility.			Immediate corrective action: Maintenance director repaired the door in dining room on the first floclose and properly latch. This repalso completed on the exit door act to the kitchen. Action as it applies to others: All doors were checked to ensure the and latch properly. Date of completion:6/4/2019_Recurrence will be prevented by:	or to self air was djacent exit	

PRINTED: 06/04/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245067 B. WING 04/24/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 SOUTHEAST FIRST STREET** THE EMERALDS AT FARIBAULT LLC FARIBAULT, MN 55021 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 223 | Continued From page 3 K 223 Maintenance director will enter into Tel□s During the walk-through inspection of the facility program to check atrly. All exit doors to observed the following: ensure they close and latch properly. (1) Exit door in the Dining Room (1st FL) did not The correction will be monitored by: self-close and latch properly upon testing Maintenance director, Adm., or designee (2) Exit door set in the corridor adjacent to the will monitor for compliance. 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 324 Cooking Facilities K 324 6/4/19 CFR(s): NFPA 101 SS=F 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, \* 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

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	TO TOTT WILD TO THE	& MEDICAID SERVICES			OI OI	ND NO.	0930-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	25		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245067	B. WING		production and the state of the	04/2	24/2019
	PROVIDER OR SUPPLIER	LT LLC		50	TREET ADDRESS, CITY, STATE, ZIP CODE DO SOUTHEAST FIRST STREET ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 324	Continued From pa	ge 4	КЗ	324	3		
K 353 SS=F	by: The facility failed to (19.3.2.5.1 through  This deficient pract (77) the residents smoke compartment Findings Include:  On facility tour betwon 04/24/2019, observed the following  During the walk-throbserved the training was not connected electrical power soon  This deficient pract Facility Maintenant discovery.  Sprinkler System - CFR(s): NFPA 101  Sprinkler System - Automatic sprinkler inspected, tested, awith NFPA 25, Start Testing, and Mainta Protection Systems maintenance, inspermaintained in a secaravailable.	ween 09:00 AM and 01:00 PM servations and staff interview ing:  ough inspection of the facility ng stove in the Therapy Rm to a secured ( keyed lock-out )		853	Immediate corrective action: Maintenance director has disconne the training stove in therapy dept. a keyed lock out at the electrical par Action as it applies to others: Train stove has a sticker affixed to the strindicating it is non-operational Date of completion:6/4/2019Recurrence will be prevented by: Maintenance director will enter into program to check qtrly. To make strill non-operational The correction will be monitored by Maintenance director, Adm., or des will monitor for compliance.	nd nel ning ove — Tel□s ure it is	6/4/19

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
2		245067	B. WING		04/24/2019		
NAME OF PROVIDER OR SUPPLIER  THE EMERALDS AT FARIBAULT LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE COMPLETION		
K 353	Continued From page 5		K 3	K 353			
	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:			Immediate corrective action: The gon the sprinkler riser will be change along with the 5 year sprinkler system being inspected.  Action as it applies to others: Sprin system inspection will be scheduled inspected every 5 years and gauge:	ed em ikler d to be		
	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.			replaced Date of completion:6/4/2019 Recurrence will be prevented by: Maintenance director will enter into program to check annually. The correction will be monitored by: Maintenance director, Adm., or desi will monitor for compliance.	 Tel⊡s		