Electronically delivered

September 25, 2020

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

RE: CCN: 245067
Cycle Start Date: August 25, 2020

Dear Administrator:

We previously informed you that we were imposing enforcement remedies.

On September 10, 2020, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(b), is rescinded.

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 14, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 14, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 14, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by October 10, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Emeralds At Faribault Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 10, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 25, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered
September 25, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: 8XWH11

Dear Administrator:

The above facility was surveyed on September 9, 2020 through September 10, 2020 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:

Sarah Grebenc, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING _____ B. WING _____	C 09/10/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/9/20 - 9/10/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to not be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be unsubstantiated: H5067033C, H5067034C. The following complaints were found to be substantiated: H5067036C- substantiated without deficiency and H5067035C- substantiated with deficiency cited at F684. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 684 SS=G	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	F 684		10/23/20

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

Electronically Signed | 10/05/2020

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 684	Continued From page 1 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 thoroughly assess and monitor 1 of 3 residents (R1) who were reviewed for change in condition. This resulted in actual harm when a resident was admitted to the hospital intensive care unit (ICU) and diagnosed with septic shock. Findings include: The Mayo Clinic defines sepsis as a potentially life-threatening condition caused by the body's response to an infection. The body normally releases chemicals into the bloodstream to fight an infection. Sepsis occurs when the body's response to these chemicals is out of balance, triggering changes that can damage multiple organ systems. If sepsis progresses to septic shock, blood pressure drops dramatically. This may lead to death. Sepsis is most dangerous in older adults and people with chronic conditions. R1's quarterly Minimum Data Set (MDS) dated 8/19/20, identified R1 had intact cognition. R1 had not rejected cares. Further, R1 required extensive assist from staff with bed mobility, transfers, dressing, eating and toileting. R1 had diagnoses which included multiple sclerosis (MS), heart failure and septicemia. R1's care plan at the time of survey (9/9/20 -9/10/20) did not identify a focus problem area for risk of infection.	F 684	F Tags F684 SS=G. Based on interview and document review, the facility failed to thoroughly assess and monitor 1 of 3 residents (R1) who were reviewed for change in condition. This resulted in actual harm when a resident was admitted to the hospital intensive care unit (ICU) and diagnosed with septic shock. The residents at the Emeralds at Faribault have the right to have their condition thoroughly assessed and monitored for change in condition and addressed per standards of practice. The Emeralds at Faribault staff have a responsibility to keep the medical record up to date so that other staff can be aware of any change or potential change in condition to further assess and monitor, addressing any concerns per standards of practice and facility policy. Facility policy titled Change in Condition, indicates the nurse will record in the residents' medical record information relative to changes in the resident's medical/mental condition or status. The Change in Condition policy has been reviewed and found to be appropriate. Emeralds at Faribault staff are to document changes in a resident's condition in their progress notes and address any concerns as needed.	

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F 684	Continued From page 2 R1's care plan dated 10/15/18, indicated R1 had a diagnosis of multiple sclerosis (MS), which impacted all aspects of R1's life. R1 would like to remain free from unforeseen complications due to medical history. The care plan directed staff to observe for changes in condition or abilities, further evaluate, and report pertinent information to the medical doctor or nurse practitioner for follow up. R1's progress note (PN) dated 7/31/20, at 11:06 p.m. indicated R1 had declined lunch and supper. R1 had multiple bouts of diarrhea and vomiting. The doctor recommended to send resident to emergency room (ER) if condition worsens or per resident's request. R1's PN's lacked documentation of comprehensive assessment at that time to include vital signs (VS) such as blood pressure, pulse, temperature or oxygen (O2) sats. R1's PN dated 8/1/20 - 8/2/20 lacked further evaluation such as documentation of ongoing assessment or monitoring of R1's condition during their illness. The PN also lacked documentation of R1 being sent to the hospital. R1's hospital discharge summary dated 8/12/20, indicated R1 was admitted to the hospital on 8/3/20, and discharged on 8/12/20. R1's principal diagnoses included septic shock, encephalopathy and E.coli urinary tract infection (UTI). R1 went from the ER and was admitted to the ICU. During interview on 9/9/20, at 10:09 a.m., R1 stated was in the hospital but was really sick and did not remember why. R1 stated had lived at this nursing facility for over two years.	F 684	R1s chart was reviewed and it was identified that assessments were lacking around the time of the change in condition in August that resulted in a hospital stay. All staff were educated that if a change of condition presents, they are to document resident's change in a progress note, as well as put an order in to monitor vital signs for 24 hours. This education was completed on 9/11/2020. IDT will monitor progress for all residents each business day to identify any change of condition that needs to be addressed and followed up on with the provider. These will be discussed at daily group clinical meeting. DON or designee will perform daily business day audits x 4 weeks for appropriateness of documentation, addressing any concerns and providing written follow up education PRN. Audit results will be reviewed by QAPI committee for further recommendations. Completed October 23, 2020	

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F 684	Continued From page 3 During interview on 9/9/20, at 11:43 a.m. family member (FM)-A stated was talking to R1 on the phone on 8/2/20, and recognized increased confusion. FM-A was aware R1 had diarrhea, vomiting and was tired. FM-A then called the facility nursing station and spoke to the charge nurse. After that phone call, R1 was transferred to the ER, then to ICU then to a medical surgical unit over the course of the 10 day hospital stay. FM-A stated the ER doctor said R1 had severe sepsis and dehydration. FM-A stated R1 has a history of UTI's and the facility should have pushed fluids and done more to prevent the progression of the illness to sepsis. During phone interview on 9/9/20, at 1:20 p.m. nursing assistant (NA)-A recalled working with R1 on 7/31/20, and R1 had not felt well and had diarrhea. NA-A reported it to the nurse. During phone interview on 9/9/20, at 1:51 p.m. R1's primary care physician (PCP) was aware of R1's hospitalization and illness from 8/2/20 - 8/12/20. PCP stated R1 was frail. Septic shock would take a couple days to progress, it would not have a sudden onset. PCP stated would expect nursing to monitor more frequently and to check vitals more often in a resident with acute illness. PCP further stated "the picture was unclear" what the sepsis originated from and if hospitalization could have been prevented had there been early monitoring in place. During interview on 9/9/20, at 2:36 p.m. the director of nursing and facility administrator were not sure which day R1 had been sent to the ER or what R1's condition was like on 8/1 - 8/2/20 during the illness. There were no progress notes	F 684		

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F 684	Continued From page 4	F 684		

to review in the chart. They stated the documentation lacked assessments and monitoring. DON said the expectation was "if something happened the nurses should document it."

During interview on 9/10/20, at 9:05 a.m. licensed practical nurse (LPN)-A stated had worked as charge nurse and nurse on the floor on 8/1/20. LPN-A stated was not made aware that R1 was ill. LPN-A stated would have ensured more monitoring was in place. Furthermore, the expectation was to enter a progress note when there was a change so other staff are aware. LPN-A reviewed the medical record and stated it lacked information on R1's status while ill and of their later transfer out.

During interview on 9/10/20, at 9:24 a.m. registered nurse (RN)-A recalled working with R1 on 7/31/20. RN-A had notified the doctor via phone that R1 had multiple emesis and diarrhea. RN-A administered loperamide (anti-diarrhea medication) and Zofran (anti-nausea medication). RN-A stated had thought R1's VS were stable at this time, however, the VS are not documented so RN-A did not know the specifics. RN-A stated had verbally passed the information on to the night shift that R1 was ill. RN-A said a resident ill with vomiting and diarrhea the expectation would be to notify the charge nurse, update family and doctor. Additionally, using nursing judgement, would next check VS more often, document VS in the medical record, ask resident how they are feeling more often, monitor intake and output (I&O). RN-A looked up in the medical record and agreed VS, I&O or increased monitoring were not documented.

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F 684	Continued From page 5	F 684		

During phone interview on 9/10/10, at 9:53 a.m. registered nurse (RN)-B recalled having sent R1 to the ER on 8/2/20 in the afternoon or evening. RN-B stated had gone into R1's room at the beginning of the shift. RN-B observed R1 was not able to find words and was confused so R1 was sent to the ER. RN-B stated was not sure if R1 had a change in condition when receiving nurse to nurse report at the beginning of the shift, since this is not documented. RN-B also stated the medical record was lacking documentation of R1's condition before being sent out to the ER. RN-B said typically VS are taken before paramedics arrive. RN-B was unsure if had taken VS as it was not documented in the medical record, but remembered R1's condition was "concerning."

R1's ambulance run report dated 8/2/20, dispatched at 12:52 p.m., indicated staff reported to emergency medical services staff (EMS) that R1 had history of frequent UTI's dementia and one previous stroke. Ambulance run report also indicated staff reported to EMS that R1 had been acting altered all day compared to baseline and had an episode of slurred speech. While in the ambulance the heart monitor showed atrial fibrillation and VS within normal range. Oxygen saturations decreased to 86% and supplemental oxygen was applied.

R1's hospital admission paperwork dated 8/3/20, indicated, in the ER on 8/2/20, R1 required increase in supplemental oxygen from 2 to 4 liters and mental status fluctuated. The ER consulted with the physician intensivist (physician who provides special care for critically ill patients) and had been recommended R1 transfer to progressive care unit.

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THE EMERALDS AT FARIBAULT LLC	**500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 6 Facility policy titled Change in Condition, undated, indicated the nurse will record in the residents' medical record information relative to changes in the resident's medical/mental condition or status. A policy on Nursing Standards of Care was requested, however, the facility stated they did not have one.	F 684		

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	00571	A. BUILDING: _____ B. WING _____	C 09/10/2020

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2 000	Initial Comments	2 000		

*****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 9/9/20 to 9/10/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to not be in compliance with the MN State Licensure.

The following complaints were found to be unsubstantiated: H5067033C and H5067034C.

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2 000	Continued From page 1 The following complaints were found to be substantiated: H5067035C and H5067036C. Licensing orders were issued. Please indicate on your electronic plan of correction that you have reviewed these orders, and identify the date when they will be corrected.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly assess and monitor 1 of 3 residents (R1) who were reviewed for change in condition. This resulted in actual harm when a resident was admitted to the hospital intensive care unit (ICU) and diagnosed with septic shock. Findings include: The Mayo Clinic defines sepsis as a potentially life-threatening condition caused by the body's	2 830	Completed	9/11/20

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2 830	Continued From page 2	2 830		

response to an infection. The body normally releases chemicals into the bloodstream to fight an infection. Sepsis occurs when the body's response to these chemicals is out of balance, triggering changes that can damage multiple organ systems. If sepsis progresses to septic shock, blood pressure drops dramatically. This may lead to death. Sepsis is most dangerous in older adults and people with chronic conditions.

R1's quarterly Minimum Data Set (MDS) dated 8/19/20, identified R1 had intact cognition. R1 had not rejected cares. Further, R1 required extensive assist from staff with bed mobility, transfers, dressing, eating and toileting. R1 had diagnoses which included multiple sclerosis (MS), heart failure and septicemia.

R1's care plan at the time of survey (9/9/20 -9/10/20) did not identify a focus problem area for risk of infection.

R1's care plan dated 10/15/18, indicated R1 had a diagnosis of multiple sclerosis (MS), which impacted all aspects of R1's life. R1 would like to remain free from unforeseen complications due to medical history. The care plan directed staff to observe for changes in condition or abilities, further evaluate, and report pertinent information to the medical doctor or nurse practitioner for follow up.

R1's progress note (PN) dated 7/31/20, at 11:06 p.m. indicated R1 had declined lunch and supper. R1 had multiple bouts of diarrhea and vomiting. The doctor recommended to send resident to emergency room (ER) if condition worsens or per resident's request. R1's PN's lacked documentation of comprehensive assessment at that time to include vital signs (VS) such as blood

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2 830	Continued From page 3 pressure, pulse, temperature or oxygen (O2) sats. R1's PN dated 8/1/20 - 8/2/20 lacked further evaluation such as documentation of ongoing assessment or monitoring of R1's condition during their illness. The PN also lacked documentation of R1 being sent to the hospital. R1's hospital discharge summary dated 8/12/20, indicated R1 was admitted to the hospital on 8/3/20, and discharged on 8/12/20. R1's principal diagnoses included septic shock, encephalopathy and E.coli urinary tract infection (UTI). R1 went from the ER and was admitted to the ICU. During interview on 9/9/20, at 10:09 a.m., R1 stated was in the hospital but was really sick and did not remember why. R1 stated had lived at this nursing facility for over two years. During interview on 9/9/20, at 11:43 a.m. family member (FM)-A stated was talking to R1 on the phone on 8/2/20, and recognized increased confusion. FM-A was aware R1 had diarrhea, vomiting and was tired. FM-A then called the facility nursing station and spoke to the charge nurse. After that phone call, R1 was transferred to the ER, then to ICU then to a medical surgical unit over the course of the 10 day hospital stay. FM-A stated the ER doctor said R1 had severe sepsis and dehydration. FM-A stated R1 has a history of UTI's and the facility should have pushed fluids and done more to prevent the progression of the illness to sepsis. During phone interview on 9/9/20, at 1:20 p.m. nursing assistant (NA)-A recalled working with R1 on 7/31/20, and R1 had not felt well and had diarrhea. NA-A reported it to the nurse.	2 830		

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2 830	Continued From page 4 During phone interview on 9/9/20, at 1:51 p.m. R1's primary care physician (PCP) was aware of R1's hospitalization and illness from 8/2/20 - 8/12/20. PCP stated R1 was frail. Septic shock would take a couple days to progress, it would not have a sudden onset. PCP stated would expect nursing to monitor more frequently and to check vitals more often in a resident with acute illness. PCP further stated "the picture was unclear" what the sepsis originated from and if hospitalization could have been prevented had there been early monitoring in place. During interview on 9/9/20, at 2:36 p.m. the director of nursing and facility administrator were not sure which day R1 had been sent to the ER or what R1's condition was like on 8/1 - 8/2/20 during the illness. There were no progress notes to review in the chart. They stated the documentation lacked assessments and monitoring. DON said the expectation was "if something happened the nurses should document it." During interview on 9/10/20, at 9:05 a.m. licensed practical nurse (LPN)-A stated had worked as charge nurse and nurse on the floor on 8/1/20. LPN-A stated was not made aware that R1 was ill. LPN-A stated would have ensured more monitoring was in place. Furthermore, the expectation was to enter a progress note when there was a change so other staff are aware. LPN-A reviewed the medical record and stated it lacked information on R1's status while ill and of their later transfer out. During interview on 9/10/20, at 9:24 a.m. registered nurse (RN)-A recalled working with R1 on 7/31/20. RN-A had notified the doctor via	2 830		

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2 830	Continued From page 5	2 830		

phone that R1 had multiple emesis and diarrhea. RN-A administered loperamide (anti-diarrhea medication) and Zofran (anti-nausea medication). RN-A stated had thought R1's VS were stable at this time, however, the VS are not documented so RN-A did not know the specifics. RN-A stated had verbally passed the information on to the night shift that R1 was ill. RN-A said a resident ill with vomiting and diarrhea the expectation would be to notify the charge nurse, update family and doctor. Additionally, using nursing judgement, would next check VS more often, document VS in the medical record, ask resident how they are feeling more often, monitor intake and output (I&O). RN-A looked up in the medical record and agreed VS, I&O or increased monitoring were not documented.

During phone interview on 9/10/10, at 9:53 a.m. registered nurse (RN)-B recalled having sent R1 to the ER on 8/2/20 in the afternoon or evening. RN-B stated had gone into R1's room at the beginning of the shift. RN-B observed R1 was not able to find words and was confused so R1 was sent to the ER. RN-B stated was not sure if R1 had a change in condition when receiving nurse to nurse report at the beginning of the shift, since this is not documented. RN-B also stated the medical record was lacking documentation of R1's condition before being sent out to the ER. RN-B said typically VS are taken before paramedics arrive. RN-B was unsure if had taken VS as it was not documented in the medical record, but remembered R1's condition was "concerning."

R1's ambulance run report dated 8/2/20, dispatched at 12:52 p.m., indicated staff reported to emergency medical services staff (EMS) that R1 had history of frequent UTI's dementia and

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2 830	Continued From page 6 one previous stroke. Ambulance run report also indicated staff reported to EMS that R1 had been acting altered all day compared to baseline and had an episode of slurred speech. While in the ambulance the heart monitor showed atrial fibrillation and VS within normal range. Oxygen saturations decreased to 86% and supplemental oxygen was applied. R1's hospital admission paperwork dated 8/3/20, indicated, in the ER on 8/2/20, R1 required increase in supplemental oxygen from 2 to 4 liters and mental status fluctuated. The ER consulted with the physician intensivist (physician who provides special care for critically ill patients) and had been recommended R1 transfer to progressive care unit. Facility policy titled Change in Condition, undated, indicated the nurse will record in the residents' medical record information relative to changes in the resident's medical/mental condition or status. A policy on Nursing Standards of Care was requested, however, the facility stated they did not have one. SUGGEST METHOD FOR CORRECTION: The director of nursing or designee could review policies and procedures, train staff, and implement measures to assure residents are receiving appropriate assessment and necessary interventions. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		