



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 3, 2025

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

RE: CCN: 245067
Cycle Start Date: May 1, 2025

Dear Administrator:

On May 28, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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Electronically delivered

June 3, 2025

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

Re: Reinspection Results
Event ID: J5TI12

Dear Administrator:

On May 28, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 1, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 13, 2025

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

RE: CCN: 245067
Cycle Start Date: May 1, 2025

Dear Administrator:

On May 1, 2025, a 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.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 1, 2025 (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 November 1, 2025 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

The Emeralds At Faribault Llc

May 13, 2025

Page 4

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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Electronically delivered
May 13, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: J5TI11

Dear Administrator:

The above facility was surveyed on April 28, 2025 through May 1, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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 feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/01/2025
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/28/25 to 5/1/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were completed. Your facility was found not in compliance with the MN State Licensure and the following correction orders are issued. Please	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

05/15/25

Minnesota Department of Health

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2 000	Continued From page 1 indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H50673432C (MN108925), H50673430C (MN108926), H50673429C (MN109479), H50673431C (MN109573), H50673433C (MN109643) 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading	2 000			

Minnesota Department of Health

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2 000	Continued From page 2 completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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.	2 000			
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded with the potential for inaccurate federal reimbursement and resident care planning for 1 of 1 resident (R77) reviewed for MDS accuracy. Findings include: R77's completed discharge return not anticipated (DRNA) MDS, dated 2/4/25, identified R77 discharged on 2/4/25, with a recorded discharge status reading, "04. Short-Term General Hospital (acute hospital, IPPS)."	2 550	Corrected	5/23/25	

Minnesota Department of Health

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2 550	Continued From page 3 R77's census had an admitted date of 1/13/25, and discharged date of 2/4/25. R77's progress note, dated 2/4/25, identified R77 discharged home to an assisted living care facility at approximately 11:00 a.m. by medical transport. R77's discharge instructions and summary dated 2/4/25, indicated that R77 was admitted on 1/13/25, and discharged to Fairbault Senior Living on 2/4/25, following a course of therapy. During an interview on 4/30/25 at 8:35 a.m., licensed practical nurse (LPN-D), the facility MDS coordinator, reviewed R77's MDS dated 2/4/25, and confirmed the discharge was coded for hospitalization and should have been coded for assisted living. LPN-D stated that R77's discharge MDS was coded as #4, a short-term general hospital and should have been coded as #1 assisted living facility discharge. MDS Completion Policy was requested, but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to performing Minimum Data Set (MDS) assessments and the collection of required information. The director of nursing or designee should educate staff to the policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring.	2 550			

Minnesota Department of Health

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2 550	Continued From page 4	2 550			
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview, observation, and documentation review, the facility failed to ensure a comprehensive care plan was developed and maintained to ensure appropriate care was provided for 1 of 1 resident (R51) reviewed for smoking. Findings include: R51's admission Minimum Data Set (MDS) assessment, dated 2/19/25, indicated R51 had intact cognition with no hallucinations or delusions present and no behaviors. Section J: Health Conditions indicated R51 currently used tobacco. Section O: Special Treatments and Programs	2 555	Corrected	5/23/25	

Minnesota Department of Health

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2 555	Continued From page 5 indicated R51 used oxygen. R51's Admission Record, printed 5/1/25, identified R51's admission date to the facility as 2/13/25. Furthermore, it identified the following relevant diagnoses: nicotine dependence, emphysema (chronic lung disease that progressively damages the tiny air sacs in the lungs), and congestive heart failure (condition where the heart doesn't pump blood as efficiently as it should). During an interview on 4/28/25 at 6:54 p.m., R51 stated she smoked cigarettes. R51 stated she had smoked for "a long time." R51 stated the facility "assessed me to make sure I am ok to smoke." R51 stated she had smoked since she has been at the facility and staff had been aware of her smoking. R51 stated she currently used oxygen at night only and did not wear it during the day. R51 stated she never wore her oxygen when she smoked. R51's care plan, reviewed on 4/28/25, lacked evidence of R51 being a current cigarette smoker. Furthermore, the care plan lacked the identification of safety interventions needed during the smoking assessments (i.e., ensuring resident removes oxygen while smoking). R51's Smoking Evaluations, dated 2/13/25, 2/17/25 and 4/14/25, identified R51 as a current smoker. During interview on 4/30/25 at 10:41 a.m., registered nurse (RN)-B verified they work with and were familiar with R51. RN-B stated R51 currently smoked and had smoked since admitting to the facility. RN-B reviewed R51 electronic medical record (EMR) and verified	2 555			

Minnesota Department of Health

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2 555	Continued From page 6 three smoking assessments had been completed. RN-B stated if a resident was identified as a smoker it should be on the care plan as "everything should be on the care plan." RN-B verified R51 lacked identification that R51 was a smoker. RN-B verified they were adding it to the care plan during the interview, stating, "it should be on there." During an interview on 5/1/25 at 8:48 a.m., registered nurse manager (RN)-D stated when a resident admitted to the facility, a smoking assessment was to be completed which included observing the resident smoke, and assessing for safety risks and concerns. RN-D stated if a resident was a smoker it needs to be added to the care plan. RN-D stated R51 currently smoked. RN-D reviewed R51's EMR and verified smoking assessments completed on 2/13/25, 2/17/25, and 4/14/25. RN-D reviewed R51's care plan and stated, "I might be wrong, but it shows a date initiated 4/30/25, for smoking but I am not sure if I am looking at it right." During an interview on 5/1/25 at 9:29 a.m., director of nursing (DON) reviewed R51's EMR. DON verified R51 was a current smoker, had smoked since admission, and the care plan had not been updated until 4/30/25 (two days after survey entrance). DON stated it was important to have a comprehensive care plan as "that is how you care for the resident." A facility policy titled Care Planning, dated 11/2024, indicated "The care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident." SUGGESTED METHOD OF CORRECTION:	2 555			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/01/2025
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2 555	Continued From page 7 The director of nursing (DON) or designee should create and/or review or revise policies and procedures related to creating and implementing a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555			
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed ensure the care plan was	2 570	Corrected		5/23/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/01/2025
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2 570	Continued From page 8 updated and revised to reflect current interventions for 1 of 1 resident (R62) reviewed for positioning and mobility. Findings include: R62's quarterly Minimum Data Set (MDS) dated 2/28/25, identified R62 as independent with mobility, had no upper extremity impairment (shoulder, elbow, wrist, hand), and used a walker. R62's Occupational Therapy Discharge Summary dated for services March 12, 2025, through April 9, 2025, indicated therapy was provided seven times for muscle weakness. R62's therapy involved improved strength for the left wrist, and R62 was given a brace on 4/9/25. Therapy directed R62 to wear the brace as tolerated. R62's care plan with a review date of 3/17/25, indicated a walking program of 200 feet one to three times per day with an assist of one during ambulation, bed movements, and transfers. The care plan lacked updates after R62 was discharged from therapy to walk independently with his walker and given a brace for his left wrist. R62's progress note dated 4/11/25, indicated R62 had a diagnoses of chronic kidney disease, type two diabetes, orthostatic hypotension, dehydration, and a failure to thrive (gain weight). R62's medications were noted as increasing a risk for falls and that R62 was an assist of one with transfers and mobility and with all activities of daily living. R62's progress note dated 4/17/25, indicated R62 was seen by the medical doctor and no new orders or changes to the current plan of care. R62 was also seen by the nurse practitioner on	2 570			

Minnesota Department of Health

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2 570	Continued From page 9 4/16 no new orders or changes to the current plan of care. During observation and interview on 4/28/25 at 4:10 p.m., R62 was wearing a black brace on his left wrist. R62 stated the brace was for significant pain but was unable to explain the reason for its use or where it came from. During an interview on 4/30/25 at 10:54 a.m., director of therapy (DOT)-A stated that R62 had recently undergone therapy for hand weakness and joint pain in the thumb, with therapy sessions from March 12, 2025, through April 9, 2025. DOT-A also confirmed that R62 had participated in therapy on three separate occasions in 2024. Additionally, DOT-A confirmed that the brace on R62's left hand was used for joint pain and the brace was applied intermittently with R62 being independent with its use, and continued use was recommended. R62 discharged with independent use of a walker and self-cares. DOT-A stated R62 needed no supervision with the walker or the brace at the time of discharge and managed these items independently. Nursing managed any care plans or concerns related to their use. R62 was given a "green card" and walked the entire facility. DOT-A confirmed R62's care plan stated he was on a walking program of 200 feet one to three times a day with staff assist and acknowledged the care plan needed to be revised. Licensed practical nurse (LPN)-D, who shared a desk with therapy, joined the interview, reviewed R62's care plan, and acknowledged R62 was now independent with his walker and was no longer on the walking program. Additionally, LPN-D stated the wrist brace wasn't care planned because R62 was independent with its use and the walking program was a standing order and did not need revision.	2 570			

Minnesota Department of Health

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2 570	Continued From page 10 During an interview on 4/30/25 at 12:26 p.m., registered nurse (RN)-D stated all braces and splits should be care planned and positioning should be checked under skin to make sure it is intact. RN-D reviewed R62's care plan and confirmed the care plan did not mention the brace worn on the left wrist. RN-D stated it was important to put braces on the care plan to monitor for alteration of skin integrity and skin breakdown. A policy titled Care Planning revised on 11/2024 and stated the care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to creating and implementing a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570			

Minnesota Department of Health

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2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide services to maintain and/or prevent loss of range of motion and contracture care for 1 of 1 residents (R51) reviewed for limited range of motion. Findings include: R51's admission Minimum Data Set (MDS) assessment, dated 2/19/25, indicated R51 had intact cognition with no hallucinations, delusions, behaviors or rejection of care. In addition, R51 had no impairment in function limitation in range of motion, utilized a wheelchair for mobility, dependent on staff for lower body dressing and dependent on staff for transfers. R51's Admission Record, printed 5/1/25, indicated the following relevant diagnoses: chronic pain, abnormalities of gait and mobility,	2 895	Corrected	5/23/25	

Minnesota Department of Health

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2 895	Continued From page 12 dorsalgia (back pain), muscle weakness, disease of spinal cord, restless sleep syndrome and cervicalgia (neck pain). During an interview on 4/28/25 at 6:51 p.m., R51 stated she was not getting physical therapy (PT). R51 stated she had been getting occupational therapy (OT) but hadn't received any OT in "probably at least two weeks." R51 expressed frustration stating, "this is the whole reason I am here," and "I am not getting therapy." R51 stated one of the therapy staff had told her that the nursing staff could "work with my legs in bed" but "they aren't doing that." R51 stated she can no longer straighten her left leg which she could do prior to coming to the facility and indicated she currently used a Hoyer lift (a medical device used to transfer individuals, who cannot bear weight, with limited mobility from one place to another, such as a bed to a wheelchair). A Nursing Order-External Facility note, dated 3/4/25, indicated "Patient is cleared to toe touch during transfer while wearing a Darco shoe." A Nursing Order-External Facility note, dated 4/15/25, indicated "It is also recommended that the patient participate in physical therapy daily at the facility, while maintaining non-weight bearing status to the left heel, but can do to-touch transfers on the left foot. Darco shoes were provided during a previous appointment for this reason." A Nursing Order-External Facility note, dated 4/22/25, indicated "It is also recommended that the patient participate in physical therapy daily at the facility, while maintaining non-weight bearing status to the left heel, but can do to-touch transfers on the left foot. Darco shoes were	2 895			

Minnesota Department of Health

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2 895	Continued From page 13 provided during a previous appointment for this reason." R51's care plan, printed 5/1/25, lacked evidence of a restorative nursing program. Furthermore, lacked evidence of PT recommendations or recent assessments. During an interview on 4/30/25 at 10:39 a.m., registered nurse (RN)-B stated that nursing and therapy work together to coordinate care for residents. RN-B stated therapy would update nursing when there were changes to how residents ambulated, transferred or were new to the program. RN-B reviewed R51's electronic medical record (EMR) and verified R51 was discharged from OT on 4/16/25. RN-B verified R51 was not receiving any restorative nursing services after reviewing R51's EMR and three-ring binder that contains information on exercises for residents participating in the restorative nursing program. RN-B verified R51 was not receiving PT services, and stated R51 relied heavily on caregiver assistance. During an interview on 4/30/25 at 11:04 a.m., registered nurse manager (RN)-D reviewed R51's EMR. RN-D stated they reviewed communication with outside providers and had reviewed Nursing Order-External Facility Notes listed above. RN-D stated she had talked to therapy about changing R51 to "toe touch." RN-D stated she could not remember when she had talked to therapy, did not have documentation regarding the conversation, and stated she thought it was when she had reviewed the first note during "stand up" (interdisciplinary team meeting). RN-D verified R51 should have been assessed by therapy. During an interview on 4/30/25 at 11:11 a.m.,	2 895			

Minnesota Department of Health

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2 895	Continued From page 14 director of therapy (DOT)-A stated all residents had standing orders for therapy evaluations. DOT-A stated nursing communicated to therapy when a resident needed to be assessed or reassessed. DOT-A verified R51 was currently not getting any therapy (PT/OT) services. DOT-A stated R51 had PT services from 2/16/25 to 3/13/25, and OT services from 2/16/25 to 4/16/25. DOT-A stated R51 had not been reassessed for PT services since being discharged, and stated he had been given a copy of one of the Nursing Order-External Facility notes, did not remember exactly when it was, but did verify it was after R51 had discharged from PT services. DOT-A reviewed R51's EMR and verified there was no restorative nursing program. DOT-A stated R51 had "not been able to move her legs on her own since admission," and "we tried to get her to move her legs, but she always asked for help." DOT-A verified R51 transferred with a Hoyer lift since admission. DOT-A verified that a PT assessment should have been completed for R51. DOT-A stated R51 might not be able to bear weight, but it would be important to prevent any contractures. During a follow up interview on 5/01/25 at 8:56 a.m., RN-D verified R51 did not receive and had not received any restorative nursing services. During an interview on 5/01/25 at 9:34 a.m., director of nursing (DON) stated he had reviewed R51's EMR. DON stated R51 should have been reassessed by therapy. DON stated it was important to work with therapy and have a restorative nursing program to "see how we can improve your life and prevent things that shouldn't happen and live a better life." DON stated R51 was going to be reassessed by therapy today, and he had followed up with R51 that morning.	2 895			

Minnesota Department of Health

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2 895	Continued From page 15 DON had assessed R51 that morning (5/1/25) and stated R51 did not have any contractures in lower or upper extremities, decrease in extension of legs and therapy would complete a full reassessment this day. A facility policy titled Medication and Treatment Orders, dated 2/24, indicated "Orders for medications and treatment will be transcribed accurately and in a timely fashion." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for limited range of motion/ambulation to assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895			
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician	2 900			5/23/25

Minnesota Department of Health

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2 900	Continued From page 16 authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and, if needed, determine or develop proactive interventions to help address pressure injury risk and development after a new pressure injury was identified (i.e., change of condition) for 1 of 2 residents (R13) reviewed whom had active pressure injuries. Findings include: The Centers for Medicare (CMS) State Operations Manual (SOM) Appendix PP, dated 2/2023, identified definitions for pressure ulcer care and treatment. This included guidance provided on the several stages of injury definition which included, "Stage 3 Pressure Ulcer: Full-thickness skin loss ... subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible ... depth of tissue damage varies by anatomical location ... Undermining and tunneling may occur ... " R13's quarterly Minimum Data Set (MDS), dated 2/3/25, identified R13 had intact cognition along with multiple medical conditions including heart failure, high blood pressure, and multiple sclerosis (MS). The MDS outlined R13 consumed multiple high-risk medications including opioids,	2 900	Corrected		

Minnesota Department of Health

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2 900	Continued From page 17 diuretics and antiplatelets. Further, the MDS identified R13 was at-risk for pressure injury development and had one current stage IV pressure injury which had not been present upon admission. On 4/28/25 at 3:05 p.m., R13 was observed lying in bed while in her room. R13 had an air-alternating pressure mattress (APM) on her bed and was interviewed. R13 stated she had "a sore on my butt" which staff did a dressing change on multiple times a day. R13 stated she felt the wound was "slowly" healing but would likely never resolve. R13 stated she obtained the wound from sitting in her wheelchair for extended periods and reiterated it would likely never heal adding, "No matter what I do, it will never go away." R13 denied concerns with the wound and requested to end the interview due to feeling unwell. R13's Abbott Northwestern Hospital Wound Clinic Progress Note, dated 4/10/25, identified R13 was seen in the office for a wound check. R13's past medical history of her wounds was outlined within the note. This identified R13 presented in August 2024, for initial evaluation of the sacrum wound which had been present for " ... a few weeks and that it began without a clear cause." A section labeled, "Treatment Course," identified each visit and subsequent information of the wound and it's progress. On 1/27/25, the note recorded R13 was seen by a plastic surgeon and an MRI was ordered. R13 was recorded as being on protein supplement daily and having wound cares done " ... one or two times daily." On 4/10/25, the note recorded R13 was identified to have "a new wound to the right IT [ischial tuberosity] today." R13 was listed as continuing to get up in her wheelchair for approximately four hour	2 900			

Minnesota Department of Health

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2 900	Continued From page 18 increments every other day, still smoking, and still using protein supplement. The note recorded R13's new wound as, "Pressure Injury Stage [blank space] Stage 3," and listed it as having some slough present and being 3.4 X 1.5 X 0.1 (cm) in size. R13's care plan, printed 4/30/25, identified R13's actual or potential medical and/or care-related problems and corresponding interventions to address them. The care plan identified R13 had an alteration in skin integrity and required extensive assistance with bed mobility adding, "Resident runs the show ..." The care plan listed multiple interventions to address R13's skin risk and concerns including limiting her time seated in the powered wheelchair, monitoring skin integrity with cares, and using an air mattress. The last time the interventions were revised prior to the onsite survey was recorded as, "09/27/2024," with multiple interventions being added and/or revised on 4/29/25 and 4/30/25 (after survey started). R13's MHM (Monarch Healthcare Management) Skin Evaluation and Skin Risk Factors V-2, loaded 10/20/24, was identified with dictation present, "In Progress." However, the entire evaluation was left blank and not completed. There were no additional Skin Evaluation and Skin Risk Factors V-2 evaluations loaded or completed in the record. On 4/29/25 at 12:36 p.m., nursing assistant (NA)-A was interviewed, and verified they had cared for R13 prior adding, "[I've] worked with her many times." NA-A explained they often helped the nurses complete R13's wound care and stated R13 rarely got up from her bed due to her own choice. NA-A stated R13 would also, at times, refuse meals and seemed not "not really	2 900			

Minnesota Department of Health

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2 900	Continued From page 19 want you in there much." NA-A stated R13 used an air mattress and nurses would mix medications into her mashed potatoes. NA-A stated they were unsure how long R13 had the sacral pressure wound but added, "Since I started [working there]." NA-A described R13 as being somewhat "dismissive and independent" with her cares adding, "She knows what she wants." R13's dietary progress note, dated 4/24/25, identified a nutrition follow-up was completed due to R13's weight and wound adding, "Discussed resident at IDT [interdisciplinary team] wound meeting." R13's weight was outlined as stable and added, "Will discuss with nurse manager about increasing protein powder to 2 scoops per serving to better meet protein needs which would provide ~24 gm [grams] protein." However, the note lacked evidence of what, if any, other factors the IDT had reviewed which could contribute to pressure ulcer risk or skin breakdown (i.e., mobility, medication use, continence) to determine what, if any, interventions were needed to reduce the risk of skin breakdown and promote healing since R13 developed a new pressure injury on 4/10/25. When interviewed on 4/29/25 at 1:37 p.m., registered nurse (RN)-A stated they had worked with R13 multiple times prior. RN-A explained R13 did not like to get up from bed and would only get into her electric wheelchair "like every 3rd day" which was usually just so she could smoke outside. RN-A verified R13 had an active wound on her sacrum and expressed it was larger sized than an orange (fruit) adding "oh, it's bigger." RN-A stated the wound was slow to heal due to R13 being resistive with interventions and getting out of bed adding R13 had "super, super fragile skin." RN-A stated they were aware of R13	2 900			

Minnesota Department of Health

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2 900	Continued From page 20 having a second wound now, however, RN-A stated they felt it was "a little tiny one" and due to bandage-tape being pulled off the skin. RN-A stated they felt the wounds were both getting better just slowly adding aloud, "It's really slow to heal." RN-A stated the nurse manager would like know more about the wounds as they tracked it and measure it. On 4/30/25 at 9:36 a.m., licensed practical nurse manager (LPN)-C was interviewed, and verified they had a chance to review R13's medical record. LPN-C verified R13 had two active pressure injuries which both developed in-house, and explained R13 "beats to her own drum" with cares and interventions. LPN-C stated the wound was checked for measurements and status every week, and R13 was also being seen by an outside wound clinic for it at times. LPN-C stated R13 had been educated on the risks of not allowing repositioning and being so specific with what interventions she would allow. LPN-C explained the right IT pressure injury was new and recorded as a "stage three pressure area" from the wound clinic. LPN-C verified the first recorded evidence of the wound was on 4/10/25 from the wound clinic note, and explained when a new wound developed the staff wanted to obtain treatment orders, update the provider, and then the "plan of care" needed to be updated. LPN-C stated R13's wound treatments were "tweaked" due to the new wound. LPN-C stated the facility' skin evaluation evaluation (i.e., MHM Skin Evaluation and Skin Risk Factors V-2) was just "an extra tool" to help review someone adding the "comprehensive part" of the review could be more within the IDT discussion which happened every morning. LPN-C then provided a Microsoft Word document which had IDT notes listed on it.	2 900			

Minnesota Department of Health

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2 900	Continued From page 21 The untitled page, undated, identified R13's name along with, "New Wound Right IT." The page outlined, "IDT discussed and reviewed Care Plan and orders for any changes to interventions. Resident continues 'to run the show' and does not allow [hospital] wound clinic repositioning direction. Uses pillows. New Orders for wound healing, dietician involved, provider updated, Resident involved." However, the provided document lacked evidence what, if any, other interventions were considered, offered, refused despite R13 having multiple wounds and being resistive to recommendations. Further, R13's medical record was reviewed and lacked documented evidence R13 had been comprehensively reassessed for pressure wound risk or what, if any, interventions were considered, adopted or agreeable despite R13 developing another wound with some interventions, such as monitoring and an air mattress, already in place prior to the right IT wound developing. At this time, the director of nursing (DON) joined the interview via telephone. DON explained a new wound should be assessed and photographed, then the provider and family should be updated. DON stated the IDT would then discuss the wound and review the care plan. DON stated they felt "everything was in place" for R13 and reiterated R13 likes to "do her own thing" with cares she will allow. DON stated the skin evaluation form was "just a tool" and expressed they didn't feel completing one was necessarily required for a new wound development adding, "We don't have a policy for that." LPN-C verified R13's medical record lacked evidence of a comprehensive reassessment being done in the evaluations or progress notes. DON acknowledged the actual medical record possibly	2 900			

Minnesota Department of Health

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2 900	Continued From page 22 lacked evidence of the IDT' discussion on R13's new pressure injury adding aloud, "I see what you're saying." DON stated having the documentation in the medical record was important to promote continuity of care. A facility-provided Skin Assessment & Wound Management policy, dated 2/2025, identified a pressure ulcer risk assessment (Braden Scale) would be completed per an established schedule and, "Skin Evaluation and Skin Risk Factors Form is completed before initial MDS, annually, and upon significant change." A section labeled, "New Skin Problem," outlined a series of steps to be completed for developed pressure injuries which included notifying the provider, completing education with the resident, and initiating the Skin and Wound Evaluation (i.e., weekly monitoring). However, the policy section lacked direction or guidance on how a comprehensive reassessment process would look or be documented within the medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on pressure injury evaluation and assessment; then educate nursing staff and audit on an ongoing basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 900			
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the	2 910			5/23/25

Minnesota Department of Health

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2 910	Continued From page 23 unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a resident with a catheter had medical justification for continued use and failed to attempt a trial removal, if recommended, for one of one resident (R35) reviewed for indwelling catheter. Findings include: R35's quarterly Minimum Data Set (MDS), dated 3/25/25, indicated R35 had moderate cognitive impairment, required supervision with toileting and moderate assistance with bathing and had an indwelling catheter in place. R35's admission MDS, dated 5/23/22, indicated R35 was admitted with an indwelling catheter in place. R35's Diagnoses, dated 5/16/22, indicated R35 had several medical diagnoses related to potential need for an indwelling catheter including "other obstructive and reflex uropathy" which can hinder the normal flow or urine, unspecified retention of urine, renal hypoplasia (a congenital	2 910	Corrected		

Minnesota Department of Health

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2 910	Continued From page 24 condition in which one or both kidneys are underdeveloped), benign prostatic hyperplasia with and without lower urinary tract symptoms (a non-cancerous enlargement of the prostate gland), and infection and inflammatory reaction due to indwelling urethral catheter. However, the electronic medical record (EMR) failed to demonstrate duration of the retention, attempts (if any) to manage without a catheter, and medical justification for why the catheter was necessary on an ongoing basis (i.e neurogenic bladder). The EMR further lacked any evidence of post void residual (PVRs) to determine the extend of R35's urine retention. A urology note for R35, dated 7/28/22, stated "anticipate "SP" (suprapubic catheter - a urinary catheter that is surgically inserted through the abdominal wall directly into the bladder) on 8/17/22. The EMR lacked any evidence of follow up on this order or potential for a SP catheter to be placed. During an interview on 4/30/25 at 9:41 a.m., R35 stated he believed he had his catheter since coming to Minnesota years ago to "prevent urine leaking on the plane." R35 stated it has had an indwelling catheter since then because he has only had 2-3 urinary tract infections with the indwelling catheter in place. During an interview on 4/30/25 at 12:42 p.m., nurse manager and registered nurse (RN)-D stated she emailed R35's provider that day about an appropriate catheter diagnosis, stating "I don't believe we have [one]." RN-D further stated the facility had not attempted to remove R35's catheter since his admission to the care facility to assess the extent of his urine retention or if it could be managed without an indwelling catheter.	2 910			

Minnesota Department of Health

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2 910	Continued From page 25 During a follow up interview on 4/30/25 at 2:33 p.m., RN-D stated R35 had an appointment with urology on 5/1/25, and she would follow up on the goal for his catheter, including a proper diagnosis, order for a removal attempt, or a supra pubic placement, stating it was not clear what the goal for his indwelling catheter currently was. A facility policy titled Indwelling Catheter Care Procedure was provided, however it only spoke to proper care of a residents catheter while in place i.e. peri care with a catheter, emptying catheter bags and ensuring they are draining properly. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on indwelling catheter evaluation and assessment; then educate nursing staff and audit on an ongoing basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 910			
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the three-compartment dish sink was of proper	21015	Corrected		5/23/25

Minnesota Department of Health

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21015	Continued From page 26 sanitization parts per million (ppm) which had the potential to affect all 76 residents who received meals from the main kitchen. Furthermore, the facility failed ensure employees wore beard restraints to prevent hair from contacting food. Findings Include: A report titled Diet/consistency Rollup printed on 4/30/25, categorized each diet and had total meals served out of the main kitchen as 76. During the initial kitchen walk through conducted on 4/28/25 at 1:22 p.m., an area over the three-compartment sink had logs for documentation of water sanitization for April 2025, completed for April 1-24th. Above the sink were two large bottles held by a wire rack with two tubes that ran down into the three compartment sink, both were empty. The bottle on the left was labeled quaternary sanitizer and the one on the right was labeled pot/pan detergent and sanitizer. A large bottle of Dawn dishwashing detergent sat on the far right of the three-compartment sink. A cook was wearing a navy-blue baseball cap and had a beard that extended from the chin approximately 1". During an interview on 4/28/25 at 2:11 p.m., culinary services director (DOC)-A confirmed hair nets were available for employees and donned one himself. DOC-A stated employees needed to either wear a hat or a hairnet. DOC-A then stated if a beard was "too big" they need to wear a cover or shave it, and after a couple of days beards should be shaved or covered or else it could fall into the resident's food. DOC-A could not recall a facility policy on beards in the kitchen, but said employees would be written up if they didn't wear a beard restraint. DOC-A confirmed beard	21015			

Minnesota Department of Health

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21015	Continued From page 27 restraints were not available for employees at the kitchen entrance or in the office on 4/28/25. During an observation on 4/29/25 at 11:43 a.m., The pots/pan detergent and sanitizer bottle above the three compartment sink had approximately 1 inch of a blue bubbly solution. On the right hand of the three-compartment sink was a large bottle of Dawn dish detergent. During an observation and interview on 4/29/25 at 12:07 p.m., cook (C)-A removed a puree mixer lid and blade from the drying rack located on the left of the three-compartment sink. C-A stated the puree mixer was hand washed with Dawn and often Dawn detergent was added to the pots/pans bottle above the sink. Dawn and water were then mixed and the sink was filled to wash pots, pans, and kitchen utensils. During an interview on 4/29/25 at 2:08 p.m., dietary aid (DA)-A stated the three-compartment sink area was used for pots and pans. The pots and pans were scrubbed with Dawn and then used to cook. All resident dishware was put through dishwasher. During an observation on 4/30/25 at 12:41 p.m., Dawn dish detergent was used to wash a clear/gray plastic top to the puree mixer. The top was rinsed off and set on the side of the sink to dry. These items were rinsed less than 30 seconds. During an interview on 4/30/25 at 12:43 p.m. C-A stated no thermometer was available to check the water coming out of the sink and confirmed a puree blender top were hand washed with Dawn and other kitchen utensils.	21015			

Minnesota Department of Health

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21015	Continued From page 28 During an observation on 5/1/25 at 9:44 a.m., a three-compartment sink had a large bottle of Dawn dish soap. During an interview on 5/1/25 at 10:31 a.m., DOC-B stated the facility policy allowed for manually washing dishes in the three-compartment sink, but all dishes needed to be sent through the dishwasher to be sanitized. DOC-B stated he was not aware the cooks were manually washing and reusing the items without sending the items through the dishwasher and replied, "oh no, they can't do that" to which the nearby DOC-A responded, "yes we talked about that". DOC-B also confirmed beards should be no longer than a ½" for all Monarch facilities and that C-A should wear a beard cover. Facility Policy titled Sanitization, revised October 2008, "#9 Manual washing and sanitizing will employ a three-step process for washing, rinsing and sanitizing. C: Sanitize with hot water or chemical sanitizing solution. Chemical sanitizing solution may consist of: Chlorine, Iodine, Quaternary ammonium. Facility Policy titled Cleaning and Disinfection, revised September 2012, "Mixer bowls, beaters, grinders, pots, pans, roasters, electric knife, blades, food thermometers, etc. 1. Wash in 3 compartment sink or dishwasher: a. 1st compartment-soap and water (110-120 degrees Fahrenheit). B. 2nd compartment-clear water for rinsing (120 degrees Fahrenheit). c. 3rd compartment-Detergent/disinfectant (170 degrees Fahrenheit for 2 minutes). 2. Allow to remain wet for 10 minutes to air dry. Facility Policy titled Food Preparation and Service, revised April 2019, "Food and nutrition	21015			

Minnesota Department of Health

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21015	Continued From page 29 services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food" SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate infection control technique is maintained in the kitchen. The facility could update or create policies and procedures, and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits periodically to ensure compliance. The facility should report audit findings to Quality Assurance Performance Improvement (QAPI) for further recommendations and to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015			
21675	MN Rule 4658.1410 Linen Nursing home staff must handle, store, process, and transport linens so as to prevent the spread of infection according to the infection control program and policies as required by part 4658.0800. These laundering policies must comply with the manufacturer's instructions for the laundering equipment and products and include a wash formula addressing the time, temperature, water hardness, bleach, and final pH. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure soiled personal	21675	Corrected		5/23/25

Minnesota Department of Health

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21675	Continued From page 30 laundry and linens were bagged (i.e., contained) at the point-of-use and transported in a manner to reduce the risk of cross-contamination and potential infectious spread in 1 of 1 main washrooms and 2 of 2 units (70's, 90's) reviewed. This had potential to affect all 75 residents within the care center. Findings include: On 4/29/25 at 7:57 a.m., the campus' main laundry washroom was toured with housekeeper (HSK)-A present. HSK-A explained they were the primary person who completed laundry for the care center, and they then provided a tour of the laundry process and the machines used. The soiled linen receiving area and washroom were located on one side of the hallway and folding area (clean) on the opposite. However, in the hallway between these areas were a series of mobile, off-white colored hard plastic bins including one labeled, "Soiled Linen Only," in black paint. The bin was covered with a light-blue colored cloth covering which was lifted exposing it's contents which was soiled white linens and personal clothing, much of which was not bagged but rather loose in the bin causing articles to touch. HSK-A verified the items were not bagged and expressed they should have been prior to transport. HSK-A stated the bin was likely brought down last evening by the nursing assistant (NA) staff. HSK-A stated they had, at times, noticed soiled laundry items to be coming down to the main washroom not bagged adding aloud "on occasion, yes." HSK-A stated they had talked about the issue with the care center administrator in the past, however, added, "But not as frequently as maybe I should have, to be honest." HSK-A then verified they had not collected any soiled linen from the units today yet.	21675			

Minnesota Department of Health

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21675	Continued From page 31 A tour of the '70's Unit' was then completed. The soiled utility room was opened with HSK-A present which, inside, had three mobile, off-white containers similar to the one observed by the washroom. HSK-A stated two were used for trash and one was used for soiled linens and personal clothing. The laundry container had a balled-up light-blue cloth cover inside the corner of the container and, again, nearly all of the soiled laundry inside was not bagged. HSK-A stated they items should be bagged at the point-of-use and not transported loosely like it appeared had happened adding aloud, "[They should be] bagging in, bagging out." HSK-A stated most of the personal laundry and linens were laundered by the care center adding, "Pretty much [yes]." HSK-A stated the soiled linen should be bagged to help prevent "cross contamination" between the garments. Following, a tour of the '90's Unit' was then completed. The soiled utility room was opened with HSK-A present which, inside, had multiple mobile, off-white containers similar to the one observed by the washroom and '70's unit.' The container for soiled linens and laundry was uncovered and, inside, nearly all of the garments and linens were not bagged. Further, sitting on top of the soiled laundry was two yellow-colored bags which had markings on them to indicate potential bio-hazard (i.e., isolation room, active infection). HSK-A verified the items were not covered or bagged and stated aloud, "That will be addressed today." HSK-A stated they did complete audits of laundry care which included walking around with the administrator and observing general cleanliness. HSK-A stated they would provide these for review.	21675			

Minnesota Department of Health

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21675	Continued From page 32 A series of three Monthly Facility Tour Form(s), dated 12/27/24 to 3/28/25, were provided. These outlined various areas of the care center and provided spacing to record a score (0 to 10) of cleanliness of the corresponding area. A section was listed, "Laundry/Linen," which outlined three specific areas to review including linen closets, personals, and laundry room. The spacing provided to write-out any "comments" was left blank and no concerns were written. However, the provided audits all lacked evidence the soiled utility rooms (where soiled linens were kept until transport to the washroom) were included in the review or audit process. On 4/30/25 at 10:01 a.m., the interim director of nursing (DON) was interviewed, and they verified they were the campus' infection preventionist (IP). DON explained they have educated staff through staff meetings and such about the need to bag soiled items where collected, and he verified soiled laundry and linens should be bagged prior to transport. This was important to do as staff could "spread infections from one place to another." DON added, "We will continue to do staff education and follow-up with the staff." A facility-provided Infection Prevention and Control Program policy, dated 11/2024, identified the facility would establish and maintain an infection prevention and control program (IPCP) designed to provide a safe, sanitary and comfortable environment. The policy outlined several steps taken with this program including infection surveillance, antibiotic stewardship and data analysis; however, the policy lacked information on soiled linen handling or transportation. A separate, facility-provided Skill 6. Gown, Glove, and Bag Linen protocol, undated, identified a checklist for staff to	21675			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/01/2025
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21675	Continued From page 33 implement with gown removal and soiled item collection in an isolation room. This identified, "5. Remove the soiled linen. Keep the linen contained during removal and place in the appropriate bag/receptacle." A facility' policy on soiled laundry handling and transportation was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on soiled linen handling and transport to ensure accuracy; then educate floor staff and audit routinely to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21675			
21705	MN Rule 4658.1415 Subp. 6 Plant Housekeeping, Operation, & Maintenance Subp. 6. Heating, air conditioning, and ventilation. A nursing home must operate and maintain the mechanical systems to provide comfortable and safe temperatures, air changes, and humidity levels. Temperatures in all resident areas must be maintained according to items A to C: A. For construction of a new physical plant, a nursing home must maintain a temperature range of 71 degrees Fahrenheit to 81 degrees Fahrenheit at all times. B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season. C. Variations of the temperatures required by items A and B are allowed if the variations are based on documented resident preferences.	21705			5/23/25

Minnesota Department of Health

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21705	Continued From page 34 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a sanitary and homelike environment for 1 of 1 residents (R40) whose tube feeding pole and equipment had dried, white substance on it. Findings include: R40's quarterly Minimum Data Set (MDS) dated 2/25/25, identified R40 with intact cognition and diagnoses of depression, anxiety, chronic respiratory failure resulting in oxygen dependence, and a history of head and neck cancer with all nutrition through a percutaneous endoscopic gastrostomy (PEG) tube (soft flexible feeding tube inserted through the abdominal wall into the stomach). During observation on 4/28/25 at 5:07 p.m., R40's tube feeding (TF) pole was coated with dried white substance on entire surface of the pole and all five legs of the base. The TF unit/machine had greasy smeared substance on the entire front programming screen. During interview with licensed practical nurse (LPN)-A on 4/29/25 at 1:03 p.m., LPN-A stated the nursing staff was responsible for wiping down and cleaning tube feeding equipment if there were spills or visible soil on the unit and pole. During observation on 4/29/25 at 1:06 p.m., R40's tube feeding (TF) pole was coated with dried white substance on the entire surface of the pole and all five legs of the base. The TF unit/machine had greasy smeared substance on the entire front programming screen.	21705	Corrected		

Minnesota Department of Health

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21705	Continued From page 35 During observation and interview with registered nurse (RN)-B on 4/29/25 at 1:18 p.m., RN-B stated "everyone" is responsible for making sure patient care equipment was clean. "If we see if it is dirty we should clean it so the gunk doesn't dry like concrete." During observation and interview with RN-B on 4/29/25 at 1:21 p.m., RN-B looked at R40's TF pole and machine and stated, "that is horrible". RN-B stated the white substance appeared to be TF solution that was not wiped up after nurses prepared to administer the solution and following disconnecting the feedings from R40. During interview with R40's spouse on 4/29/25 at 1:22 p.m., R24 stated the pole was soiled in appearance and, "It is not good to look at. No one wipes up their spills or messes." During interview with R40 on 4/29/25 at 2:07 p.m., R40 stated the TF pole and machine "is always cruddy looking". R40 stated he had never seen any staff member clean or wipe up the TF solution or wipe down the feeding equipment before or after attaching the feeding to his PEG. During interview with director of nursing (DON) on 4/29/25 at 10:50 a.m., DON stated expectation of nursing staff to be cleaning and wiping the machine, pole, and the base of the pole if there is spillage or visible soil on them. DON stated it was a concern for infection control and dignity for the resident. Facility policy requested for environmental cleaning of patient care equipment and not received.	21705			

Minnesota Department of Health

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21705	Continued From page 36 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21705			
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was maintained for 2 of 2 residents (R54, R74) who utilized urinary catheters. Findings include: R54 R54's annual Minimum Data Set (MDS) dated 4/17/25 identified R54 with intact cognition,	21810	Corrected		5/23/25

Minnesota Department of Health

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21810	Continued From page 37 impairment of both lower extremities, dependent on staff for toileting hygiene and lower body dressing and had an indwelling catheter (tube for urine collection from bladder to a bag outside of the body). During observation on 4/28/25 at 1:42 p.m., R74 was lying in bed with an uncovered large urine drainage bag attached to side of bed visible to the hallway. During observation on 4/28/25 at 2:39 p.m., R74 was lying in bed with an uncovered large urine drainage bag attached to side of bed visible to the hallway. Two staff walked past the room. At 5:13 p.m., a staff member pushed a meal cart past R74's room. At 5:15 p.m., one staff member was observed inside the room speaking to R74 and left the room. During observation and interview with R74 on 4/28/25 at 6:35 p.m., R74 was lying in bed with an uncovered large urine drainage bag attached to side of the bed visible to the hallway. R74 stated, "staff have never asked me if I wanted a cover on my urine bag." And "I imagine other people would not feel comfortable looking at my urine in this bag. I guess I would not like to see anyone else's urine in their bag if I think about it." During observation and interview on 4/29/25 at 8:39 a.m., registered nurse (RN)-B was obtaining medications from the medication cart which was located across the hall from R54. RN-B observed the uncovered partially filled large urine drainage bag from hall and stated, "catheter bag should be covered for dignity and decency." R74 R74's admissions MDS dated 4/6/25 identified	21810			

Minnesota Department of Health

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21810	Continued From page 38 R74 with intact cognition, required substantial to maximal assist with toileting hygiene and lower body dressing, and had an indwelling catheter. During observation on 4/29/25 at 8:03 a.m., R74 wheeled self around hallway seated in wheelchair with large urine drainage bag attached to underside of wheelchair. R74 wheeled self to nursing station where four residents were eating a meal at tables adjacent to the nursing station. The urine bag was visible and uncovered. During observation and interview on 4/29/25 at 8:31 a.m., licensed practical nurse (LPN)-A observed R74 wheel past her as she was obtaining medications from medication cart and stated, "that [urine bag] should be covered for dignity." During interview with R74 on 4/30/25 at 10:04 a.m., R74 stated, "It [catheter drainage bag] was never covered until yesterday when they [staff] came in and put one[sic] cover on it. I don't want to see another person's pee[urine]. I should be more respectful." During interview with director of nursing (DON) on 4/30/25 at 10:48 a.m., DON stated, "Foley [catheter] need to be covered" and stated the uncovered catheter bags were a concern for infection control and dignity. Facility policy for dignity was requested and not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility	21810			

Minnesota Department of Health

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21810	Continued From page 39 could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810			
21860	MN St. Statute 144.651 Subd. 16 Patients & Residents of HC Fac.Bill of Rights Subd. 16. Confidentiality of records. Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Copies of records and written information from the records shall be made available in accordance with this subdivision and section 144.335. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third party payment contracts, or where otherwise provided by law. This MN Requirement is not met as evidenced by: During observation and interview, the facility failed to ensure resident records that contained private, medical, and personal information were not accessible to unauthorized personnel. This	21860	Corrected	5/23/25	

Minnesota Department of Health

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21860	Continued From page 40 had the potential to affect 20 residents on the first floor of facility, and all 13 residents on the second floor whose personal information was listed on exposed care sheets. Findings include: During observation and interview starting on 4/29/25 at 12:54 p.m., licensed practical nurse (LPN)-A was observed to leave medication cart and enter a resident room. A patient care sheet was left on top of the medication cart showing private patient information for 8 residents. At 12:58 p.m., three staff members walked past the cart. Upon returning to medication cart at 1:01 p.m., LPN-A stated the unattended care sheet belonged to another clinician and "he should have moved it" demonstrating turning the form over and placed it under the work laptop. LPN-A stated the uncovered unattended care sheet had private patient information and it was important to secure that information to only those who require it. During observation and interview starting on 4/29/25 at 3:44 p.m., an unattended care sheet with 12 residents' private health care information was observed on top of medication cart in the hallway of first floor. Three staff members walked past the cart. Then registered nurse (RN)-C exited resident room and walked to the medication cart. RN-C stated he had left the exposed care sheet on the medication cart. RN-C stated he should not have left it unattended "due to privacy and HIPAA". During observation and interview starting on 4/30/25 at 7:41 a.m., trained medication aide (TMA)-A left medication cart unattended with an exposed patient care sheet containing information for all 13 residents of the second floor. The	21860			

Minnesota Department of Health

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21860	Continued From page 41 medication cart was located across from the dining room and residents were starting to appear for breakfast. One resident moved past the cart and another staff member walked past the cart. At 7:44 a.m., TMA-A returned to the medication cart and stated she had left the care sheet unattended and exposed. TMA-A stated, "I should flip that over for privacy". During interview with director of nursing (DON) on 4/30/25 at 10:48 a.m., DON stated unattended and exposed patient care sheets were a HIPAA violation and impacted dignity and privacy. DON stated "[it]should not be done" to ensure resident information is not available for everyone to see. Undated facility policy titled HIPAA state, "Simple tips to remain compliant: Don't not leave care sheets or other client identifying papers laying out." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for maintaining confidentiality of records. All staff could be educated as necessary to the importance of compliance with handling and securing medical records. The DON or designee, could perform observational audits to ensure staff are locking access to medical records when not physically present. The DON or designee could take that information to QAPI to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: (21) days.	21860			
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights	21880			5/23/25

Minnesota Department of Health

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21880	Continued From page 42 Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that 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			

Minnesota Department of Health

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21880	Continued From page 43 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure grievances were sufficiently acted upon for 1 of 1 resident (R53) reviewed for grievances. Findings Include: R53's quarterly Minimum Data Set (MDS) dated 3/21/25, indicated R53 was cognitively intact. During an interview on 4/28/25 at 4:28 p.m., R53 stated approximately two months ago, during an evening shift a nursing assistant entered her room and attempted to change an incontinent brief. R53 was concerned because she didn't wear incontinent briefs, and the aid was unkind during the encounter. The following morning R53 reported the incident to staff. During a subsequent interview on 4/29/25 at 1:28 p.m., R53 stated she filed a grievance approximately two months ago and requested the nursing assistant not return to the unit. R53 confirmed that no one from the facility followed up with the results of the grievance. R53 stated the aid did work on the unit after staff was made aware of the incident and told residents he had been off for two weeks "having a party". R53's progress notes failed to mention an incident which occurred on or around February 2025 through March 2025. Facility Report of Grievances/Complaints/Care Concerns 2024-2025 contained a list of	21880	Corrected		

Minnesota Department of Health

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21880	Continued From page 44 grievances related to care concerns and lost items. The list lacked indication R53 filed a grievance. During an interview on 4/29/25 at 2:21 p.m., nursing assistant (NA)-D stated the completed grievance forms were kept on file in the social workers office. The process would be if a resident had a concern, staff would talk to the charge nurse. Grievance forms were completed by the residents, or a social worker could assist with the forms. During an interview on 4/29/25 at 2:46 p.m., registered nurse (RN)-D stated all grievances were given to social services and resolved using an electronic software, Med Trainer. RN-D stated R53's grievance was unfamiliar, but whomever was working should have filed a grievance immediately. During an interview on 4/30/25 at 9:13 a.m., social services (SS)-A stated when a resident filed a grievance, social services, the DON, and the Administrator would start collecting staff and resident statements. If the grievance fell under nursing, nursing aids, or resident cares the DON would follow-up. Grievances were manually entered into Med Trainer and once the hard copy was scanned into the program, the paper could be discarded. All statements, education, or resolutions were scanned into Med Trainer. SS-A was not 100% familiar with R53's grievance but remembered hearing about a concern with an employee. During an interview 4/30/25 at 9:15 a.m., Administrator in Training (AIT) called the DON who stated the previous social services director, SS-B, was involved in addressing the concern.	21880			

Minnesota Department of Health

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21880	Continued From page 45 During an interview 4/30/25 at 9:31 a.m., Activities Director(A)-A stated R53 asked why the facility didn't follow up with the grievance form. A-A then reported her concern to facility leadership. During an interview 4/30/25 at 9:48 a.m., (SS)-B stated no involvement in R53's grievance in February or March of 2025. During an interview 4/30/25 at 9:53 a.m., Administrator stated on or about 3/7/25, a nursing assistant entered R53's room without checking the Kardex, the aid started to do cares, R53 said to stop, and he left the room. The administrator indicated the issue was addressed with the aid, however was unable to locate the grievance form, or any written resolution provided to R53. Administrator confirmed someone was aware of the incident and it was investigated but there was no resolution or follow up by the facility provided to R53 at that time. Facility Policy titled Complaint and Grievance, revised 9/2023 stated, "a grievance form should be completed when a complaint has been given to any employee of the facility". "All completed grievance forms will be kept on record at the facility for a period of no less than three years". SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to greivances to ensure grievances are acted upon and the resident given a resolution to the identified grievance. The director of nursing, social worker, or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure	21880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/01/2025
NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT FARIBAULT LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
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21880	Continued From page 46 grievacnes are acted upon and the resolution notification is made to the resident and/or family. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880			

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/28/25 to 5/1/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were completed. Your facility was found not in compliance with the MN State Licensure and the following correction orders are issued. Please	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

05/15/25

Minnesota Department of Health

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2 000	Continued From page 1 indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H50673432C (MN108925), H50673430C (MN108926), H50673429C (MN109479), H50673431C (MN109573), H50673433C (MN109643) 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading	2 000			

Minnesota Department of Health

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2 000	Continued From page 2 completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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.	2 000			
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded with the potential for inaccurate federal reimbursement and resident care planning for 1 of 1 resident (R77) reviewed for MDS accuracy. Findings include: R77's completed discharge return not anticipated (DRNA) MDS, dated 2/4/25, identified R77 discharged on 2/4/25, with a recorded discharge status reading, "04. Short-Term General Hospital (acute hospital, IPPS)."	2 550	Corrected	5/23/25	

Minnesota Department of Health

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2 550	Continued From page 3 R77's census had an admitted date of 1/13/25, and discharged date of 2/4/25. R77's progress note, dated 2/4/25, identified R77 discharged home to an assisted living care facility at approximately 11:00 a.m. by medical transport. R77's discharge instructions and summary dated 2/4/25, indicated that R77 was admitted on 1/13/25, and discharged to Fairbault Senior Living on 2/4/25, following a course of therapy. During an interview on 4/30/25 at 8:35 a.m., licensed practical nurse (LPN-D), the facility MDS coordinator, reviewed R77's MDS dated 2/4/25, and confirmed the discharge was coded for hospitalization and should have been coded for assisted living. LPN-D stated that R77's discharge MDS was coded as #4, a short-term general hospital and should have been coded as #1 assisted living facility discharge. MDS Completion Policy was requested, but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to performing Minimum Data Set (MDS) assessments and the collection of required information. The director of nursing or designee should educate staff to the policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring.	2 550			

Minnesota Department of Health

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2 550	Continued From page 4	2 550			
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview, observation, and documentation review, the facility failed to ensure a comprehensive care plan was developed and maintained to ensure appropriate care was provided for 1 of 1 resident (R51) reviewed for smoking. Findings include: R51's admission Minimum Data Set (MDS) assessment, dated 2/19/25, indicated R51 had intact cognition with no hallucinations or delusions present and no behaviors. Section J: Health Conditions indicated R51 currently used tobacco. Section O: Special Treatments and Programs	2 555	Corrected	5/23/25	

Minnesota Department of Health

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2 555	Continued From page 5 indicated R51 used oxygen. R51's Admission Record, printed 5/1/25, identified R51's admission date to the facility as 2/13/25. Furthermore, it identified the following relevant diagnoses: nicotine dependence, emphysema (chronic lung disease that progressively damages the tiny air sacs in the lungs), and congestive heart failure (condition where the heart doesn't pump blood as efficiently as it should). During an interview on 4/28/25 at 6:54 p.m., R51 stated she smoked cigarettes. R51 stated she had smoked for "a long time." R51 stated the facility "assessed me to make sure I am ok to smoke." R51 stated she had smoked since she has been at the facility and staff had been aware of her smoking. R51 stated she currently used oxygen at night only and did not wear it during the day. R51 stated she never wore her oxygen when she smoked. R51's care plan, reviewed on 4/28/25, lacked evidence of R51 being a current cigarette smoker. Furthermore, the care plan lacked the identification of safety interventions needed during the smoking assessments (i.e., ensuring resident removes oxygen while smoking). R51's Smoking Evaluations, dated 2/13/25, 2/17/25 and 4/14/25, identified R51 as a current smoker. During interview on 4/30/25 at 10:41 a.m., registered nurse (RN)-B verified they work with and were familiar with R51. RN-B stated R51 currently smoked and had smoked since admitting to the facility. RN-B reviewed R51 electronic medical record (EMR) and verified	2 555			

Minnesota Department of Health

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2 555	Continued From page 6 three smoking assessments had been completed. RN-B stated if a resident was identified as a smoker it should be on the care plan as "everything should be on the care plan." RN-B verified R51 lacked identification that R51 was a smoker. RN-B verified they were adding it to the care plan during the interview, stating, "it should be on there." During an interview on 5/1/25 at 8:48 a.m., registered nurse manager (RN)-D stated when a resident admitted to the facility, a smoking assessment was to be completed which included observing the resident smoke, and assessing for safety risks and concerns. RN-D stated if a resident was a smoker it needs to be added to the care plan. RN-D stated R51 currently smoked. RN-D reviewed R51's EMR and verified smoking assessments completed on 2/13/25, 2/17/25, and 4/14/25. RN-D reviewed R51's care plan and stated, "I might be wrong, but it shows a date initiated 4/30/25, for smoking but I am not sure if I am looking at it right." During an interview on 5/1/25 at 9:29 a.m., director of nursing (DON) reviewed R51's EMR. DON verified R51 was a current smoker, had smoked since admission, and the care plan had not been updated until 4/30/25 (two days after survey entrance). DON stated it was important to have a comprehensive care plan as "that is how you care for the resident." A facility policy titled Care Planning, dated 11/2024, indicated "The care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident." SUGGESTED METHOD OF CORRECTION:	2 555			

Minnesota Department of Health

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2 555	Continued From page 7 The director of nursing (DON) or designee should create and/or review or revise policies and procedures related to creating and implementing a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555			
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed ensure the care plan was	2 570	Corrected		5/23/25

Minnesota Department of Health

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2 570	Continued From page 8 updated and revised to reflect current interventions for 1 of 1 resident (R62) reviewed for positioning and mobility. Findings include: R62's quarterly Minimum Data Set (MDS) dated 2/28/25, identified R62 as independent with mobility, had no upper extremity impairment (shoulder, elbow, wrist, hand), and used a walker. R62's Occupational Therapy Discharge Summary dated for services March 12, 2025, through April 9, 2025, indicated therapy was provided seven times for muscle weakness. R62's therapy involved improved strength for the left wrist, and R62 was given a brace on 4/9/25. Therapy directed R62 to wear the brace as tolerated. R62's care plan with a review date of 3/17/25, indicated a walking program of 200 feet one to three times per day with an assist of one during ambulation, bed movements, and transfers. The care plan lacked updates after R62 was discharged from therapy to walk independently with his walker and given a brace for his left wrist. R62's progress note dated 4/11/25, indicated R62 had a diagnoses of chronic kidney disease, type two diabetes, orthostatic hypotension, dehydration, and a failure to thrive (gain weight). R62's medications were noted as increasing a risk for falls and that R62 was an assist of one with transfers and mobility and with all activities of daily living. R62's progress note dated 4/17/25, indicated R62 was seen by the medical doctor and no new orders or changes to the current plan of care. R62 was also seen by the nurse practitioner on	2 570			

Minnesota Department of Health

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2 570	Continued From page 9 4/16 no new orders or changes to the current plan of care. During observation and interview on 4/28/25 at 4:10 p.m., R62 was wearing a black brace on his left wrist. R62 stated the brace was for significant pain but was unable to explain the reason for its use or where it came from. During an interview on 4/30/25 at 10:54 a.m., director of therapy (DOT)-A stated that R62 had recently undergone therapy for hand weakness and joint pain in the thumb, with therapy sessions from March 12, 2025, through April 9, 2025. DOT-A also confirmed that R62 had participated in therapy on three separate occasions in 2024. Additionally, DOT-A confirmed that the brace on R62's left hand was used for joint pain and the brace was applied intermittently with R62 being independent with its use, and continued use was recommended. R62 discharged with independent use of a walker and self-cares. DOT-A stated R62 needed no supervision with the walker or the brace at the time of discharge and managed these items independently. Nursing managed any care plans or concerns related to their use. R62 was given a "green card" and walked the entire facility. DOT-A confirmed R62's care plan stated he was on a walking program of 200 feet one to three times a day with staff assist and acknowledged the care plan needed to be revised. Licensed practical nurse (LPN)-D, who shared a desk with therapy, joined the interview, reviewed R62's care plan, and acknowledged R62 was now independent with his walker and was no longer on the walking program. Additionally, LPN-D stated the wrist brace wasn't care planned because R62 was independent with its use and the walking program was a standing order and did not need revision.	2 570			

Minnesota Department of Health

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2 570	Continued From page 10 During an interview on 4/30/25 at 12:26 p.m., registered nurse (RN)-D stated all braces and splits should be care planned and positioning should be checked under skin to make sure it is intact. RN-D reviewed R62's care plan and confirmed the care plan did not mention the brace worn on the left wrist. RN-D stated it was important to put braces on the care plan to monitor for alteration of skin integrity and skin breakdown. A policy titled Care Planning revised on 11/2024 and stated the care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to creating and implementing a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570			

Minnesota Department of Health

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2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide services to maintain and/or prevent loss of range of motion and contracture care for 1 of 1 residents (R51) reviewed for limited range of motion. Findings include: R51's admission Minimum Data Set (MDS) assessment, dated 2/19/25, indicated R51 had intact cognition with no hallucinations, delusions, behaviors or rejection of care. In addition, R51 had no impairment in function limitation in range of motion, utilized a wheelchair for mobility, dependent on staff for lower body dressing and dependent on staff for transfers. R51's Admission Record, printed 5/1/25, indicated the following relevant diagnoses: chronic pain, abnormalities of gait and mobility,	2 895	Corrected	5/23/25	

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2 895	Continued From page 12 dorsalgia (back pain), muscle weakness, disease of spinal cord, restless sleep syndrome and cervicalgia (neck pain). During an interview on 4/28/25 at 6:51 p.m., R51 stated she was not getting physical therapy (PT). R51 stated she had been getting occupational therapy (OT) but hadn't received any OT in "probably at least two weeks." R51 expressed frustration stating, "this is the whole reason I am here," and "I am not getting therapy." R51 stated one of the therapy staff had told her that the nursing staff could "work with my legs in bed" but "they aren't doing that." R51 stated she can no longer straighten her left leg which she could do prior to coming to the facility and indicated she currently used a Hoyer lift (a medical device used to transfer individuals, who cannot bear weight, with limited mobility from one place to another, such as a bed to a wheelchair). A Nursing Order-External Facility note, dated 3/4/25, indicated "Patient is cleared to toe touch during transfer while wearing a Darco shoe." A Nursing Order-External Facility note, dated 4/15/25, indicated "It is also recommended that the patient participate in physical therapy daily at the facility, while maintaining non-weight bearing status to the left heel, but can do to-touch transfers on the left foot. Darco shoes were provided during a previous appointment for this reason." A Nursing Order-External Facility note, dated 4/22/25, indicated "It is also recommended that the patient participate in physical therapy daily at the facility, while maintaining non-weight bearing status to the left heel, but can do to-touch transfers on the left foot. Darco shoes were	2 895			

Minnesota Department of Health

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2 895	Continued From page 13 provided during a previous appointment for this reason." R51's care plan, printed 5/1/25, lacked evidence of a restorative nursing program. Furthermore, lacked evidence of PT recommendations or recent assessments. During an interview on 4/30/25 at 10:39 a.m., registered nurse (RN)-B stated that nursing and therapy work together to coordinate care for residents. RN-B stated therapy would update nursing when there were changes to how residents ambulated, transferred or were new to the program. RN-B reviewed R51's electronic medical record (EMR) and verified R51 was discharged from OT on 4/16/25. RN-B verified R51 was not receiving any restorative nursing services after reviewing R51's EMR and three-ring binder that contains information on exercises for residents participating in the restorative nursing program. RN-B verified R51 was not receiving PT services, and stated R51 relied heavily on caregiver assistance. During an interview on 4/30/25 at 11:04 a.m., registered nurse manager (RN)-D reviewed R51's EMR. RN-D stated they reviewed communication with outside providers and had reviewed Nursing Order-External Facility Notes listed above. RN-D stated she had talked to therapy about changing R51 to "toe touch." RN-D stated she could not remember when she had talked to therapy, did not have documentation regarding the conversation, and stated she thought it was when she had reviewed the first note during "stand up" (interdisciplinary team meeting). RN-D verified R51 should have been assessed by therapy. During an interview on 4/30/25 at 11:11 a.m.,	2 895			

Minnesota Department of Health

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2 895	Continued From page 14 director of therapy (DOT)-A stated all residents had standing orders for therapy evaluations. DOT-A stated nursing communicated to therapy when a resident needed to be assessed or reassessed. DOT-A verified R51 was currently not getting any therapy (PT/OT) services. DOT-A stated R51 had PT services from 2/16/25 to 3/13/25, and OT services from 2/16/25 to 4/16/25. DOT-A stated R51 had not been reassessed for PT services since being discharged, and stated he had been given a copy of one of the Nursing Order-External Facility notes, did not remember exactly when it was, but did verify it was after R51 had discharged from PT services. DOT-A reviewed R51's EMR and verified there was no restorative nursing program. DOT-A stated R51 had "not been able to move her legs on her own since admission," and "we tried to get her to move her legs, but she always asked for help." DOT-A verified R51 transferred with a Hoyer lift since admission. DOT-A verified that a PT assessment should have been completed for R51. DOT-A stated R51 might not be able to bear weight, but it would be important to prevent any contractures. During a follow up interview on 5/01/25 at 8:56 a.m., RN-D verified R51 did not receive and had not received any restorative nursing services. During an interview on 5/01/25 at 9:34 a.m., director of nursing (DON) stated he had reviewed R51's EMR. DON stated R51 should have been reassessed by therapy. DON stated it was important to work with therapy and have a restorative nursing program to "see how we can improve your life and prevent things that shouldn't happen and live a better life." DON stated R51 was going to be reassessed by therapy today, and he had followed up with R51 that morning.	2 895			

Minnesota Department of Health

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2 895	Continued From page 15 DON had assessed R51 that morning (5/1/25) and stated R51 did not have any contractures in lower or upper extremities, decrease in extension of legs and therapy would complete a full reassessment this day. A facility policy titled Medication and Treatment Orders, dated 2/24, indicated "Orders for medications and treatment will be transcribed accurately and in a timely fashion." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for limited range of motion/ambulation to assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895			
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician	2 900			5/23/25

Minnesota Department of Health

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2 900	Continued From page 16 authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and, if needed, determine or develop proactive interventions to help address pressure injury risk and development after a new pressure injury was identified (i.e., change of condition) for 1 of 2 residents (R13) reviewed whom had active pressure injuries. Findings include: The Centers for Medicare (CMS) State Operations Manual (SOM) Appendix PP, dated 2/2023, identified definitions for pressure ulcer care and treatment. This included guidance provided on the several stages of injury definition which included, "Stage 3 Pressure Ulcer: Full-thickness skin loss ... subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible ... depth of tissue damage varies by anatomical location ... Undermining and tunneling may occur ... " R13's quarterly Minimum Data Set (MDS), dated 2/3/25, identified R13 had intact cognition along with multiple medical conditions including heart failure, high blood pressure, and multiple sclerosis (MS). The MDS outlined R13 consumed multiple high-risk medications including opioids,	2 900	Corrected		

Minnesota Department of Health

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2 900	Continued From page 17 diuretics and antiplatelets. Further, the MDS identified R13 was at-risk for pressure injury development and had one current stage IV pressure injury which had not been present upon admission. On 4/28/25 at 3:05 p.m., R13 was observed lying in bed while in her room. R13 had an air-alternating pressure mattress (APM) on her bed and was interviewed. R13 stated she had "a sore on my butt" which staff did a dressing change on multiple times a day. R13 stated she felt the wound was "slowly" healing but would likely never resolve. R13 stated she obtained the wound from sitting in her wheelchair for extended periods and reiterated it would likely never heal adding, "No matter what I do, it will never go away." R13 denied concerns with the wound and requested to end the interview due to feeling unwell. R13's Abbott Northwestern Hospital Wound Clinic Progress Note, dated 4/10/25, identified R13 was seen in the office for a wound check. R13's past medical history of her wounds was outlined within the note. This identified R13 presented in August 2024, for initial evaluation of the sacrum wound which had been present for " ... a few weeks and that it began without a clear cause." A section labeled, "Treatment Course," identified each visit and subsequent information of the wound and it's progress. On 1/27/25, the note recorded R13 was seen by a plastic surgeon and an MRI was ordered. R13 was recorded as being on protein supplement daily and having wound cares done " ... one or two times daily." On 4/10/25, the note recorded R13 was identified to have "a new wound to the right IT [ischial tuberosity] today." R13 was listed as continuing to get up in her wheelchair for approximately four hour	2 900			

Minnesota Department of Health

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2 900	Continued From page 18 increments every other day, still smoking, and still using protein supplement. The note recorded R13's new wound as, "Pressure Injury Stage [blank space] Stage 3," and listed it as having some slough present and being 3.4 X 1.5 X 0.1 (cm) in size. R13's care plan, printed 4/30/25, identified R13's actual or potential medical and/or care-related problems and corresponding interventions to address them. The care plan identified R13 had an alteration in skin integrity and required extensive assistance with bed mobility adding, "Resident runs the show ..." The care plan listed multiple interventions to address R13's skin risk and concerns including limiting her time seated in the powered wheelchair, monitoring skin integrity with cares, and using an air mattress. The last time the interventions were revised prior to the onsite survey was recorded as, "09/27/2024," with multiple interventions being added and/or revised on 4/29/25 and 4/30/25 (after survey started). R13's MHM (Monarch Healthcare Management) Skin Evaluation and Skin Risk Factors V-2, loaded 10/20/24, was identified with dictation present, "In Progress." However, the entire evaluation was left blank and not completed. There were no additional Skin Evaluation and Skin Risk Factors V-2 evaluations loaded or completed in the record. On 4/29/25 at 12:36 p.m., nursing assistant (NA)-A was interviewed, and verified they had cared for R13 prior adding, "[I've] worked with her many times." NA-A explained they often helped the nurses complete R13's wound care and stated R13 rarely got up from her bed due to her own choice. NA-A stated R13 would also, at times, refuse meals and seemed not "not really	2 900			

Minnesota Department of Health

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2 900	Continued From page 19 want you in there much." NA-A stated R13 used an air mattress and nurses would mix medications into her mashed potatoes. NA-A stated they were unsure how long R13 had the sacral pressure wound but added, "Since I started [working there]." NA-A described R13 as being somewhat "dismissive and independent" with her cares adding, "She knows what she wants." R13's dietary progress note, dated 4/24/25, identified a nutrition follow-up was completed due to R13's weight and wound adding, "Discussed resident at IDT [interdisciplinary team] wound meeting." R13's weight was outlined as stable and added, "Will discuss with nurse manager about increasing protein powder to 2 scoops per serving to better meet protein needs which would provide ~24 gm [grams] protein." However, the note lacked evidence of what, if any, other factors the IDT had reviewed which could contribute to pressure ulcer risk or skin breakdown (i.e., mobility, medication use, continence) to determine what, if any, interventions were needed to reduce the risk of skin breakdown and promote healing since R13 developed a new pressure injury on 4/10/25. When interviewed on 4/29/25 at 1:37 p.m., registered nurse (RN)-A stated they had worked with R13 multiple times prior. RN-A explained R13 did not like to get up from bed and would only get into her electric wheelchair "like every 3rd day" which was usually just so she could smoke outside. RN-A verified R13 had an active wound on her sacrum and expressed it was larger sized than an orange (fruit) adding "oh, it's bigger." RN-A stated the wound was slow to heal due to R13 being resistive with interventions and getting out of bed adding R13 had "super, super fragile skin." RN-A stated they were aware of R13	2 900			

Minnesota Department of Health

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2 900	Continued From page 20 having a second wound now, however, RN-A stated they felt it was "a little tiny one" and due to bandage-tape being pulled off the skin. RN-A stated they felt the wounds were both getting better just slowly adding aloud, "It's really slow to heal." RN-A stated the nurse manager would like know more about the wounds as they tracked it and measure it. On 4/30/25 at 9:36 a.m., licensed practical nurse manager (LPN)-C was interviewed, and verified they had a chance to review R13's medical record. LPN-C verified R13 had two active pressure injuries which both developed in-house, and explained R13 "beats to her own drum" with cares and interventions. LPN-C stated the wound was checked for measurements and status every week, and R13 was also being seen by an outside wound clinic for it at times. LPN-C stated R13 had been educated on the risks of not allowing repositioning and being so specific with what interventions she would allow. LPN-C explained the right IT pressure injury was new and recorded as a "stage three pressure area" from the wound clinic. LPN-C verified the first recorded evidence of the wound was on 4/10/25 from the wound clinic note, and explained when a new wound developed the staff wanted to obtain treatment orders, update the provider, and then the "plan of care" needed to be updated. LPN-C stated R13's wound treatments were "tweaked" due to the new wound. LPN-C stated the facility' skin evaluation evaluation (i.e., MHM Skin Evaluation and Skin Risk Factors V-2) was just "an extra tool" to help review someone adding the "comprehensive part" of the review could be more within the IDT discussion which happened every morning. LPN-C then provided a Microsoft Word document which had IDT notes listed on it.	2 900			

Minnesota Department of Health

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2 900	Continued From page 21 The untitled page, undated, identified R13's name along with, "New Wound Right IT." The page outlined, "IDT discussed and reviewed Care Plan and orders for any changes to interventions. Resident continues 'to run the show' and does not allow [hospital] wound clinic repositioning direction. Uses pillows. New Orders for wound healing, dietician involved, provider updated, Resident involved." However, the provided document lacked evidence what, if any, other interventions were considered, offered, refused despite R13 having multiple wounds and being resistive to recommendations. Further, R13's medical record was reviewed and lacked documented evidence R13 had been comprehensively reassessed for pressure wound risk or what, if any, interventions were considered, adopted or agreeable despite R13 developing another wound with some interventions, such as monitoring and an air mattress, already in place prior to the right IT wound developing. At this time, the director of nursing (DON) joined the interview via telephone. DON explained a new wound should be assessed and photographed, then the provider and family should be updated. DON stated the IDT would then discuss the wound and review the care plan. DON stated they felt "everything was in place" for R13 and reiterated R13 likes to "do her own thing" with cares she will allow. DON stated the skin evaluation form was "just a tool" and expressed they didn't feel completing one was necessarily required for a new wound development adding, "We don't have a policy for that." LPN-C verified R13's medical record lacked evidence of a comprehensive reassessment being done in the evaluations or progress notes. DON acknowledged the actual medical record possibly	2 900			

Minnesota Department of Health

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2 900	Continued From page 22 lacked evidence of the IDT' discussion on R13's new pressure injury adding aloud, "I see what you're saying." DON stated having the documentation in the medical record was important to promote continuity of care. A facility-provided Skin Assessment & Wound Management policy, dated 2/2025, identified a pressure ulcer risk assessment (Braden Scale) would be completed per an established schedule and, "Skin Evaluation and Skin Risk Factors Form is completed before initial MDS, annually, and upon significant change." A section labeled, "New Skin Problem," outlined a series of steps to be completed for developed pressure injuries which included notifying the provider, completing education with the resident, and initiating the Skin and Wound Evaluation (i.e., weekly monitoring). However, the policy section lacked direction or guidance on how a comprehensive reassessment process would look or be documented within the medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on pressure injury evaluation and assessment; then educate nursing staff and audit on an ongoing basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 900			
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the	2 910			5/23/25

Minnesota Department of Health

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2 910	Continued From page 23 unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a resident with a catheter had medical justification for continued use and failed to attempt a trial removal, if recommended, for one of one resident (R35) reviewed for indwelling catheter. Findings include: R35's quarterly Minimum Data Set (MDS), dated 3/25/25, indicated R35 had moderate cognitive impairment, required supervision with toileting and moderate assistance with bathing and had an indwelling catheter in place. R35's admission MDS, dated 5/23/22, indicated R35 was admitted with an indwelling catheter in place. R35's Diagnoses, dated 5/16/22, indicated R35 had several medical diagnoses related to potential need for an indwelling catheter including "other obstructive and reflex uropathy" which can hinder the normal flow or urine, unspecified retention of urine, renal hypoplasia (a congenital	2 910	Corrected		

Minnesota Department of Health

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2 910	Continued From page 24 condition in which one or both kidneys are underdeveloped), benign prostatic hyperplasia with and without lower urinary tract symptoms (a non-cancerous enlargement of the prostate gland), and infection and inflammatory reaction due to indwelling urethral catheter. However, the electronic medical record (EMR) failed to demonstrate duration of the retention, attempts (if any) to manage without a catheter, and medical justification for why the catheter was necessary on an ongoing basis (i.e neurogenic bladder). The EMR further lacked any evidence of post void residual (PVRs) to determine the extend of R35's urine retention. A urology note for R35, dated 7/28/22, stated "anticipate "SP" (suprapubic catheter - a urinary catheter that is surgically inserted through the abdominal wall directly into the bladder) on 8/17/22. The EMR lacked any evidence of follow up on this order or potential for a SP catheter to be placed. During an interview on 4/30/25 at 9:41 a.m., R35 stated he believed he had his catheter since coming to Minnesota years ago to "prevent urine leaking on the plane." R35 stated it has had an indwelling catheter since then because he has only had 2-3 urinary tract infections with the indwelling catheter in place. During an interview on 4/30/25 at 12:42 p.m., nurse manager and registered nurse (RN)-D stated she emailed R35's provider that day about an appropriate catheter diagnosis, stating "I don't believe we have [one]." RN-D further stated the facility had not attempted to remove R35's catheter since his admission to the care facility to assess the extent of his urine retention or if it could be managed without an indwelling catheter.	2 910			

Minnesota Department of Health

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2 910	Continued From page 25 During a follow up interview on 4/30/25 at 2:33 p.m., RN-D stated R35 had an appointment with urology on 5/1/25, and she would follow up on the goal for his catheter, including a proper diagnosis, order for a removal attempt, or a supra pubic placement, stating it was not clear what the goal for his indwelling catheter currently was. A facility policy titled Indwelling Catheter Care Procedure was provided, however it only spoke to proper care of a residents catheter while in place i.e. peri care with a catheter, emptying catheter bags and ensuring they are draining properly. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on indwelling catheter evaluation and assessment; then educate nursing staff and audit on an ongoing basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 910			
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the three-compartment dish sink was of proper	21015	Corrected		5/23/25

Minnesota Department of Health

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21015	Continued From page 26 sanitization parts per million (ppm) which had the potential to affect all 76 residents who received meals from the main kitchen. Furthermore, the facility failed ensure employees wore beard restraints to prevent hair from contacting food. Findings Include: A report titled Diet/consistency Rollup printed on 4/30/25, categorized each diet and had total meals served out of the main kitchen as 76. During the initial kitchen walk through conducted on 4/28/25 at 1:22 p.m., an area over the three-compartment sink had logs for documentation of water sanitization for April 2025, completed for April 1-24th. Above the sink were two large bottles held by a wire rack with two tubes that ran down into the three compartment sink, both were empty. The bottle on the left was labeled quaternary sanitizer and the one on the right was labeled pot/pan detergent and sanitizer. A large bottle of Dawn dishwashing detergent sat on the far right of the three-compartment sink. A cook was wearing a navy-blue baseball cap and had a beard that extended from the chin approximately 1". During an interview on 4/28/25 at 2:11 p.m., culinary services director (DOC)-A confirmed hair nets were available for employees and donned one himself. DOC-A stated employees needed to either wear a hat or a hairnet. DOC-A then stated if a beard was "too big" they need to wear a cover or shave it, and after a couple of days beards should be shaved or covered or else it could fall into the resident's food. DOC-A could not recall a facility policy on beards in the kitchen, but said employees would be written up if they didn't wear a beard restraint. DOC-A confirmed beard	21015			

Minnesota Department of Health

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21015	Continued From page 27 restraints were not available for employees at the kitchen entrance or in the office on 4/28/25. During an observation on 4/29/25 at 11:43 a.m., The pots/pan detergent and sanitizer bottle above the three compartment sink had approximately 1 inch of a blue bubbly solution. On the right hand of the three-compartment sink was a large bottle of Dawn dish detergent. During an observation and interview on 4/29/25 at 12:07 p.m., cook (C)-A removed a puree mixer lid and blade from the drying rack located on the left of the three-compartment sink. C-A stated the puree mixer was hand washed with Dawn and often Dawn detergent was added to the pots/pans bottle above the sink. Dawn and water were then mixed and the sink was filled to wash pots, pans, and kitchen utensils. During an interview on 4/29/25 at 2:08 p.m., dietary aid (DA)-A stated the three-compartment sink area was used for pots and pans. The pots and pans were scrubbed with Dawn and then used to cook. All resident dishware was put through dishwasher. During an observation on 4/30/25 at 12:41 p.m., Dawn dish detergent was used to wash a clear/gray plastic top to the puree mixer. The top was rinsed off and set on the side of the sink to dry. These items were rinsed less than 30 seconds. During an interview on 4/30/25 at 12:43 p.m. C-A stated no thermometer was available to check the water coming out of the sink and confirmed a puree blender top were hand washed with Dawn and other kitchen utensils.	21015			

Minnesota Department of Health

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21015	Continued From page 28 During an observation on 5/1/25 at 9:44 a.m., a three-compartment sink had a large bottle of Dawn dish soap. During an interview on 5/1/25 at 10:31 a.m., DOC-B stated the facility policy allowed for manually washing dishes in the three-compartment sink, but all dishes needed to be sent through the dishwasher to be sanitized. DOC-B stated he was not aware the cooks were manually washing and reusing the items without sending the items through the dishwasher and replied, "oh no, they can't do that" to which the nearby DOC-A responded, "yes we talked about that". DOC-B also confirmed beards should be no longer than a ½" for all Monarch facilities and that C-A should wear a beard cover. Facility Policy titled Sanitization, revised October 2008, "#9 Manual washing and sanitizing will employ a three-step process for washing, rinsing and sanitizing. C: Sanitize with hot water or chemical sanitizing solution. Chemical sanitizing solution may consist of: Chlorine, Iodine, Quaternary ammonium. Facility Policy titled Cleaning and Disinfection, revised September 2012, "Mixer bowls, beaters, grinders, pots, pans, roasters, electric knife, blades, food thermometers, etc. 1. Wash in 3 compartment sink or dishwasher: a. 1st compartment-soap and water (110-120 degrees Fahrenheit). B. 2nd compartment-clear water for rinsing (120 degrees Fahrenheit). c. 3rd compartment-Detergent/disinfectant (170 degrees Fahrenheit for 2 minutes). 2. Allow to remain wet for 10 minutes to air dry. Facility Policy titled Food Preparation and Service, revised April 2019, "Food and nutrition	21015			

Minnesota Department of Health

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21015	Continued From page 29 services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food" SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate infection control technique is maintained in the kitchen. The facility could update or create policies and procedures, and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits periodically to ensure compliance. The facility should report audit findings to Quality Assurance Performance Improvement (QAPI) for further recommendations and to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015			
21675	MN Rule 4658.1410 Linen Nursing home staff must handle, store, process, and transport linens so as to prevent the spread of infection according to the infection control program and policies as required by part 4658.0800. These laundering policies must comply with the manufacturer's instructions for the laundering equipment and products and include a wash formula addressing the time, temperature, water hardness, bleach, and final pH. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure soiled personal	21675	Corrected	5/23/25	

Minnesota Department of Health

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21675	Continued From page 30 laundry and linens were bagged (i.e., contained) at the point-of-use and transported in a manner to reduce the risk of cross-contamination and potential infectious spread in 1 of 1 main washrooms and 2 of 2 units (70's, 90's) reviewed. This had potential to affect all 75 residents within the care center. Findings include: On 4/29/25 at 7:57 a.m., the campus' main laundry washroom was toured with housekeeper (HSK)-A present. HSK-A explained they were the primary person who completed laundry for the care center, and they then provided a tour of the laundry process and the machines used. The soiled linen receiving area and washroom were located on one side of the hallway and folding area (clean) on the opposite. However, in the hallway between these areas were a series of mobile, off-white colored hard plastic bins including one labeled, "Soiled Linen Only," in black paint. The bin was covered with a light-blue colored cloth covering which was lifted exposing it's contents which was soiled white linens and personal clothing, much of which was not bagged but rather loose in the bin causing articles to touch. HSK-A verified the items were not bagged and expressed they should have been prior to transport. HSK-A stated the bin was likely brought down last evening by the nursing assistant (NA) staff. HSK-A stated they had, at times, noticed soiled laundry items to be coming down to the main washroom not bagged adding aloud "on occasion, yes." HSK-A stated they had talked about the issue with the care center administrator in the past, however, added, "But not as frequently as maybe I should have, to be honest." HSK-A then verified they had not collected any soiled linen from the units today yet.	21675			

Minnesota Department of Health

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21675	Continued From page 31 A tour of the '70's Unit' was then completed. The soiled utility room was opened with HSK-A present which, inside, had three mobile, off-white containers similar to the one observed by the washroom. HSK-A stated two were used for trash and one was used for soiled linens and personal clothing. The laundry container had a balled-up light-blue cloth cover inside the corner of the container and, again, nearly all of the soiled laundry inside was not bagged. HSK-A stated they items should be bagged at the point-of-use and not transported loosely like it appeared had happened adding aloud, "[They should be] bagging in, bagging out." HSK-A stated most of the personal laundry and linens were laundered by the care center adding, "Pretty much [yes]." HSK-A stated the soiled linen should be bagged to help prevent "cross contamination" between the garments. Following, a tour of the '90's Unit' was then completed. The soiled utility room was opened with HSK-A present which, inside, had multiple mobile, off-white containers similar to the one observed by the washroom and '70's unit.' The container for soiled linens and laundry was uncovered and, inside, nearly all of the garments and linens were not bagged. Further, sitting on top of the soiled laundry was two yellow-colored bags which had markings on them to indicate potential bio-hazard (i.e., isolation room, active infection). HSK-A verified the items were not covered or bagged and stated aloud, "That will be addressed today." HSK-A stated they did complete audits of laundry care which included walking around with the administrator and observing general cleanliness. HSK-A stated they would provide these for review.	21675			

Minnesota Department of Health

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21675	Continued From page 32 A series of three Monthly Facility Tour Form(s), dated 12/27/24 to 3/28/25, were provided. These outlined various areas of the care center and provided spacing to record a score (0 to 10) of cleanliness of the corresponding area. A section was listed, "Laundry/Linen," which outlined three specific areas to review including linen closets, personals, and laundry room. The spacing provided to write-out any "comments" was left blank and no concerns were written. However, the provided audits all lacked evidence the soiled utility rooms (where soiled linens were kept until transport to the washroom) were included in the review or audit process. On 4/30/25 at 10:01 a.m., the interim director of nursing (DON) was interviewed, and they verified they were the campus' infection preventionist (IP). DON explained they have educated staff through staff meetings and such about the need to bag soiled items where collected, and he verified soiled laundry and linens should be bagged prior to transport. This was important to do as staff could "spread infections from one place to another." DON added, "We will continue to do staff education and follow-up with the staff." A facility-provided Infection Prevention and Control Program policy, dated 11/2024, identified the facility would establish and maintain an infection prevention and control program (IPCP) designed to provide a safe, sanitary and comfortable environment. The policy outlined several steps taken with this program including infection surveillance, antibiotic stewardship and data analysis; however, the policy lacked information on soiled linen handling or transportation. A separate, facility-provided Skill 6. Gown, Glove, and Bag Linen protocol, undated, identified a checklist for staff to	21675			

Minnesota Department of Health

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21675	Continued From page 33 implement with gown removal and soiled item collection in an isolation room. This identified, "5. Remove the soiled linen. Keep the linen contained during removal and place in the appropriate bag/receptacle." A facility' policy on soiled laundry handling and transportation was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on soiled linen handling and transport to ensure accuracy; then educate floor staff and audit routinely to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21675			
21705	MN Rule 4658.1415 Subp. 6 Plant Housekeeping, Operation, & Maintenance Subp. 6. Heating, air conditioning, and ventilation. A nursing home must operate and maintain the mechanical systems to provide comfortable and safe temperatures, air changes, and humidity levels. Temperatures in all resident areas must be maintained according to items A to C: A. For construction of a new physical plant, a nursing home must maintain a temperature range of 71 degrees Fahrenheit to 81 degrees Fahrenheit at all times. B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season. C. Variations of the temperatures required by items A and B are allowed if the variations are based on documented resident preferences.	21705			5/23/25

Minnesota Department of Health

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21705	Continued From page 34 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a sanitary and homelike environment for 1 of 1 residents (R40) whose tube feeding pole and equipment had dried, white substance on it. Findings include: R40's quarterly Minimum Data Set (MDS) dated 2/25/25, identified R40 with intact cognition and diagnoses of depression, anxiety, chronic respiratory failure resulting in oxygen dependence, and a history of head and neck cancer with all nutrition through a percutaneous endoscopic gastrostomy (PEG) tube (soft flexible feeding tube inserted through the abdominal wall into the stomach). During observation on 4/28/25 at 5:07 p.m., R40's tube feeding (TF) pole was coated with dried white substance on entire surface of the pole and all five legs of the base. The TF unit/machine had greasy smeared substance on the entire front programming screen. During interview with licensed practical nurse (LPN)-A on 4/29/25 at 1:03 p.m., LPN-A stated the nursing staff was responsible for wiping down and cleaning tube feeding equipment if there were spills or visible soil on the unit and pole. During observation on 4/29/25 at 1:06 p.m., R40's tube feeding (TF) pole was coated with dried white substance on the entire surface of the pole and all five legs of the base. The TF unit/machine had greasy smeared substance on the entire front programming screen.	21705	Corrected		

Minnesota Department of Health

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21705	Continued From page 35 During observation and interview with registered nurse (RN)-B on 4/29/25 at 1:18 p.m., RN-B stated "everyone" is responsible for making sure patient care equipment was clean. "If we see if it is dirty we should clean it so the gunk doesn't dry like concrete." During observation and interview with RN-B on 4/29/25 at 1:21 p.m., RN-B looked at R40's TF pole and machine and stated, "that is horrible". RN-B stated the white substance appeared to be TF solution that was not wiped up after nurses prepared to administer the solution and following disconnecting the feedings from R40. During interview with R40's spouse on 4/29/25 at 1:22 p.m., R24 stated the pole was soiled in appearance and, "It is not good to look at. No one wipes up their spills or messes." During interview with R40 on 4/29/25 at 2:07 p.m., R40 stated the TF pole and machine "is always cruddy looking". R40 stated he had never seen any staff member clean or wipe up the TF solution or wipe down the feeding equipment before or after attaching the feeding to his PEG. During interview with director of nursing (DON) on 4/29/25 at 10:50 a.m., DON stated expectation of nursing staff to be cleaning and wiping the machine, pole, and the base of the pole if there is spillage or visible soil on them. DON stated it was a concern for infection control and dignity for the resident. Facility policy requested for environmental cleaning of patient care equipment and not received.	21705			

Minnesota Department of Health

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21705	Continued From page 36 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21705	Corrected		5/23/25
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was maintained for 2 of 2 residents (R54, R74) who utilized urinary catheters. Findings include: R54 R54's annual Minimum Data Set (MDS) dated 4/17/25 identified R54 with intact cognition,	21810			

Minnesota Department of Health

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21810	Continued From page 37 impairment of both lower extremities, dependent on staff for toileting hygiene and lower body dressing and had an indwelling catheter (tube for urine collection from bladder to a bag outside of the body). During observation on 4/28/25 at 1:42 p.m., R74 was lying in bed with an uncovered large urine drainage bag attached to side of bed visible to the hallway. During observation on 4/28/25 at 2:39 p.m., R74 was lying in bed with an uncovered large urine drainage bag attached to side of bed visible to the hallway. Two staff walked past the room. At 5:13 p.m., a staff member pushed a meal cart past R74's room. At 5:15 p.m., one staff member was observed inside the room speaking to R74 and left the room. During observation and interview with R74 on 4/28/25 at 6:35 p.m., R74 was lying in bed with an uncovered large urine drainage bag attached to side of the bed visible to the hallway. R74 stated, "staff have never asked me if I wanted a cover on my urine bag." And "I imagine other people would not feel comfortable looking at my urine in this bag. I guess I would not like to see anyone else's urine in their bag if I think about it." During observation and interview on 4/29/25 at 8:39 a.m., registered nurse (RN)-B was obtaining medications from the medication cart which was located across the hall from R54. RN-B observed the uncovered partially filled large urine drainage bag from hall and stated, "catheter bag should be covered for dignity and decency." R74 R74's admissions MDS dated 4/6/25 identified	21810			

Minnesota Department of Health

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21810	Continued From page 38 R74 with intact cognition, required substantial to maximal assist with toileting hygiene and lower body dressing, and had an indwelling catheter. During observation on 4/29/25 at 8:03 a.m., R74 wheeled self around hallway seated in wheelchair with large urine drainage bag attached to underside of wheelchair. R74 wheeled self to nursing station where four residents were eating a meal at tables adjacent to the nursing station. The urine bag was visible and uncovered. During observation and interview on 4/29/25 at 8:31 a.m., licensed practical nurse (LPN)-A observed R74 wheel past her as she was obtaining medications from medication cart and stated, "that [urine bag] should be covered for dignity." During interview with R74 on 4/30/25 at 10:04 a.m., R74 stated, "It [catheter drainage bag] was never covered until yesterday when they [staff] came in and put one[sic] cover on it. I don't want to see another person's pee[urine]. I should be more respectful." During interview with director of nursing (DON) on 4/30/25 at 10:48 a.m., DON stated, "Foley [catheter] need to be covered" and stated the uncovered catheter bags were a concern for infection control and dignity. Facility policy for dignity was requested and not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility	21810			

Minnesota Department of Health

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21810	Continued From page 39 could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810			
21860	MN St. Statute 144.651 Subd. 16 Patients & Residents of HC Fac.Bill of Rights Subd. 16. Confidentiality of records. Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Copies of records and written information from the records shall be made available in accordance with this subdivision and section 144.335. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third party payment contracts, or where otherwise provided by law. This MN Requirement is not met as evidenced by: During observation and interview, the facility failed to ensure resident records that contained private, medical, and personal information were not accessible to unauthorized personnel. This	21860	Corrected	5/23/25	

Minnesota Department of Health

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21860	Continued From page 40 had the potential to affect 20 residents on the first floor of facility, and all 13 residents on the second floor whose personal information was listed on exposed care sheets. Findings include: During observation and interview starting on 4/29/25 at 12:54 p.m., licensed practical nurse (LPN)-A was observed to leave medication cart and enter a resident room. A patient care sheet was left on top of the medication cart showing private patient information for 8 residents. At 12:58 p.m., three staff members walked past the cart. Upon returning to medication cart at 1:01 p.m., LPN-A stated the unattended care sheet belonged to another clinician and "he should have moved it" demonstrating turning the form over and placed it under the work laptop. LPN-A stated the uncovered unattended care sheet had private patient information and it was important to secure that information to only those who require it. During observation and interview starting on 4/29/25 at 3:44 p.m., an unattended care sheet with 12 residents' private health care information was observed on top of medication cart in the hallway of first floor. Three staff members walked past the cart. Then registered nurse (RN)-C exited resident room and walked to the medication cart. RN-C stated he had left the exposed care sheet on the medication cart. RN-C stated he should not have left it unattended "due to privacy and HIPAA". During observation and interview starting on 4/30/25 at 7:41 a.m., trained medication aide (TMA)-A left medication cart unattended with an exposed patient care sheet containing information for all 13 residents of the second floor. The	21860			

Minnesota Department of Health

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21860	Continued From page 41 medication cart was located across from the dining room and residents were starting to appear for breakfast. One resident moved past the cart and another staff member walked past the cart. At 7:44 a.m., TMA-A returned to the medication cart and stated she had left the care sheet unattended and exposed. TMA-A stated, "I should flip that over for privacy". During interview with director of nursing (DON) on 4/30/25 at 10:48 a.m., DON stated unattended and exposed patient care sheets were a HIPAA violation and impacted dignity and privacy. DON stated "[it]should not be done" to ensure resident information is not available for everyone to see. Undated facility policy titled HIPAA state, "Simple tips to remain compliant: Don't not leave care sheets or other client identifying papers laying out." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for maintaining confidentiality of records. All staff could be educated as necessary to the importance of compliance with handling and securing medical records. The DON or designee, could perform observational audits to ensure staff are locking access to medical records when not physically present. The DON or designee could take that information to QAPI to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: (21) days.	21860			
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights	21880			5/23/25

Minnesota Department of Health

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21880	Continued From page 42 Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that 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			

Minnesota Department of Health

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21880	Continued From page 43 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure grievances were sufficiently acted upon for 1 of 1 resident (R53) reviewed for grievances. Findings Include: R53's quarterly Minimum Data Set (MDS) dated 3/21/25, indicated R53 was cognitively intact. During an interview on 4/28/25 at 4:28 p.m., R53 stated approximately two months ago, during an evening shift a nursing assistant entered her room and attempted to change an incontinent brief. R53 was concerned because she didn't wear incontinent briefs, and the aid was unkind during the encounter. The following morning R53 reported the incident to staff. During a subsequent interview on 4/29/25 at 1:28 p.m., R53 stated she filed a grievance approximately two months ago and requested the nursing assistant not return to the unit. R53 confirmed that no one from the facility followed up with the results of the grievance. R53 stated the aid did work on the unit after staff was made aware of the incident and told residents he had been off for two weeks "having a party". R53's progress notes failed to mention an incident which occurred on or around February 2025 through March 2025. Facility Report of Grievances/Complaints/Care Concerns 2024-2025 contained a list of	21880	Corrected		

Minnesota Department of Health

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21880	Continued From page 44 grievances related to care concerns and lost items. The list lacked indication R53 filed a grievance. During an interview on 4/29/25 at 2:21 p.m., nursing assistant (NA)-D stated the completed grievance forms were kept on file in the social workers office. The process would be if a resident had a concern, staff would talk to the charge nurse. Grievance forms were completed by the residents, or a social worker could assist with the forms. During an interview on 4/29/25 at 2:46 p.m., registered nurse (RN)-D stated all grievances were given to social services and resolved using an electronic software, Med Trainer. RN-D stated R53's grievance was unfamiliar, but whomever was working should have filed a grievance immediately. During an interview on 4/30/25 at 9:13 a.m., social services (SS)-A stated when a resident filed a grievance, social services, the DON, and the Administrator would start collecting staff and resident statements. If the grievance fell under nursing, nursing aids, or resident cares the DON would follow-up. Grievances were manually entered into Med Trainer and once the hard copy was scanned into the program, the paper could be discarded. All statements, education, or resolutions were scanned into Med Trainer. SS-A was not 100% familiar with R53's grievance but remembered hearing about a concern with an employee. During an interview 4/30/25 at 9:15 a.m., Administrator in Training (AIT) called the DON who stated the previous social services director, SS-B, was involved in addressing the concern.	21880			

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21880	Continued From page 45 During an interview 4/30/25 at 9:31 a.m., Activities Director(A)-A stated R53 asked why the facility didn't follow up with the grievance form. A-A then reported her concern to facility leadership. During an interview 4/30/25 at 9:48 a.m., (SS)-B stated no involvement in R53's grievance in February or March of 2025. During an interview 4/30/25 at 9:53 a.m., Administrator stated on or about 3/7/25, a nursing assistant entered R53's room without checking the Kardex, the aid started to do cares, R53 said to stop, and he left the room. The administrator indicated the issue was addressed with the aid, however was unable to locate the grievance form, or any written resolution provided to R53. Administrator confirmed someone was aware of the incident and it was investigated but there was no resolution or follow up by the facility provided to R53 at that time. Facility Policy titled Complaint and Grievance, revised 9/2023 stated, "a grievance form should be completed when a complaint has been given to any employee of the facility". "All completed grievance forms will be kept on record at the facility for a period of no less than three years". SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to greivances to ensure grievances are acted upon and the resident given a resolution to the identified grievance. The director of nursing, social worker, or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure	21880			

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21880	Continued From page 46 grievacnes are acted upon and the resolution notification is made to the resident and/or family. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880			

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

PRINTED: 05/16/2025
FORM APPROVED
OMB NO. 0938-0391

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E 000	Initial Comments On 4/28/25 to 5/1/25, a survey for compliance with CMS Appendix Z, the Emergency Preparedness Requirements for Long Term Care Facilities, was conducted during a standard recertification survey. The Emeralds at Faribault was found in compliance with the requirements. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 4/28/25 to 5/1/25, a standard recertification survey was conducted by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were also completed. The Emeralds at Faribault was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H50673432C (MN108925) H50673430C (MN108926) H50673429C (MN109479) H50673431C (MN109573) H50673433C (MN109643) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/15/2025

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

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F 000	Continued From page 1	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550			5/23/25

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F 550	Continued From page 2 interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was maintained for 2 of 2 residents (R54, R74) who utilized urinary catheters. Findings include: R54 R54's annual Minimum Data Set (MDS) dated 4/17/25 identified R54 with intact cognition, impairment of both lower extremities, dependent on staff for toileting hygiene and lower body dressing and had an indwelling catheter (tube for urine collection from bladder to a bag outside of the body). During observation on 4/28/25 at 1:42 p.m., R74 was lying in bed with an uncovered large urine drainage bag attached to side of bed visible to the hallway. During observation on 4/28/25 at 2:39 p.m., R74 was lying in bed with an uncovered large urine drainage bag attached to side of bed visible to the hallway. Two staff walked past the room. At 5:13 p.m., a staff member pushed a meal cart past R74's room. At 5:15 p.m., one staff member was observed inside the room speaking to R74 and	F 550	Plan of CorrectionF550 Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: R54, R74s and all residents with Catheter drainage bags have been covered. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents with catheter bags have the potential to be affected by the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has educated staff that all drainage bags need to be covered The facility will complete daily audits X		

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F 550	Continued From page 3 left the room. During observation and interview with R74 on 4/28/25 at 6:35 p.m., R74 was lying in bed with an uncovered large urine drainage bag attached to side of the bed visible to the hallway. R74 stated, "staff have never asked me if I wanted a cover on my urine bag." And "I imagine other people would not feel comfortable looking at my urine in this bag. I guess I would not like to see anyone else's urine in their bag if I think about it." During observation and interview on 4/29/25 at 8:39 a.m., registered nurse (RN)-B was obtaining medications from the medication cart which was located across the hall from R54. RN-B observed the uncovered partially filled large urine drainage bag from hall and stated, "catheter bag should be covered for dignity and decency." R74 R74's admissions MDS dated 4/6/25 identified R74 with intact cognition, required substantial to maximal assist with toileting hygiene and lower body dressing, and had an indwelling catheter. During observation on 4/29/25 at 8:03 a.m., R74 wheeled self around hallway seated in wheelchair with large urine drainage bag attached to underside of wheelchair. R74 wheeled self to nursing station where four residents were eating a meal at tables adjacent to the nursing station. The urine bag was visible and uncovered. During observation and interview on 4/29/25 at 8:31 a.m., licensed practical nurse (LPN)-A observed R74 wheel past her as she was obtaining medications from medication cart and stated, "that [urine bag] should be covered for	F 550	5 days for two weeks, and then weekly audits for two weeks. Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent: The facility will review the progress of the plan of correction during the QAPI committee meetings.Completion date: 05/23/2025		

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F 550	Continued From page 4 dignity." During interview with R74 on 4/30/25 at 10:04 a.m., R74 stated, "It [catheter drainage bag] was never covered until yesterday when they [staff] came in and put one[sic] cover on it. I don't want to see another person's pee[urine]. I should be more respectful." During interview with director of nursing (DON) on 4/30/25 at 10:48 a.m., DON stated, "Foley [catheter] need to be covered" and stated the uncovered catheter bags were a concern for infection control and dignity. Facility policy for dignity was requested and not received.	F 550			
F 583 SS=B	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other	F 583			5/23/25

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F 583	Continued From page 5 materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: During observation and interview, the facility failed to ensure resident records that contained private, medical, and personal information were not accessible to unauthorized personnel. This had the potential to affect 20 residents on the first floor of facility, and all 13 residents on the second floor whose personal information was listed on exposed care sheets. Findings include: During observation and interview starting on 4/29/25 at 12:54 p.m., licensed practical nurse (LPN)-A was observed to leave medication cart and enter a resident room. A patient care sheet was left on top of the medication cart showing private patient information for 8 residents. At 12:58 p.m., three staff members walked past the cart. Upon returning to medication cart at 1:01 p.m., LPN-A stated the unattended care sheet belonged to another clinician and "he should have moved it" demonstrating turning the form over	F 583	Plan of CorrectionF583 Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: Resident care sheets have been removed from public areas. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice. The measures the facility will take or systems the facility will alter to ensure that		

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F 583	Continued From page 6 and placed it under the work laptop. LPN-A stated the uncovered unattended care sheet had private patient information and it was important to secure that information to only those who require it. During observation and interview starting on 4/29/25 at 3:44 p.m., an unattended care sheet with 12 residents' private health care information was observed on top of medication cart in the hallway of first floor. Three staff members walked past the cart. Then registered nurse (RN)-C exited resident room and walked to the medication cart. RN-C stated he had left the exposed care sheet on the medication cart. RN-C stated he should not have left it unattended "due to privacy and HIPAA". During observation and interview starting on 4/30/25 at 7:41 a.m., trained medication aide (TMA)-A left medication cart unattended with an exposed patient care sheet containing information for all 13 residents of the second floor. The medication cart was located across from the dining room and residents were starting to appear for breakfast. One resident moved past the cart and another staff member walked past the cart. At 7:44 a.m., TMA-A returned to the medication cart and stated she had left the care sheet unattended and exposed. TMA-A stated, "I should flip that over for privacy". During interview with director of nursing (DON) on 4/30/25 at 10:48 a.m., DON stated unattended and exposed patient care sheets were a HIPAA violation and impacted dignity and privacy. DON stated "[it]should not be done" to ensure resident information is not available for everyone to see. Undated facility policy titled HIPAA state, "Simple	F 583	the problem will be corrected and will not occur: The facility has educated staff that all protected information needs to be kept private The facility will complete daily audits X 5 days for two weeks, and then weekly audits for two weeks. Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent: The facility will review the progress of the plan of correction during the QAPI committee meetings. Completion date: 05/23/2025		

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F 583	Continued From page 7	F 583			
F 584 SS=D	tips to remain compliant: Don't not leave care sheets or other client identifying papers laying out." Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584			5/23/25

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F 584	Continued From page 8 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a sanitary and homelike environment for 1 of 1 residents (R40) whose tube feeding pole and equipment had dried, white substance on it. Findings include: R40's quarterly Minimum Data Set (MDS) dated 2/25/25, identified R40 with intact cognition and diagnoses of depression, anxiety, chronic respiratory failure resulting in oxygen dependence, and a history of head and neck cancer with all nutrition through a percutaneous endoscopic gastrostomy (PEG) tube (soft flexible feeding tube inserted through the abdominal wall into the stomach). During observation on 4/28/25 at 5:07 p.m., R40's tube feeding (TF) pole was coated with dried white substance on entire surface of the pole and all five legs of the base. The TF unit/machine had greasy smeared substance on the entire front programming screen. During interview with licensed practical nurse (LPN)-A on 4/29/25 at 1:03 p.m., LPN-A stated the nursing staff was responsible for wiping down and cleaning tube feeding equipment if there were spills or visible soil on the unit and pole.			F 584	Plan of CorrectionF584Homelike Environment Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: The facility has cleaned R40s tube feeding pole and all other residents with tube feeding poles. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents with tube feeding ploes have the potential to be affected by the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has educated staff that all gtube poles need to be cleaned when dirty.		

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F 584	Continued From page 9 During observation on 4/29/25 at 1:06 p.m., R40's tube feeding (TF) pole was coated with dried white substance on the entire surface of the pole and all five legs of the base. The TF unit/machine had greasy smeared substance on the entire front programming screen. During observation and interview with registered nurse (RN)-B on 4/29/25 at 1:18 p.m., RN-B stated "everyone" is responsible for making sure patient care equipment was clean. "If we see if it is dirty we should clean it so the gunk doesn't dry like concrete." During observation and interview with RN-B on 4/29/25 at 1:21 p.m., RN-B looked at R40's TF pole and machine and stated, "that is horrible". RN-B stated the white substance appeared to be TF solution that was not wiped up after nurses prepared to administer the solution and following disconnecting the feedings from R40. During interview with R40's spouse on 4/29/25 at 1:22 p.m., R24 stated the pole was soiled in appearance and, "It is not good to look at. No one wipes up their spills or messes." During interview with R40 on 4/29/25 at 2:07 p.m., R40 stated the TF pole and machine "is always cruddy looking". R40 stated he had never seen any staff member clean or wipe up the TF solution or wipe down the feeding equipment before or after attaching the feeding to his PEG. During interview with director of nursing (DON) on 4/29/25 at 10:50 a.m., DON stated expectation of nursing staff to be cleaning and wiping the machine, pole, and the base of the pole if there is			F 584	The facility will complete daily audits X 5 days for two weeks, and then weekly audits for two weeks. Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent: The facility will review the progress of the plan of correction during the QAPI committee meetings.Completion date: 05/23/2025		

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F 584	Continued From page 10 spillage or visible soil on them. DON stated it was a concern for infection control and dignity for the resident.	F 584			
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:	F 585			5/23/25

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F 585	Continued From page 11 (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and	F 585			

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F 585	Continued From page 12 as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure grievances were sufficiently acted upon for 1 of 1 resident (R53) reviewed for grievances. Findings Include: R53's quarterly Minimum Data Set (MDS) dated 3/21/25, indicated R53 was cognitively intact. During an interview on 4/28/25 at 4:28 p.m., R53 stated approximately two months ago, during an evening shift a nursing assistant entered her room and attempted to change an incontinent	F 585	Plan of CorrectionF585Grievances Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: The facility documented the grievance and followed up with R53 How will the facility identify other residents		

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F 585	Continued From page 13 brief. R53 was concerned because she didn't wear incontinent briefs, and the aid was unkind during the encounter. The following morning R53 reported the incident to staff. During a subsequent interview on 4/29/25 at 1:28 p.m., R53 stated she filed a grievance approximately two months ago and requested the nursing assistant not return to the unit. R53 confirmed that no one from the facility followed up with the results of the grievance. R53 stated the aid did work on the unit after staff was made aware of the incident and told residents he had been off for two weeks "having a party". R53's progress notes failed to mention an incident which occurred on or around February 2025 through March 2025. Facility Report of Grievances/Complaints/Care Concerns 2024-2025 contained a list of grievances related to care concerns and lost items. The list lacked indication R53 filed a grievance. During an interview on 4/29/25 at 2:21 p.m., nursing assistant (NA)-D stated the completed grievance forms were kept on file in the social workers office. The process would be if a resident had a concern, staff would talk to the charge nurse. Grievance forms were completed by the residents, or a social worker could assist with the forms. During an interview on 4/29/25 at 2:46 p.m., registered nurse (RN)-D stated all grievances were given to social services and resolved using an electronic software, Med Trainer. RN-D stated R53's grievance was unfamiliar, but whomever was working should have filed a grievance	F 585	having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has educated social services staff that all grievances must be documented. The facility will complete daily audits X 5 days for two weeks, and then weekly audits for two weeks. Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent: The facility will review the progress of the plan of correction during the QAPI committee meetings.Completion date: 05/23/2025		

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F 585	Continued From page 14 immediately. During an interview on 4/30/25 at 9:13 a.m., social services (SS)-A stated when a resident filed a grievance, social services, the DON, and the Administrator would start collecting staff and resident statements. If the grievance fell under nursing, nursing aids, or resident cares the DON would follow-up. Grievances were manually entered into Med Trainer and once the hard copy was scanned into the program, the paper could be discarded. All statements, education, or resolutions were scanned into Med Trainer. SS-A was not 100% familiar with R53's grievance but remembered hearing about a concern with an employee. During an interview 4/30/25 at 9:15 a.m., Administrator in Training (AIT) called the DON who stated the previous social services director, SS-B, was involved in addressing the concern. During an interview 4/30/25 at 9:31 a.m., Activities Director(A)-A stated R53 asked why the facility didn't follow up with the grievance form. A-A then reported her concern to facility leadership. During an interview 4/30/25 at 9:48 a.m., (SS)-B stated no involvement in R53's grievance in February or March of 2025. During an interview 4/30/25 at 9:53 a.m., Administrator stated on or about 3/7/25, a nursing assistant entered R53's room without checking the Kardex, the aid started to do cares, R53 said to stop, and he left the room. The administrator indicated the issue was addressed with the aid, however was unable to locate the grievance form,	F 585			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/01/2025
NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT FARIBAULT LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
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F 585	Continued From page 15 or any written resolution provided to R53. Administrator confirmed someone was aware of the incident and it was investigated but there was no resolution or follow up by the facility provided to R53 at that time.	F 585			
F 656 SS=D	Facility Policy titled Complaint and Grievance, revised 9/2023 stated, "a grievance form should be completed when a complaint has been given to any employee of the facility". "All completed grievance forms will be kept on record at the facility for a period of no less than three years". Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656			5/23/25

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F 656	Continued From page 16 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and documentation review, the facility failed to ensure a comprehensive care plan was developed and maintained to ensure appropriate care was provided for 1 of 1 resident (R51) reviewed for smoking. Findings include: R51's admission Minimum Data Set (MDS) assessment, dated 2/19/25, indicated R51 had intact cognition with no hallucinations or delusions present and no behaviors. Section J: Health Conditions indicated R51 currently used tobacco. Section O: Special Treatments and Programs indicated R51 used oxygen.	F 656	Plan of CorrectionF656Comprehensive Care plan Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: R51s care plan was updated to include her status as a smoker How will the facility identify other residents having the potential to be affected by the		

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F 656	Continued From page 17 R51's Admission Record, printed 5/1/25, identified R51's admission date to the facility as 2/13/25. Furthermore, it identified the following relevant diagnoses: nicotine dependence, emphysema (chronic lung disease that progressively damages the tiny air sacs in the lungs), and congestive heart failure (condition where the heart doesn't pump blood as efficiently as it should). During an interview on 4/28/25 at 6:54 p.m., R51 stated she smoked cigarettes. R51 stated she had smoked for "a long time." R51 stated the facility "assessed me to make sure I am ok to smoke." R51 stated she had smoked since she has been at the facility and staff had been aware of her smoking. R51 stated she currently used oxygen at night only and did not wear it during the day. R51 stated she never wore her oxygen when she smoked. R51's care plan, reviewed on 4/28/25, lacked evidence of R51 being a current cigarette smoker. Furthermore, the care plan lacked the identification of safety interventions needed during the smoking assessments (i.e., ensuring resident removes oxygen while smoking). R51's Smoking Evaluations, dated 2/13/25, 2/17/25 and 4/14/25, identified R51 as a current smoker. During interview on 4/30/25 at 10:41 a.m., registered nurse (RN)-B verified they work with and were familiar with R51. RN-B stated R51 currently smoked and had smoked since admitting to the facility. RN-B reviewed R51 electronic medical record (EMR) and verified	F 656	same deficient practice? All residents have the potential to be affected by the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has educated the nurse leadership team that care plans should include their smoking status The facility has reviewed all smokers to ensure that their care plans address smoking in their care plan. The facility will complete daily audits X 5 days for two weeks, and then weekly audits for two weeks. Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent: The facility will review the progress of the plan of correction during the QAPI committee meetings. Completion date: 05/23/2025		

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F 656	Continued From page 18 three smoking assessments had been completed. RN-B stated if a resident was identified as a smoker it should be on the care plan as "everything should be on the care plan." RN-B verified R51 lacked identification that R51 was a smoker. RN-B verified they were adding it to the care plan during the interview, stating, "it should be on there." During an interview on 5/1/25 at 8:48 a.m., registered nurse manager (RN)-D stated when a resident admitted to the facility, a smoking assessment was to be completed which included observing the resident smoke, and assessing for safety risks and concerns. RN-D stated if a resident was a smoker it needs to be added to the care plan. RN-D stated R51 currently smoked. RN-D reviewed R51's EMR and verified smoking assessments completed on 2/13/25, 2/17/25, and 4/14/25. RN-D reviewed R51's care plan and stated, "I might be wrong, but it shows a date initiated 4/30/25, for smoking but I am not sure if I am looking at it right." During an interview on 5/1/25 at 9:29 a.m., director of nursing (DON) reviewed R51's EMR. DON verified R51 was a current smoker, had smoked since admission, and the care plan had not been updated until 4/30/25 (two days after survey entrance). DON stated it was important to have a comprehensive care plan as "that is how you care for the resident." A facility policy titled Care Planning, dated 11/2024, indicated "The care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident."			F 656			

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F 657 F 657 SS=D	Continued From page 19 Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed ensure the care plan was updated and revised to reflect current interventions for 1 of 1 resident (R62) reviewed for positioning and mobility. Findings include:	F 657 F 657			5/23/25
			Plan of CorrectionF657Care plan timing and revision Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in		

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F 657	Continued From page 20 R62's quarterly Minimum Data Set (MDS) dated 2/28/25, identified R62 as independent with mobility, had no upper extremity impairment (shoulder, elbow, wrist, hand), and used a walker. R62's Occupational Therapy Discharge Summary dated for services March 12, 2025, through April 9, 2025, indicated therapy was provided seven times for muscle weakness. R62's therapy involved improved strength for the left wrist, and R62 was given a brace on 4/9/25. Therapy directed R62 to wear the brace as tolerated. R62's care plan with a review date of 3/17/25, indicated a walking program of 200 feet one to three times per day with an assist of one during ambulation, bed movements, and transfers. The care plan lacked updates after R62 was discharged from therapy to walk independently with his walker and given a brace for his left wrist. R62's progress note dated 4/11/25, indicated R62 had a diagnoses of chronic kidney disease, type two diabetes, orthostatic hypotension, dehydration, and a failure to thrive (gain weight). R62's medications were noted as increasing a risk for falls and that R62 was an assist of one with transfers and mobility and with all activities of daily living. R62's progress note dated 4/17/25, indicated R62 was seen by the medical doctor and no new orders or changes to the current plan of care. R62 was also seen by the nurse practitioner on 4/16 no new orders or changes to the current plan of care. During observation and interview on 4/28/25 at			F 657	response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: R62s care plan was revised to reflect that he no longer requires a brace or a walking program. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has educated the nurse leadership team that care plans should be updated at least quarterly, but as needed when there are changes in a residents care needs. The facility has reviewed all residents on a walking program or splint to insure that the care plans are correct. The facility will complete daily audits X 5 days for two weeks, and then weekly audits for two weeks. Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent: The facility will review the progress of the plan of correction during the QAPI committee meetings. Completion date: 05/23/2025		

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F 657	Continued From page 21 4:10 p.m., R62 was wearing a black brace on his left wrist. R62 stated the brace was for significant pain but was unable to explain the reason for its use or where it came from. During an interview on 4/30/25 at10:54 a.m., director of therapy (DOT)-A stated that R62 had recently undergone therapy for hand weakness and joint pain in the thumb, with therapy sessions from March 12, 2025, through April 9, 2025. DOT-A also confirmed that R62 had participated in therapy on three separate occasions in 2024. Additionally, DOT-A confirmed that the brace on R62's left hand was used for joint pain and the brace was applied intermittently with R62 being independent with its use, and continued use was recommended. R62 discharged with independent use of a walker and self-cares. DOT-A stated R62 needed no supervision with the walker or the brace at the time of discharge and managed these items independently. Nursing managed any care plans or concerns related to their use. R62 was given a "green card" and walked the entire facility. DOT-A confirmed R62's care plan stated he was on a walking program of 200 feet one to three times a day with staff assist and acknowledged the care plan needed to be revised. Licensed practical nurse (LPN)-D, who shared a desk with therapy, joined the interview, reviewed R62's care plan, and acknowledged R62 was now independent with his walker and was no longer on the walking program. Additionally, LPN-D stated the wrist brace wasn't care planned because R62 was independent with its use and the walking proram was a standing order and did not need revision. During an interview on 4/30/25 at12:26 p.m., registered nurse (RN)-D stated all braces and			F 657			

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F 657	Continued From page 22 splits should be care planned and positioning should be checked under skin to make sure it is intact. RN-D reviewed R62's care plan and confirmed the care plan did not mention the brace worn on the left wrist. RN-D stated it was important to put braces on the care plan to monitor for alteration of skin integrity and skin breakdown. A policy titled Care Planning revised on 11/2024 and stated the care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes.	F 657			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to reassess a resident with known constipation to determine what, if any, new interventions could be put in place to prevent constipation for one of one resident (R28) reviewed for constipation.	F 684	Plan of CorrectionF684Quality of Care Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in		5/23/25

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F 684	Continued From page 23 Findings include: R28's quarterly Minimum Data Set (MDS), dated 4/17/25, indicated R28 was cognitively intact, was frequently incontinent of bowel without a bowel program, and required substantial to maximum assistance with toileting. R28's diagnoses, dated 3/7/25, indicated R28 had several medical diagnoses including Parkinson's Disease in which constipation is a common symptom. R28's bowel movements document in April indicated R28 often went three or more days in between bowel movements. R28's first documented bowel movement in April was 4/10/25, indicating 10 days without a bowel movement. R28 also did not have a bowel movement between 4/17/25 and 4/20/25 indicating three days between bowel movements, between 4/20/25 and 4/26/25 indicating 6 days between bowel movements, and between 4/20/25 and 4/29/25 only 1 small bowel movement was documented. R28's Orders indicated R28 had an order for Polyethylene Glycol Powder (Miralax) 17 grams by mouth two times a day for constipation, dated 1/22/25, and Senna- Docusate Sodium 8.6-50 milligrams (ml) two tablets two times a day for constipation, dated 12/3/24. R28's most recent Bowel Evaluation, dated 11/13/24, indicated R28 was continent of bowel but lacked any further assessment of R28's typical bowel movement patterns, what was normal or abnormal for her, and interventions	F 684	response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: R28 has been reassessed for bowel management How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents with diagnosis or complaint of constipation have the potential to be affected by the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has re-educated staff on the bowel management program. The facility will complete daily audits on all residents with diagnosis of constipation and all residents with bowel movement alerts X 5 days for two weeks, and then weekly audits on for two weeks. Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent: The facility will review the progress of the plan of correction during the QAPI committee meetings. Completion date: 05/23/2025		

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F 684	Continued From page 24 attempted, or in place, to prevent constipation. R28's progress notes, dated 4/1/25 - 4/28/25, lacked any notes of R28's constipation or intervention used to promote bowel movements. On 4/29/25, it was documented R28 reported constipation to the nursing assistant (NA) and was offered milk of magnesia and an additional Senna in addition to her scheduled Miralax and Senna. It was also documented on 4/29/28, that R28 was also given prune juice by the nurse. During an interview on 4/28/25 at 5:15 p.m., R28 stated she had not had a complete bowel movement in over a week, stating she was often constipated due to her diagnosis of Parkinson's disease and was starting to have stomach pain due to her constipation. During an interview on 4/30/25 at 9:48 a.m., NA-E stated it was expected that the NAs document each shift if a resident had a bowel movement, stating the NAs did not do any of the tracking of bowel movements but that the nurses should be tracking when a resident had a bowel movement last to determine if they needed additional interventions to promote a bowel movement. NA-E stated R28 struggled with constipation but was unsure what the nurses did to help her manage her constipation. During an interview on 4/30/25 at 10:43 a.m., licensed practical nurse (LPN)-E stated it was expected that bowel movements were tracked, stating the NAs should let the nurses know if a resident had not had a bowel movement and that the clinical manager also tracked bowel movements. LPN-E stated most residents were already on Senna or Miralax but if it "gets bad"	F 684			

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F 684	Continued From page 25 and a resident does not have a bowel movement in 3-4 days then a suppository should be given. LPN-E stated Milk of Magnesia was also available to give to residents as needed and any interventions used to promote a bowel movement should be documented in progress notes. LPN-E stated R28 seemed to struggle with constipation and reported that the Miralax was not effective for her so LPN-E would offer her milk of magnesia. During an interview on 4/30/25 at 12:42, nurse manager and registered nurse (RN)-D confirmed R28 struggled with constipation and stated the expectation was that on day three of no bowel movement the nurses should be offering prune juice or Milk of Magnesia, and if there is no bowel movement by bedtime that day the nurses should be offering to administer a suppository. RN-D stated R28 at times would toilet herself independently and the NAs should be asking R28 each shift if she had a bowel movement. During a follow up interview on 5/1/25 at 7:58 a.m., RN-D stated bowel assessments were completed on admission, annually, with a significant change in condition and as needed. RN-D confirmed R28 should be reassessed to determine what changes could be made to her bowel regiment to prevent frequent episodes of constipation and that she had reached out to the provider yesterday. A policy on constipation management was requested and not received.	F 684			
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing	F 685			5/23/25

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F 685	Continued From page 26 To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow-up and implement treatment for improved hearing for 1 of 1 resident (R62) who had complaints of hearing loss which were not addressed. Findings include: R62's admission Minimum Data Set (MDS) dated 9/25/24, identified R62 as highly impaired with the absence of useful hearing, did not wear hearing aids, and had a diagnosis of unspecified sensorineural hearing loss. R62's care plan initiated 9/23/24, indicated the use of a pocket talker to aid in communication, but failed to mention the use of R62's hearing aids. R62's most recent care plan with a review date of 3/24/25 indicated sensorineural hearing loss bilaterally. The care plan indicated the use of a pocket talker to aid in communication as needed and to speak clearly and distinctly to the resident, but failed to mention R62's hearing aids.	F 685	Plan of CorrectionF685Hearing/Vision Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: R62 has been reevaluated for hearing and vision. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has re-educated staff on following the care sheets and offering		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/01/2025
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F 685	Continued From page 27 R62's physician's note dated 12/12/24, indicated R62 wore hearing aids. R62's quarterly Minimum Data Set (MDS) dated 2/28/25, identified R62 had no cognitive impairment. Further, R62 had moderate difficulty with hearing and did not wear hearing aids. R62's treatment administration records (TAR) were reviewed from December 2024 through April 2025. The TAR failed to list any type of hearing device for R62 during this timeframe, and included orders started 4/29/25 to place and remove hearing aids. R62's quarterly MHM Hearing and Vision Form V3 dated 2/27/25, selected moderate difficulty for ability to hear and indicated R62 did not use hearing aids. During observation and interview on 4/28/25 at 5:52 p.m., R62 indicated he could not hear, had difficulty communicating his needs, and wanted to know if the facility was going to help with hearing aids. R62 was observed with no hearing aids. During an interview on 4/29/25 3:25 p.m., nursing assistant (NA)-B stated NAs carried care sheets to determine what residents had adaptive equipment but failed to have a care sheet readily available. NA-B located a care sheet from an office down the hall dated 4/18/25, and confirmed no hearing aids were listed for any of the residents on the unit which included R62. NA-B stated residents should tell staff if they wear hearing aids, but the care sheets should be updated with that information in case the resident couldn't inform the aid. NA-B confirmed the	F 685	residents their hearing aids. The facility will complete daily audits X 5 days for two weeks, and then weekly audits for two weeks. Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent: The facility will review the progress of the plan of correction during the QAPI committee meetings. Completion date: 05/23/2025		

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

PRINTED: 05/16/2025
FORM APPROVED
OMB NO. 0938-0391

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F 685	Continued From page 28 treatment administration record in the computer identified residents who needed hearing aids placed in the morning and removed at night. NA-B confirmed R62's care sheet and care plan did not indicate hearing aids, but R62 had a new order dated 4/29/25 to remove hearing aids. Nursing assistant (NA)-C also confirmed the care sheets were not accurate for the residents on the unit since there were two other residents who both also wore hearing aids. During an interview on 4/30/25 at 8:40 a.m. nursing assistant (NA)-D stated R62 had hearing aids for years but hasn't worn them frequently until this morning. NA-D stated the activities director (A)-A found batteries and A-A mentioned having R62 wear his hearing aides today, 4/30/25, but NA-D could not confirm. During an interview on 4/30/25 at 8:48 a.m., A-A reported that during a conversation with R62 on 4/29/25, R62 mentioned having difficulty hearing and was offered a pocket talker. R62 also noted that he had hearing aids in the closet but hadn't worn them in a while. R62 then removed two hearing aids from a tote, and A-A assisted with inserting new batteries. During interview on 4/30/25 at 12:17 p.m., registered nurse (RN)-D confirmed completing the quarterly MHM Hearing and Vision Form V3 dated 2/27/25. RN-D talked with R62 and confirmed moderate difficult hearing and stated R62 denied having hearing aids in his ears nor were any on the bedside table. RN-D asked the on-duty nursing assistant who indicated R62 did not wear hearing aids, although RN-D could not recall who the aid was working during the assessment. RN-D stated. RN-D confirmed R62			F 685			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 685	Continued From page 29 did have difficulty hearing during the assessment and did not have a consent on file for a referral for hearing aids. RN-D noted a refusal in the R62's electronic medical record that he did not want a referral for hearing aids, dated 9-20-24.	F 685			
F 686 SS=D	Medication and Treatment Policy, revised 2/24 stated orders for medications and treatments will be transcribed accurately and in a timely fashion. The policy failed to directly mention hearing aids or adaptive devices. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and, if needed, determine or develop proactive interventions to help address pressure injury risk and development after a new pressure injury was identified (i.e., change of condition) for 1 of 2 residents (R13) reviewed whom had active pressure injuries.	F 686	Plan of CorrectionF686Treatment/Services to Prevent/Heal Pressure ulcers. Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in		5/23/25

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F 686	Continued From page 30 Findings include: The Centers for Medicare (CMS) State Operations Manual (SOM) Appendix PP, dated 2/2023, identified definitions for pressure ulcer care and treatment. This included guidance provided on the several stages of injury definition which included, "Stage 3 Pressure Ulcer: Full-thickness skin loss ... subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible ... depth of tissue damage varies by anatomical location ... Undermining and tunneling may occur ... " R13's quarterly Minimum Data Set (MDS), dated 2/3/25, identified R13 had intact cognition along with multiple medical conditions including heart failure, high blood pressure, and multiple sclerosis (MS). The MDS outlined R13 consumed multiple high-risk medications including opioids, diuretics and antiplatelets. Further, the MDS identified R13 was at-risk for pressure injury development and had one current stage IV pressure injury which had not been present upon admission. On 4/28/25 at 3:05 p.m., R13 was observed lying in bed while in her room. R13 had an air-alternating pressure mattress (APM) on her bed and was interviewed. R13 stated she had "a sore on my butt" which staff did a dressing change on multiple times a day. R13 stated she felt the wound was "slowly" healing but would likely never resolve. R13 stated she obtained the wound from sitting in her wheelchair for extended periods and reiterated it would likely never heal adding, "No matter what I do, it will never go	F 686	response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: R13 has been reassessed for skin breakdown and re-educated on the risks/benefits associated with her choices. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents with pressure ulcer and residents at risk for pressure ulcer have the potential to be affected by the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has re-educated the nursing leaders on comprehensive assessments of a resident when a new wound forms. The facility will complete daily audits X 5 days for two weeks, and then weekly audits for two weeks. Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent: The facility will review the progress of the plan of correction during the QAPI committee meetings. Completion date: 05/23/2025		

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F 686	Continued From page 31 away." R13 denied concerns with the wound and requested to end the interview due to feeling unwell. R13's Abbott Northwestern Hospital Wound Clinic Progress Note, dated 4/10/25, identified R13 was seen in the office for a wound check. R13's past medical history of her wounds was outlined within the note. This identified R13 presented in August 2024, for initial evaluation of the sacrum wound which had been present for " ... a few weeks and that it began without a clear cause." A section labeled, "Treatment Course," identified each visit and subsequent information of the wound and it's progress. On 1/27/25, the note recorded R13 was seen by a plastic surgeon and an MRI was ordered. R13 was recorded as being on protein supplement daily and having wound cares done " ... one or two times daily." On 4/10/25, the note recorded R13 was identified to have "a new wound to the right IT [ischial tuberosity] today." R13 was listed as continuing to get up in her wheelchair for approximately four hour increments every other day, still smoking, and still using protein supplement. The note recorded R13's new wound as, "Pressure Injury Stage [blank space] Stage 3," and listed it as having some slough present and being 3.4 X 1.5 X 0.1 (cm) in size. R13's care plan, printed 4/30/25, identified R13's actual or potential medical and/or care-related problems and corresponding interventions to address them. The care plan identified R13 had an alteration in skin integrity and required extensive assistance with bed mobility adding, "Resident runs the show ..." The care plan listed multiple interventions to address R13's skin risk and concerns including limiting her time seated in	F 686			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 686	Continued From page 32 the powered wheelchair, monitoring skin integrity with cares, and using an air mattress. The last time the interventions were revised prior to the onsite survey was recorded as, "09/27/2024," with multiple interventions being added and/or revised on 4/29/25 and 4/30/25 (after survey started). R13's MHM (Monarch Healthcare Management) Skin Evaluation and Skin Risk Factors V-2, loaded 10/20/24, was identified with dictation present, "In Progress." However, the entire evaluation was left blank and not completed. There were no additional Skin Evaluation and Skin Risk Factors V-2 evaluations loaded or completed in the record. On 4/29/25 at 12:36 p.m., nursing assistant (NA)-A was interviewed, and verified they had cared for R13 prior adding, "[I've] worked with her many times." NA-A explained they often helped the nurses complete R13's wound care and stated R13 rarely got up from her bed due to her own choice. NA-A stated R13 would also, at times, refuse meals and seemed not "not really want you in there much." NA-A stated R13 used an air mattress and nurses would mix medications into her mashed potatoes. NA-A stated they were unsure how long R13 had the sacral pressure wound but added, "Since I started [working there]." NA-A described R13 as being somewhat "dismissive and independent" with her cares adding, "She knows what she wants." R13's dietary progress note, dated 4/24/25, identified a nutrition follow-up was completed due to R13's weight and wound adding, "Discussed resident at IDT [interdisciplinary team] wound meeting." R13's weight was outlined as stable and added, "Will discuss with nurse manager			F 686			

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F 686	Continued From page 33 about increasing protein powder to 2 scoops per serving to better meet protein needs which would provide ~24 gm [grams] protein." However, the note lacked evidence of what, if any, other factors the IDT had reviewed which could contribute to pressure ulcer risk or skin breakdown (i.e., mobility, medication use, continence) to determine what, if any, interventions were needed to reduce the risk of skin breakdown and promote healing since R13 developed a new pressure injury on 4/10/25. When interviewed on 4/29/25 at 1:37 p.m., registered nurse (RN)-A stated they had worked with R13 multiple times prior. RN-A explained R13 did not like to get up from bed and would only get into her electric wheelchair "like every 3rd day" which was usually just so she could smoke outside. RN-A verified R13 had an active wound on her sacrum and expressed it was larger sized than an orange (fruit) adding "oh, it's bigger." RN-A stated the wound was slow to heal due to R13 being resistive with interventions and getting out of bed adding R13 had "super, super fragile skin." RN-A stated they were aware of R13 having a second wound now, however, RN-A stated they felt it was "a little tiny one" and due to bandage-tape being pulled off the skin. RN-A stated they felt the wounds were both getting better just slowly adding aloud, "It's really slow to heal." RN-A stated the nurse manager would like know more about the wounds as they tracked it and measure it. On 4/30/25 at 9:36 a.m., licensed practical nurse manager (LPN)-C was interviewed, and verified they had a chance to review R13's medical record. LPN-C verified R13 had two active pressure injuries which both developed in-house,	F 686			

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F 686	Continued From page 34 and explained R13 "beats to her own drum" with cares and interventions. LPN-C stated the wound was checked for measurements and status every week, and R13 was also being seen by an outside wound clinic for it at times. LPN-C stated R13 had been educated on the risks of not allowing repositioning and being so specific with what interventions she would allow. LPN-C explained the right IT pressure injury was new and recorded as a "stage three pressure area" from the wound clinic. LPN-C verified the first recorded evidence of the wound was on 4/10/25 from the wound clinic note, and explained when a new wound developed the staff wanted to obtain treatment orders, update the provider, and then the "plan of care" needed to be updated. LPN-C stated R13's wound treatments were "tweaked" due to the new wound. LPN-C stated the facility' skin evaluation evaluation (i.e., MHM Skin Evaluation and Skin Risk Factors V-2) was just "an extra tool" to help review someone adding the "comprehensive part" of the review could be more within the IDT discussion which happened every morning. LPN-C then provided a Microsoft Word document which had IDT notes listed on it. The untitled page, undated, identified R13's name along with, "New Wound Right IT." The page outlined, "IDT discussed and reviewed Care Plan and orders for any changes to interventions. Resident continues 'to run the show' and does not allow [hospital] wound clinic repositioning direction. Uses pillows. New Orders for wound healing, dietician involved, provider updated, Resident involved." However, the provided document lacked evidence what, if any, other interventions were considered, offered, refused despite R13 having multiple wounds and being resistive to recommendations. Further, R13's	F 686			

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

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F 686	Continued From page 35 medical record was reviewed and lacked documented evidence R13 had been comprehensively reassessed for pressure wound risk or what, if any, interventions were considered, adopted or agreeable despite R13 developing another wound with some interventions, such as monitoring and an air mattress, already in place prior to the right IT wound developing. At this time, the director of nursing (DON) joined the interview via telephone. DON explained a new wound should be assessed and photographed, then the provider and family should be updated. DON stated the IDT would then discuss the wound and review the care plan. DON stated they felt "everything was in place" for R13 and reiterated R13 likes to "do her own thing" with cares she will allow. DON stated the skin evaluation form was "just a tool" and expressed they didn't feel completing one was necessarily required for a new wound development adding, "We don't have a policy for that." LPN-C verified R13's medical record lacked evidence of a comprehensive reassessment being done in the evaluations or progress notes. DON acknowledged the actual medical record possibly lacked evidence of the IDT' discussion on R13's new pressure injury adding aloud, "I see what you're saying." DON stated having the documentation in the medical record was important to promote continuity of care. A facility-provided Skin Assessment & Wound Management policy, dated 2/2025, identified a pressure ulcer risk assessment (Braden Scale) would be completed per an established schedule and, "Skin Evaluation and Skin Risk Factors Form is completed before initial MDS, annually,			F 686			

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F 686	Continued From page 36 and upon significant change." A section labeled, "New Skin Problem," outlined a series of steps to be completed for developed pressure injuries which included notifying the provider, completing education with the resident, and initiating the Skin and Wound Evaluation (i.e., weekly monitoring). However, the policy section lacked direction or guidance on how a comprehensive reassessment process would look or be documented within the medical record.	F 686			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide services to maintain and/or prevent loss of range of motion and contracture care for 1 of 1 residents (R51) reviewed for limited range of motion.	F 688	Plan of CorrectionF688 ROM Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability		5/23/25

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F 688	Continued From page 37 Findings include: R51's admission Minimum Data Set (MDS) assessment, dated 2/19/25, indicated R51 had intact cognition with no hallucinations, delusions, behaviors or rejection of care. In addition, R51 had no impairment in function limitation in range of motion, utilized a wheelchair for mobility, dependent on staff for lower body dressing and dependent on staff for transfers. R51's Admission Record, printed 5/1/25, indicated the following relevant diagnoses: chronic pain, abnormalities of gait and mobility, dorsalgia (back pain), muscle weakness, disease of spinal cord, restless sleep syndrome and cervicalgia (neck pain). During an interview on 4/28/25 at 6:51 p.m., R51 stated she was not getting physical therapy (PT). R51 stated she had been getting occupational therapy (OT) but hadn't received any OT in "probably at least two weeks." R51 expressed frustration stating, "this is the whole reason I am here," and "I am not getting therapy." R51 stated one of the therapy staff had told her that the nursing staff could "work with my legs in bed" but "they aren't doing that." R51 stated she can no longer straighten her left leg which she could do prior to coming to the facility and indicated she currently used a Hoyer lift (a medical device used to transfer individuals, who cannot bear weight, with limited mobility from one place to another, such as a bed to a wheelchair). A Nursing Order-External Facility note, dated 3/4/25, indicated "Patient is cleared to toe touch during transfer while wearing a Darco shoe."			F 688	by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: R51 has been reassessed by therapy and enrolled in a restorative therapy ROM program and care planned. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents with limited mobility, neurological or musculoskeletal conditions have the potential to be affected by the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has re-educated the nursing and therapy leadership on assigning appropriate restorative programming post discharge. The facility will complete daily audits on restorative programs X 5 days for two weeks (As able pending therapy discharges) , and then weekly audits for two weeks. Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent: The facility will review the progress of the plan of correction during the QAPI		

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F 688	Continued From page 38 A Nursing Order-External Facility note, dated 4/15/25, indicated "It is also recommended that the patient participate in physical therapy daily at the facility, while maintaining non-weight bearing status to the left heel, but can do to-touch transfers on the left foot. Darco shoes were provided during a previous appointment for this reason." A Nursing Order-External Facility note, dated 4/22/25, indicated "It is also recommended that the patient participate in physical therapy daily at the facility, while maintaining non-weight bearing status to the left heel, but can do to-touch transfers on the left foot. Darco shoes were provided during a previous appointment for this reason." R51's care plan, printed 5/1/25, lacked evidence of a restorative nursing program. Furthermore, lacked evidence of PT recommendations or recent assessments. During an interview on 4/30/25 at 10:39 a.m., registered nurse (RN)-B stated that nursing and therapy work together to coordinate care for residents. RN-B stated therapy would update nursing when there were changes to how residents ambulated, transferred or were new to the program. RN-B reviewed R51's electronic medical record (EMR) and verified R51 was discharged from OT on 4/16/25. RN-B verified R51 was not receiving any restorative nursing services after reviewing R51's EMR and three-ring binder that contains information on exercises for residents participating in the restorative nursing program. RN-B verified R51 was not receiving PT services, and stated R51			F 688	committee meetings. Completion date: 05/23/2025		

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F 688	Continued From page 39 relied heavily on caregiver assistance. During an interview on 4/30/25 at 11:04 a.m., registered nurse manager (RN)-D reviewed R51's EMR. RN-D stated they reviewed communication with outside providers and had reviewed Nursing Order-External Facility Notes listed above. RN-D stated she had talked to therapy about changing R51 to "toe touch." RN-D stated she could not remember when she had talked to therapy, did not have documentation regarding the conversation, and stated she thought it was when she had reviewed the first note during "stand up" (interdisciplinary team meeting). RN-D verified R51 should have been assessed by therapy. During an interview on 4/30/25 at 11:11 a.m., director of therapy (DOT)-A stated all residents had standing orders for therapy evaluations. DOT-A stated nursing communicated to therapy when a resident needed to be assessed or reassessed. DOT-A verified R51 was currently not getting any therapy (PT/OT) services. DOT-A stated R51 had PT services from 2/16/25 to 3/13/25, and OT services from 2/16/25 to 4/16/25. DOT-A stated R51 had not been reassessed for PT services since being discharged, and stated he had been given a copy of one of the Nursing Order-External Facility notes, did not remember exactly when it was, but did verify it was after R51 had discharged from PT services. DOT-A reviewed R51's EMR and verified there was no restorative nursing program. DOT-A stated R51 had "not been able to move her legs on her own since admission," and "we tried to get her to move her legs, but she always asked for help." DOT-A verified R51 transferred with a Hoyer lift since admission. DOT-A verified that a PT assessment should have been	F 688			

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F 688	Continued From page 40 completed for R51. DOT-A stated R51 might not be able to bear weight, but it would be important to prevent any contractures. During a follow up interview on 5/01/25 at 8:56 a.m., RN-D verified R51 did not receive and had not received any restorative nursing services. During an interview on 5/01/25 at 9:34 a.m., director of nursing (DON) stated he had reviewed R51's EMR. DON stated R51 should have been reassessed by therapy. DON stated it was important to work with therapy and have a restorative nursing program to "see how we can improve your life and prevent things that shouldn't happen and live a better life." DON stated R51 was going to be reassessed by therapy today, and he had followed up with R51 that morning. DON had assessed R51 that morning (5/1/25) and stated R51 did not have any contractures in lower or upper extremities, decrease in extension of legs and therapy would complete a full reassessment this day.	F 688			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690			5/23/25

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F 690	Continued From page 41 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a resident with a catheter had medical justification for continued use and failed to attempt a trial removal, if recommended, for one of one resident (R35) reviewed for indwelling catheter. Findings include: R35's quarterly Minimum Data Set (MDS), dated	F 690	Plan of CorrectionF690 Bowel and bladder Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for		

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F 690	Continued From page 42 3/25/25, indicated R35 had moderate cognitive impairment, required supervision with toileting and moderate assistance with bathing and had an indwelling catheter in place. R35's admission MDS, dated 5/23/22, indicated R35 was admitted with an indwelling catheter in place. R35's Diagnoses, dated 5/16/22, indicated R35 had several medical diagnoses related to potential need for an indwelling catheter including "other obstructive and reflex uropathy" which can hinder the normal flow or urine, unspecified retention of urine, renal hypoplasia (a congenital condition in which one or both kidneys are underdeveloped), benign prostatic hyperplasia with and without lower urinary tract symptoms (a non-cancerous enlargement of the prostate gland), and infection and inflammatory reaction due to indwelling urethral catheter. However, the electronic medical record (EMR) failed to demonstrate duration of the retention, attempts (if any) to manage without a catheter, and medical justification for why the catheter was necessary on an ongoing basis (i.e neurogenic bladder). The EMR further lacked any evidence of post void residual (PVRs) to determine the extend of R35's urine retention. A urology note for R35, dated 7/28/22, stated "anticipate "SP" (suprapubic catheter - a urinary catheter that is surgically inserted through the abdominal wall directly into the bladder) on 8/17/22. The EMR lacked any evidence of follow up on this order or potential for a SP catheter to be placed. During an interview on 4/3025 at 9:41 a.m., R35 stated he believed he had his catheter since coming to Minnesota years ago to "prevent urine			F 690	those affected by the alleged deficient practice: R35 has an appropriate diagnosis for his catheter. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has re-educated the nursing leadership on obtaining and documenting an appropriate diagnosis for all residents with a catheter. All residents with catheters have been audited for having an appropriate diagnosis. The facility will complete daily audits X 5 days for two weeks (As able pending residents with new caths.) , and then weekly audits for two weeks. Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent: The facility will review the progress of the plan of correction during the QAPI committee meetings. Completion date: 05/23/2025		

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F 690	Continued From page 43 leaking on the plane." R35 stated it has had an indwelling catheter since then because he has only had 2-3 urinary tract infections with the indwelling catheter in place. During an interview on 4/30/25 at 12:42 p.m., nurse manager and registered nurse (RN)-D stated she emailed R35's provider that day about an appropriate catheter diagnosis, stating "I don't believe we have [one]." RN-D further stated the facility had not attempted to remove R35's catheter since his admission to the care facility to assess the extent of his urine retention or if it could be managed without an indwelling catheter. During a follow up interview on 4/30/25 at 2:33 p.m., RN-D stated R35 had an appointment with urology on 5/1/25, and she would follow up on the goal for his catheter, including a proper diagnosis, order for a removal attempt, or a supra pubic placement, stating it was not clear what the goal for his indwelling catheter currently was. A facility policy titled Indwelling Catheter Care Procedure was provided, however it only spoke to proper care of a residents catheter while in place i.e. peri care with a catheter, emptying catheter bags and ensuring they are draining properly.	F 690			
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	F 697			5/23/25

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F 697	Continued From page 44 by: Based on interview, observation and document review the facility failed to comprehensively reassess a resident for pain who was hospitalized for concerns with her pain medication and had pain medication changes, and who still reported frequent pain for one of one resident (R1) reviewed for pain. Findings include: R1's quarterly Minimum Data Set (MDS), dated 2/21/25, indicated R1 was cognitively intact and independent with most activities of daily living (ADLs). The MDS further indicated during the look back period R1 received scheduled pain medication, no PRN (as needed) pain medications, and was in pain almost constantly which effected R1's sleep and day to day activities. R1's Orders indicated R1 had several medications for pain including: Buprenorphine HCl Sublingual Tablet Sublingual, give 2 milligrams (mg) sublingually one time a day for chronic pain syndrome, dated 4/11/25; Oxycodone HCl Oral Tablet 5 mg, give 1 tablet by mouth every 6 hours as needed for Chronic pain/Nonacute pain and give 2 tablets by mouth every day with wound care, dated 4/2/25; Pregabalin Oral Capsule 150 mg, give 150 mg by mouth three times a day for pain, dated 3/12/25; and Acetaminophen Oral Tablet, give 1000 mg by mouth as needed for pain three times a day, dated 2/19/25. The orders also contained an order to "monitor for pain daily", dated 5/30/24, and to document any non-pharmacological pain interventions every shift, dated 10/15/24:			F 697	Plan of CorrectionF697Pain Management Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: A comprehensive pain assessment has been completed on R1. Care plan have been updated with appropriate pain interventions, and documentation of effectiveness and follow-up has been ensured. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents receiving pain management interventions, or who report pain, have the potential to be affected by the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Nursing staff have been re-educated on the pain management policy, including the need to complete pain assessments: Upon admission, With any change in condition, Prior to hospitalization and upon return and With any report of pain. The facility will complete daily audits X 5 days for two weeks, and then weekly		

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F 697	Continued From page 45 0: No intervention needed 1: Ice 2: Heated blankets 3: Massage 4: Repositioning 5: Music 6: Essential Oils 7: Food/Drink 8: Relaxation Breathing. R1's most current comprehensive pain assessment, dated 2/21/25, indicated R1 "reports constant pain to BLEs [bilateral lower extremities]" and reported 10/10 pain. R1's medication administration record (MAR) for April 2025 indicated R1 received as need Tylenol 10 times and as needed Oxycodone 15 times in the month of April. A hospital note for R1, dated 4/10/25, indicated R1 was hospitalized for concerns regarding over sedation due to changes to her pain medication buprenorphine. The note indicated more changes were made to her pain medication in the hospital including stopping buprenorphine film and patch and adding buprenorphine 2 mg sublingual tablet. The note also indicates changes were made to Pregabalin (a medication used to treat nerve and muscle pain). R1 electronic medical record (EMR) lacked evidence that R1 was comprehensively reassessed since having changes to her pain medications to see what, if any additional medications or pain interventions could be added to promote pain control despite R1 still frequently reporting uncontrolled pain. During observation and interview on 4/28/25 at 2:24 p.m., R1 was sitting in her room in her wheelchair, with tears in her eyes stating she had almost constant pain in her knees and shoulders.	F 697	audits for two weeks. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: The facility will review the progress of the plan of correction during the QAPI committee meetings. Completion date: 05/23/2025		

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F 697	Continued From page 46 During an interview on 4/30/25 at 9:48 a.m., R1 stated her left leg was in "excruciating" pain. During an interview on 4/30/25 at 9:48 a.m., nursing assistant (NA)-E stated R1 would complain of pain at times, and she would let the nurses know, though she did not work with R1 often. During an interview on 4/30/25 at 10:43 a.m., licensed practical nurse (LPN)-E stated R1 had been having "issues" with her legs and often had pain. LPN-E stated they would assess R1's pain level and need for non-pharmacological pain interventions prior to administering PRN pain medications but that she was not responsible for comprehensive pain assessments. During an interview on 4/30/25 at 12:42 nurse manager and registered nurse (RN)-D stated comprehensive pain assessments would be expected to be completed quarterly and with a change in condition, stating a hospitalization would be considered a change in condition and she would have expected a comprehensive pain reassessment to be completed with R1 after her hospitalization with pain medication changes. RN-D confirmed R1 had not been comprehensively assessed for pain since 2/21/25.	F 697			
F 812 SS=F	A facility policy on pain was requested and not received. Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812			5/23/25

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F 812	Continued From page 47 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the three-compartment dish sink was of proper sanitization parts per million (ppm) which had the potential to affect all 76 residents who received meals from the main kitchen. Furthermore, the facility failed ensure employees wore beard restraints to prevent hair from contacting food. Findings Include: A report titled Diet/consistency Rollup printed on 4/30/25, categorized each diet and had total meals served out of the main kitchen as 76. During the initial kitchen walk through conducted on 4/28/25 at 1:22 p.m., an area over the three-compartment sink had logs for documentation of water sanitization for April 2025, completed for April 1-24th. Above the sink			F 812	Plan of Correction F812 Food Procurement, Store/Prepare/Serve Sanitary Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: The three-compartment sink sanitization process has been corrected to meet the required parts per million (PPM) for proper sanitation. Beard restraints have been provided and are being worn by staff with facial hair to prevent contamination of food.		

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F 812	Continued From page 48 were two large bottles held by a wire rack with two tubes that ran down into the three compartment sink, both were empty. The bottle on the left was labeled quaternary sanitizer and the one on the right was labeled pot/pan detergent and sanitizer. A large bottle of Dawn dishwashing detergent sat on the far right of the three-compartment sink. A cook was wearing a navy-blue baseball cap and had a beard that extended from the chin approximately 1". During an interview on 4/28/25 at 2:11 p.m., culinary services director (DOC)-A confirmed hair nets were available for employees and donned one himself. DOC-A stated employees needed to either wear a hat or a hairnet. DOC-A then stated if a beard was "too big" they need to wear a cover or shave it, and after a couple of days beards should be shaved or covered or else it could fall into the resident's food. DOC-A could not recall a facility policy on beards in the kitchen, but said employees would be written up if they didn't wear a beard restraint. DOC-A confirmed beard restraints were not available for employees at the kitchen entrance or in the office on 4/28/25. During an observation on 4/29/25 at 11:43 a.m., The pots/pan detergent and sanitizer bottle above the three compartment sink had approximately 1 inch of a blue bubbly solution. On the right hand of the three-compartment sink was a large bottle of Dawn dish detergent. During an observation and interview on 4/29/25 at 12:07 p.m., cook (C)-A removed a puree mixer lid and blade from the drying rack located on the left of the three-compartment sink. C-A stated the puree mixer was hand washed with Dawn and often Dawn detergent was added to the pots/pans	F 812	How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents who receive meals prepared in the facility's main kitchen have the potential to be affected. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Staff education was conducted regarding the proper sanitization process using the three-compartment sink, including the correct PPM levels and use of appropriate chemical solutions per policy. Staff were re-educated on the facility's policy requiring beard restraints for any staff with facial hair when in food preparation areas. Beard restraints have been made readily available at the kitchen entrance and staff areas. The dietary team was re-trained on proper dishwashing procedures, including the use of a thermometer to verify water temperatures and required contact times. The facility will conduct daily audits x 5 days for 2 weeks and then weekly audits for two weeks Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: The facility will review the progress of the plan of correction during the QAPI committee meetings. Completion date: 05/23/2025		

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

PRINTED: 05/16/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/01/2025
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F 812	Continued From page 49 bottle above the sink. Dawn and water were then mixed and the sink was filled to wash pots, pans, and kitchen utensils. During an interview on 4/29/25 at 2:08 p.m., dietary aid (DA)-A stated the three-compartment sink area was used for pots and pans. The pots and pans were scrubbed with Dawn and then used to cook. All resident dishware was put through dishwasher. During an observation on 4/30/25 at 12:41 p.m., Dawn dish detergent was used to wash a clear/gray plastic top to the puree mixer. The top was rinsed off and set on the side of the sink to dry. These items were rinsed less than 30 seconds. During an interview on 4/30/25 at 12:43 p.m. C-A stated no thermometer was available to check the water coming out of the sink and confirmed a puree blender top were hand washed with Dawn and other kitchen utensils. During an observation on 5/1/25 at 9:44 a.m., a three-compartment sink had a large bottle of Dawn dish soap. During an interview on 5/1/25 at 10:31 a.m., DOC-B stated the facility policy allowed for manually washing dishes in the three-compartment sink, but all dishes needed to be sent through the dishwasher to be sanitized. DOC-B stated he was not aware the cooks were manually washing and reusing the items without sending the items through the dishwasher and replied, "oh no, they can't do that" to which the nearby DOC-A responded, "yes we talked about that". DOC-B also confirmed beards should be	F 812			

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F 812	Continued From page 50 no longer than a ½" for all Monarch facilities and that C-A should wear a beard cover. Facility Policy titled Sanitization, revised October 2008, "#9 Manual washing and sanitizing will employ a three-step process for washing, rinsing and sanitizing. C: Sanitize with hot water or chemical sanitizing solution. Chemical sanitizing solution may consist of: Chlorine, Iodine, Quaternary ammonium. Facility Policy titled Cleaning and Disinfection, revised September 2012, "Mixer bowls, beaters, grinders, pots, pans, roasters, electric knife, blades, food thermometers, etc. 1. Wash in 3 compartment sink or dishwasher: a. 1st compartment-soap and water (110-120 degrees Fahrenheit). B. 2nd compartment-clear water for rinsing (120 degrees Fahrenheit). c. 3rd compartment-Detergent/disinfectant (170 degrees Fahrenheit for 2 minutes). 2. Allow to remain wet for 10 minutes to air dry. Facility Policy titled Food Preparation and Service, revised April 2019, "Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food"	F 812			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880			5/23/25

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F 880	Continued From page 51 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880			

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F 880	Continued From page 52 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure soiled personal laundry and linens were bagged (i.e., contained) at the point-of-use and transported in a manner to reduce the risk of cross-contamination and potential infectious spread in 1 of 1 main washrooms and 2 of 2 units (70's, 90's) reviewed. This had potential to affect all 75 residents within the care center. Findings include: On 4/29/25 at 7:57 a.m., the campus' main laundry washroom was toured with housekeeper (HSK)-A present. HSK-A explained they were the primary person who completed laundry for the care center, and they then provided a tour of the laundry process and the machines used. The soiled linen receiving area and washroom were			F 880	Plan of CorrectionF880Infection Prevention & Control Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: The soiled laundry bins on the 70s and 90s units and the main laundry area were immediately addressed. All loose soiled linens and personal clothing were properly bagged and laundered according to protocol. Housekeeping staff received immediate re-education.		

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F 880	Continued From page 53 located on one side of the hallway and folding area (clean) on the opposite. However, in the hallway between these areas were a series of mobile, off-white colored hard plastic bins including one labeled, "Soiled Linen Only," in black paint. The bin was covered with a light-blue colored cloth covering which was lifted exposing it's contents which was soiled white linens and personal clothing, much of which was not bagged but rather loose in the bin causing articles to touch. HSK-A verified the items were not bagged and expressed they should have been prior to transport. HSK-A stated the bin was likely brought down last evening by the nursing assistant (NA) staff. HSK-A stated they had, at times, noticed soiled laundry items to be coming down to the main washroom not bagged adding aloud "on occasion, yes." HSK-A stated they had talked about the issue with the care center administrator in the past, however, added, "But not as frequently as maybe I should have, to be honest." HSK-A then verified they had not collected any soiled linen from the units today yet. A tour of the '70's Unit' was then completed. The soiled utility room was opened with HSK-A present which, inside, had three mobile, off-white containers similar to the one observed by the washroom. HSK-A stated two were used for trash and one was used for soiled linens and personal clothing. The laundry container had a balled-up light-blue cloth cover inside the corner of the container and, again, nearly all of the soiled laundry inside was not bagged. HSK-A stated they items should be bagged at the point-of-use and not transported loosely like it appeared had happened adding aloud, "[They should be] bagging in, bagging out." HSK-A stated most of the personal laundry and linens were laundered	F 880	How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by improper handling of soiled linens and personal laundry. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Staff (including nursing assistants, housekeeping, and laundry personnel) were re-educated on infection control protocols regarding the handling, containment, and transport of soiled linens. Visual reminders (signage) were posted in all soiled utility rooms and laundry areas about proper linen handling procedures. The facility will conduct random audits of soiled linen handling procedures on all shifts, 5 times weekly for 2 weeks, followed by weekly audits for 2 additional weeks Quality Assurance: Plans to monitor facility performance to make sure that corrections are achieved and are permanent: The facility will review the progress of the plan of correction during the QAPI committee meetings. Completion date: 05/23/2025		

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F 880	Continued From page 54 by the care center adding, "Pretty much [yes]." HSK-A stated the soiled linen should be bagged to help prevent "cross contamination" between the garments. Following, a tour of the '90's Unit' was then completed. The soiled utility room was opened with HSK-A present which, inside, had multiple mobile, off-white containers similar to the one observed by the washroom and '70's unit.' The container for soiled linens and laundry was uncovered and, inside, nearly all of the garments and linens were not bagged. Further, sitting on top of the soiled laundry was two yellow-colored bags which had markings on them to indicate potential bio-hazard (i.e., isolation room, active infection). HSK-A verified the items were not covered or bagged and stated aloud, "That will be addressed today." HSK-A stated they did complete audits of laundry care which included walking around with the administrator and observing general cleanliness. HSK-A stated they would provide these for review. A series of three Monthly Facility Tour Form(s), dated 12/27/24 to 3/28/25, were provided. These outlined various areas of the care center and provided spacing to record a score (0 to 10) of cleanliness of the corresponding area. A section was listed, "Laundry/Linen," which outlined three specific areas to review including linen closets, personals, and laundry room. The spacing provided to write-out any "comments" was left blank and no concerns were written. However, the provided audits all lacked evidence the soiled utility rooms (where soiled linens were kept until transport to the washroom) were included in the review or audit process.	F 880			

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F 880	Continued From page 55 On 4/30/25 at 10:01 a.m., the interim director of nursing (DON) was interviewed, and they verified they were the campus' infection preventionist (IP). DON explained they have educated staff through staff meetings and such about the need to bag soiled items where collected, and he verified soiled laundry and linens should be bagged prior to transport. This was important to do as staff could "spread infections from one place to another." DON added, "We will continue to do staff education and follow-up with the staff." A facility-provided Infection Prevention and Control Program policy, dated 11/2024, identified the facility would establish and maintain an infection prevention and control program (IPCP) designed to provide a safe, sanitary and comfortable environment. The policy outlined several steps taken with this program including infection surveillance, antibiotic stewardship and data analysis; however, the policy lacked information on soiled linen handling or transportation. A separate, facility-provided Skill 6. Gown, Glove, and Bag Linen protocol, undated, identified a checklist for staff to implement with gown removal and soiled item collection in an isolation room. This identified, "5. Remove the soiled linen. Keep the linen contained during removal and place in the appropriate bag/receptacle." A facility' policy on soiled laundry handling and transportation was not provided.	F 880			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/29/2025. At the time of this survey, THE EMERALDS AT FARIBAULT was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/16/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. THE EMERALDS AT FARIBAULT is a 4-story structure with partial basement. The facility was constructed at 5 different times. The original building is a 4-story building with no basement. It was constructed in 1908 and was determined to be of Type I (332) construction, (the 1st and 2nd floor only are used for health care). In 1960 a 1-story addition was constructed and			K 000			

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K 000	Continued From page 2 was determined to be of Type II (111) construction, with no basement. In 1971 a 1-story addition was constructed and was determined to be of Type II (111) construction, with a full basement. In 1990 a 1-story addition was constructed and was determined to be of Type II (111) construction, with no basement. In 1991 an addition was constructed and was determined to be of Type II (111) construction, with no basement. Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 109 beds and had a census of 74 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 222 SS=C	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking	K 222			5/23/25

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K 222	Continued From page 3 arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING			K 222			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/29/2025
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 222	Continued From page 4 ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed provide proper labeling of egress doors having time-delay as identified per NFPA 101 (2012 edition), Life Safety Code, section 19.2, 7.2.1.6, 7.2.1.6.1.1(4) This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/29/2025 between 9:00 AM and 1:30 PM, it was revealed by observation that exit doors having delayed egress of 15-seconds were not labeled with identifying signage. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 222	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements Immediate Correction: The facility installed signage stating "Push Until Alarm Sounds. Door Can Be Opened In 15 Seconds" on all affected exit doors. The Maintenance Director educated all maintenance and housekeeping staff during the weekly safety huddle about the requirement for delayed egress door signage and associated NFPA Life Safety Code standards. The Maintenance Director or designee will conduct audits of all egress doors daily x2 weeks, weekly x2 weeks then monthly 2 months, to ensure signage remains visible		

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K 222	Continued From page 5	K 222	and intact.		
K 741 SS=C	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4	K 741	QAPI: Findings from audits will be reported to the monthly QAPI meeting for ongoing monitoring and additional recommendations as needed. Responsible Party: Maintenance Director. Completion date 5/23/2025	5/23/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/29/2025
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K 741	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the facility smoking policy per NFPA 101 (2012 edition), Life Safety Code, section 19.7.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/29/2025 between 9:00 AM and 1:30 PM, it was revealed by a review of available documentation that the smoking policy was generic in content not providing guidance as to the approved smoking location(s) for staff, residents, and visitors. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 741	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. Immediate Correction: The Administrator revised the facility smoking policy on 05/16/2025 to identify designated smoking areas for residents, staff, and visitors. A copy of the revised policy was posted at all staff bulletin boards and signs posted at doors. Signage & Equipment: Appropriate "NO SMOKING" signage was placed in prohibited areas and smoking signs placed at designated smoking areas. Ashtrays made of non-combustible material and approved disposal containers with self-closing lids were placed in designated areas. Education provided to staff on revised smoking policy, safety procedures, and resident supervision requirements. The Maintenance Director or designee will complete audits daily x2 weeks, weekly x2 weeks and monthly x 2 months to ensure compliance with the policy and correct signage. QAPI: Compliance results will be reviewed during monthly QAPI meetings to ensure continued effectiveness of the policy. Responsible Party: Maintenance Director.		

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K 741	Continued From page 7			K 741	Completion Date 5/23/25		5/23/25
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored						

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K 923	Continued From page 8 in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.3.2.4, 11.7.3. 11.7.3.2, 5.1.3.3.2, 5.1.3.3.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 04/29/2025 between 9:00 AM and 1:30 PM, it was revealed by observation that the North - Med Gas (O2) Room, there was storage of transfill portable tanks and Liquid Oxygen Units. The identified room is not approved for transfilling. 2. On 04/29/2025 between 9:00 AM and 1:30 PM, it was revealed by observation that the North - Med Gas (O2) Room was found unsecured. 3. On 04/29/2025 between 9:00 AM and 1:30 PM, it was revealed by observation in resident RM 106 that there was a non-plumbed for use liquid oxygen tank which was positioned in the path of egress from the resident room. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 923	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements Immediate Correction: All portable transfill tanks and liquid oxygen units were removed from the unapproved North Med Gas Room. They were relocated to an approved area that meets all ventilation and construction requirements for transfilling operations. The Maintenance Director and DON provided joint education to all clinical and maintenance staff about proper medical gas storage, NFPA 99 regulations, and the risks of unauthorized transfilling. The Maintenance Director or designee will conduct daily audits of all oxygen storage and transfilling areas × 2 weeks, weekly x2 and then monthly × 2 months. QAPI Oversight: Audit results will be presented to QAPI monthly for review, tracking of trends, and further quality improvement actions. Responsible Party: Maintenance Director. Completion date 5/23/25		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/29/2025. At the time of this survey, THE EMERALDS AT FARIBAULT was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/16/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. THE EMERALDS AT FARIBAULT is a 4-story structure with partial basement. The facility was constructed at 5 different times. The original building is a 4-story building with no basement. It was constructed in 1908 and was determined to be of Type I (332) construction, (the 1st and 2nd floor only are used for health care). In 1960 a 1-story addition was constructed and	K 000			

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K 000	Continued From page 2 was determined to be of Type II (111) construction, with no basement. In 1971 a 1-story addition was constructed and was determined to be of Type II (111) construction, with a full basement. In 1990 a 1-story addition was constructed and was determined to be of Type II (111) construction, with no basement. In 1991 an addition was constructed and was determined to be of Type II (111) construction, with no basement. Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 109 beds and had a census of 74 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 222 SS=C	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking	K 222			5/23/25

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K 222	Continued From page 3 arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING			K 222			

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K 222	Continued From page 4 ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed provide proper labeling of egress doors having time-delay as identified per NFPA 101 (2012 edition), Life Safety Code, section 19.2, 7.2.1.6, 7.2.1.6.1.1(4) This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/29/2025 between 9:00 AM and 1:30 PM, it was revealed by observation that exit doors having delayed egress of 15-seconds were not labeled with identifying signage. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 222	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements Immediate Correction: The facility installed signage stating "Push Until Alarm Sounds. Door Can Be Opened In 15 Seconds" on all affected exit doors. The Maintenance Director educated all maintenance and housekeeping staff during the weekly safety huddle about the requirement for delayed egress door signage and associated NFPA Life Safety Code standards. The Maintenance Director or designee will conduct audits of all egress doors daily x2 weeks, weekly x2 weeks then monthly 2 months, to ensure signage remains visible		

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K 222	Continued From page 5	K 222	and intact.		
K 741 SS=C	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4	K 741	QAPI: Findings from audits will be reported to the monthly QAPI meeting for ongoing monitoring and additional recommendations as needed. Responsible Party: Maintenance Director. Completion date 5/23/2025	5/23/25	

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NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT FARIBAULT LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
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K 741	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the facility smoking policy per NFPA 101 (2012 edition), Life Safety Code, section 19.7.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/29/2025 between 9:00 AM and 1:30 PM, it was revealed by a review of available documentation that the smoking policy was generic in content not providing guidance as to the approved smoking location(s) for staff, residents, and visitors. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 741	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. Immediate Correction: The Administrator revised the facility smoking policy on 05/16/2025 to identify designated smoking areas for residents, staff, and visitors. A copy of the revised policy was posted at all staff bulletin boards and signs posted at doors. Signage & Equipment: Appropriate "NO SMOKING" signage was placed in prohibited areas and smoking signs placed at designated smoking areas. Ashtrays made of non-combustible material and approved disposal containers with self-closing lids were placed in designated areas. Education provided to staff on revised smoking policy, safety procedures, and resident supervision requirements. The Maintenance Director or designee will complete audits daily x2 weeks, weekly x2 weeks and monthly x 2 months to ensure compliance with the policy and correct signage. QAPI: Compliance results will be reviewed during monthly QAPI meetings to ensure continued effectiveness of the policy. Responsible Party: Maintenance Director.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/29/2025
NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT FARIBAULT LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
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K 741	Continued From page 7	K 741	Completion Date 5/23/25		5/23/25
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored				

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NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT FARIBAULT LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
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K 923	Continued From page 8 in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.3.2.4, 11.7.3. 11.7.3.2, 5.1.3.3.2, 5.1.3.3.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 04/29/2025 between 9:00 AM and 1:30 PM, it was revealed by observation that the North - Med Gas (O2) Room, there was storage of transfill portable tanks and Liquid Oxygen Units. The identified room is not approved for transfilling. 2. On 04/29/2025 between 9:00 AM and 1:30 PM, it was revealed by observation that the North - Med Gas (O2) Room was found unsecured. 3. On 04/29/2025 between 9:00 AM and 1:30 PM, it was revealed by observation in resident RM 106 that there was a non-plumbed for use liquid oxygen tank which was positioned in the path of egress from the resident room. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 923	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements Immediate Correction: All portable transfill tanks and liquid oxygen units were removed from the unapproved North Med Gas Room. They were relocated to an approved area that meets all ventilation and construction requirements for transfilling operations. The Maintenance Director and DON provided joint education to all clinical and maintenance staff about proper medical gas storage, NFPA 99 regulations, and the risks of unauthorized transfilling. The Maintenance Director or designee will conduct daily audits of all oxygen storage and transfilling areas × 2 weeks, weekly x2 and then monthly × 2 months. QAPI Oversight: Audit results will be presented to QAPI monthly for review, tracking of trends, and further quality improvement actions. Responsible Party: Maintenance Director. Completion date 5/23/25		