

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 21, 2022

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

RE: CCN: 245067

Cycle Start Date: January 21, 2022

Dear Administrator:

On January 11, 2022, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

The Emeralds At Faribault LLC January 21, 2022 Page 2

- 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:

> Elizabeth Silkey, Unit Supervisor Mankato District Office **Licensing and Certification Program Health Regulation Division** Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, Minnesota 56001

> Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

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 April 11, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

The Emeralds At Faribault LLC January 21, 2022 Page 3

In addition, if substantial compliance with the regulations is not verified by July 11, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 02/09/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		245067	B. WING				C 11/2022
	PROVIDER OR SUPPLIER	ILT LLC		50	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTHEAST FIRST STREET ARIBAULT, MN 55021	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	TS	F O	000			
	abbreviated survey Your facility was for with the requirement	h 1/11/22, a standard was conducted at your facility. und to be NOT in compliance nts of 42 CFR 483, Subpart B, ong Term Care Facilities.					
		plaint was found to be H5067081C (MN74222), with t F688.					
	SUBSTANTIATED: H5067091C (MN60 H5067080C (MN70 H5067086C (MN67 however NO deficie	plaints were found to be H5067092C (MN60814), 0828), H5067089C (MN61814), 6415), H5067093C (MN60474), 7375), H5067087C (MN67337), encies were cited due to ed by the facility prior to survey.					
	UNSUBSTANTIATI H5067082C (MN73						
	as your allegation of Departments accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required e first page of the CMS-2567 ic submission of the POC will tion of compliance.					
	onsite revisit of you validate that substa regulations has bee						
LABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

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

Electronically Signed 01/31/2022

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			DATE SURVEY COMPLETED	
		245067	B. WING			C 01/11/2022	
	PROVIDER OR SUPPLIE			5	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE	
F 688 SS=D	CFR(s): 483.25(c) §483.25(c) Mobili §483.25(c)(1) The resident who enter range of motion of services to increat prevent further de §483.25(c)(3) A re receives appropri assistance to mai the maximum pra reduction in mobi This REQUIREMI by: Based on observ review, the facility extremity (BUE) p home exercise pr consistently imple was received, to re loss of range of m reviewed for conti- Findings include: R1's quarterly Mir assessment, date intact cognition ar other behaviors. Factivities of daily I	e facility must ensure that a person the facility without limited ones not experience reduction in a range of the resident's clinical strates that a reduction in range of the propriate treatment and se range of motion and/or to be rease in range of motion. Desident with limited mobility are services, equipment, and the notation or improve mobility with cticable independence unless a ity is demonstrably unavoidable. ENT is not met as evidenced action, interview, and document a failed to ensure bilateral upper the reassive range of motion (PROM) or motion (HEP) exercises were the mented and palmar hand splint restore, maintain and prevent action for 1 of 1 resident (R1)	F6	588	Based on observation, interview, and document review, the facility failed to ensure bilateral upper extremity (BUE) passive range of motion (PROM) home exercise program (HEP) exercises wer consistently implemented and Palmar Hand Splint was received, to restore, maintain and prevent loss of range of motion for 1 of 1 resident (RI) reviewed contractures. R1 is currently being seen by occupation therapy (OT) for range of motion and contracture management. PROM and active range of motion (AROM) are currently being performed by therapists with the goal to develop a range of motion	e for nal	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		SURVEY PLETED
			A. BUILDI				,
		245067	B. WING				11/2022
NAME OF I	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		-
THE EAS	DAL DO AT FADIDAL	W.T.I.O.		500	0 SOUTHEAST FIRST STREET		
IHEEMI	ERALDS AT FARIBAI	DLI LLC		FA	RIBAULT, MN 55021		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	١	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE
F 688	Continued From page	age 2	F 6	88			
		oileting, eating; total assistance			program when appropriate. Also, O	Tis	
		personal hygiene. R1 did not			currently working on splinting tolera		
		S further identified diagnosis			with the goal for R1 to wear splints		
		of multiple sclerosis (MŠ) (An			hours per day.		
		sease causing nerve damage					
		cation between brain and rest			Once R1 has achieved the goals w	ith PT	
		osis and chronic pain			and OT, a Functional Maintenance		
	syndrome.				Program form will be completed an		
	R1's Occupational	Therapy Toolkit Passive			presented to the director of nursing the nurse manager. The staff will the		
		ated 4/23/21; identified types of			trained on the functional maintenar		
		ons, and times per day nursing			program by OT.		
		lete to BUE. Therapy			p. 19.1		
		specified PROM exercises be			All residents will be screened at the	time	
		mes to each BUE site on a			of admission to evaluate for range		
		ing staff. PROM exercises			deficits and will be treated according	gly.	
		blade, front arm raise, side			T		
		ns, making a fist, finger spread,			Those patients that flag for range of motion deficits and/or contractures		
	wrist turns.	ow bend, forearm turns, and			screened quarterly to ensure range		
	Wilst tullis.				motion has been maintained. If not		
	Review of Occupa	tional Therapy Treatment			interventions will be implemented.		
) dated 4/29/21, indicated plans			evaluation of resident ROM can be		
		ar hand splint at next session			requested by the nursing departme	nt at	
		follow-up sessions scheduled			any time if a concern arises.		
		herapy (OT) on 5/5/21,					
		5/14/21, 5/18/21, 5/21/21;			When therapy develops a functional		
	of these visits.	and splints did not occur at any			maintenance program (FMP) or ad additional interventions, education		
	of these visits.				provided to the nursing staff. The r		
	Review of Occupa	tional Therapy OT Evaluation			manager will implement to FMP by		
		nent Note (s) dated 6/9/21,			an order in PCC after updating the	F	
		peen receiving HEP of ROM of			physician. A copy of the FMP will be	Э	
	BUE by nursing da	aily, therefore would not need to			placed in the resident's room, and i	n the	
		re impairment at visit, as			Therapy Binder on the nursing unit		
		ance program (FMP) already					
	was in place.				The DON and/or designee will mon		
	On 1/10/22 at 11:0	00 a.m. R1 was observed			functional maintenance program we for four weeks and then review with		
		JU A.III. IN I WAS ODSELVED			TOLTOUL WEEKS AND THEN TEVIEW WILL	rue	

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245067	B. WING				0
NAME OF F	DOVIDED OF CURRUED	245067	D. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	01/	11/2022
	PROVIDER OR SUPPLIER ERALDS AT FARIBAU	LT LLC		50	OO SOUTHEAST FIRST STREET ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	fourth, and fifth fing observed to appear inwards toward palm to not have a palma hand. When R1 tric could extend the first third-fifth fingers rel Palms of both hand with fingernail inder R1 indicated being exercises to BLE's, During an interview occupational therap been fitted for and is splint. OT-A indicated occupational Therap hand splint around confirm the exact distaff were provided Passive Range of Nexercise program for R1's BUE, which haprior to fitting of har when recommenda staff were informed placed in nursing the exercises for BUE in R1's room, either bulletin board, and review. OT-A indicated for wheelchated contractures. OT-A	chair in room. R1's third, er of both hands; was tight, rigid, and curled on of hands. R1 was observed ar splint in place to either ed to extend her fingers, she est and second fingers,but mained flexed on both hands. Is observed to be pink in color outation, skin remained intact. I aware of having therapy but not to her BUE's. on 1/10/22 at 12:16 p.m. outsist (OT)-A indicated R1 had received bilateral palmar hand	F	588	OT to ensure progress related to the has been maintained. The results of audits will be presented at the Qual Assurance and Process Improvement Committee (QAPI) for review and for recommendations. Audits will be completed weekly x 4 monthly x 2 and results will be reported the Quality Assurance and Process Improvement Committee for further review and recommendations.	of the lity ent urther	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED
			/ BOILD			С
		245067	B. WING	i	01	/11/2022
	PROVIDER OR SUPPLIER ERALDS AT FARIBAU	LT LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F 688	When interviewed on ursing assistant (Nof R1's care needs, were provided daily consisting of each completed for each observed during int task list titled "East indicated R1's care complete during 1/2 noted to have PRO indicate any exercisall NAs document of in EMR (Electronic Review of R1's care EMAR system did remove the provided by NA-A indicated any cares or removing splints for bilateral hand complete any cares or removing splints for bilateral hand complete any cares or remover the provided by NA-A, receive any therapy application and removed any care any or splint application and removed any therapy application and removed any therapy application and removed any the EMR system. In the EMR system in the EMR system. In the EMR system is the EMR system is the EMR system. In the EMR system is the EMR system is the EMR system is the EMR system in the EMR system. In the EMR system is the EMR	on 1/10/22, at 2:05 p.m. NA)-A indicated she was aware NA-A indicated that all NAs a facility NA task list resident's care needs to be shift working. NA-A was erview to retrieve a copy of NA " updated 1/6/22, which needs for NA staff to 10/22 shift. Review of task list M exercises for BLE's, did not ses for BUE. NA-A indicated completion of resident's cares Medical Record) system. The needs provided by NAs in not indicate for NAs to perform and that she had not had to the for R1 that included applying to BUE's, nor any exercises contractures. NA-A indicated define and the shad not had to the for R1 that included applying to BUE's, nor any exercises contractures. NA-A indicated define and the shad not had to the for R1 that included applying to BUE's, nor any exercises contractures. NA-A indicated define and the shad not had to the for R1 that included applying to BUE's, nor any exercises contractures. NA-A indicated define and the shad not had to the formal the shad not had the sh	F	688		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		C (X3) DATE SURVEY	
		245067	B. WING _		01	/11/2022
	PROVIDER OR SUPPLIER ERALDS AT FARIBAU			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 688	exercises in R1's rexercises to be for to look around R1 splints, finding BLE unable to located puring an interview licensed practical religious being aware of any application and rerindicated if nursing residents receiving recommendations, be placed in nursir proceeded to look for R1's exercise removal recommending PROM there application and rerindicated in unitary when interviewed director of nursing for receiving there application and rerindicated in unitary there are interested in the continued care. No book with new written orders to update all staff of the there in the continued care. No book with new written orders to update all staff of the continued care. No book with new written or the DON's design on the DON's design on the place copy of the care plan based on which triggered nurse.	oom to be completed, verified BLE's only. NA-A proceeded 's room for palmar hand E braces and back brace but balmar hand splints. If on 1/10/22 at 2:30 p.m. hurse (LPN)-A indicated not witherapy exercises or splint moval for R1's BUE's. LPN-A was to complete anything for wherapy services; orders, and exercise hand-outs would be therapy binder. LPN-A through nursing therapy binder begimen, splint application and andations. LPN-A indicated apprecises, brace moval for BLE only. In 1/10/22 at 2:40 p.m. the (DON) indicated the process by orders; consisted of, any recommendations with the provide nursing staff with any or recommendations. Nursing on unit of any new changes in the recommendations for ursing to update unit therapy ten orders or provided by therapy staff, then apy recommendations or orders the DON would then update in therapy recommendations, rsing and NA task list to		38		
	not being aware of for R1's BUE contr	system. The DON indicated any therapy recommendation actures. The DON confirmed R1's care plan and orders. R1				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245067	B. WING		01	C I/ 11/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 500 SOUTHEAST FIRST FARIBAULT, MN 5502	STATE, ZIP CODE STREET	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 688	did not have any the BUE's. On 1/10/22, at 2:5 reviewed occupation encounter notes from the properties of the propertie	7 a.m. OT-A indicated she onal therapy treatment om 4/28/21-5/21/21, and ad occurred with trialing palmar A indicated per 4/29/21 note; nar hand splint at next session, ar as splints were placed on confirmed R1 had not been palmar hand splint once supply -A validated forgetting to place at. Furthermore, OT-A verified are not in nursing therapy book confirmed BLE exercises only in book and in R1's room. We on 1/11/22 at 11:02 a.m. (PT)-A indicated Occupational ation and Plan of Treatment bilateral hand contractures on icated based on evaluation, R1 es or worsening of bilateral. Occupational Therapy OT an of Treatment, dated 1/11/22, worsening changes to bilateral. PT-A provided therapy form, dated 1/11/22; which ng and NA staff to complete ion (ROM) program once daily indicated on form. A copy of was placed by PT-A and OT-A behind R1's bed, as well as in	F6	88		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	(X3) DATE SURVEY COMPLETED	
		245067	B. WING			C 11/2022	
	PROVIDER OR SUPPLIER	LT LLC		STREET ADDRESS, CITY, STATE, Z 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	IP CODE	11/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 688	to maintain or improfurther decline through further decline through further decline through further decline through further decline through would involve signiful carryover was compresident identification and tools, evaluation interventions used; staff training regard splint wear schedul general treatment pof the splint wear and treatment sessions	ove impairments and prevent ugh splinting device or range indicated type of program ficant training to ensure proper pleted. Policy included on of need, screening process on process, common assessment of splint fit and ling ROM program, as well as e and application removal; orinciples included assessment and tolerance was part of the , goal and documentation ogy/caregiver education, splint	F6	.88			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 21, 2022

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

Re: State Nursing Home Licensing Orders

Event ID: F60E11

Dear Administrator:

The above facility was surveyed on January 10, 2022 through January 11, 2022 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at

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.

The Emeralds At Faribault LLC January 21, 2022 Page 2

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:

Elizabeth Silkey, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, Minnesota 56001

Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

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.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

Mistain

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 02/09/2022 FORM APPROVED

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00574	B. WING		C	
		00571	B. WINO		01/1	1/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE EMI	ERALDS AT FARIBAU	ITIIC	THEAST FIRS LT, MN 5502			
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2 000	Initial Comments		2 000			
	*****	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	was conducted at y the Minnesota Depa facility was found N State Licensure. Pla plan of correction ye	TS: 1/11/22, a complaint survey our facility by surveyors from artment of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders e when they will be completed.				

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

Electronically Signed 01/31/22

TITLE

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The follow SUBSTAN a licensing The follow SUBSTAN H5067080 H5067086 however, I The follow UNSUBST H5067082 H5067084 (MN79793 The Minned documenti Orders using have been statutes/rutag numbe "ID Prefix complianc of Deficient Comply" polumn also violation of "This Rule the survey Method of Correction You have a receipt of State Minnes Information of I	ing comp TIATED: order is ing comp TIATED: C (MN60 C (MN70 NO licens ing comp ANTIATI C (MN70 /MN7982 c (MN70 /MN7982 r (MN70 /M	plaint was found to be H5067081C (MN74222), with sued at 0895. plaints were found to be H5067092C (MN60814), 0828), H5067089C (MN61814), 0415), H5067093C (MN60474), 0375), H5067087C (MN67337); 05ing orders were issued. 05laints were found to be ED: H5067090C (MN60979), 05683), H5067083C (MN73255), 05555), H5067085C (MN69087), 0466), H5067079C				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:		(3) DATE COMP	
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2 000	you electronically. is necessary for State necessary for State enter the word "CO available for text. You electronic State lice heading completion be corrected prior to the Minnesota Depais enrolled in ePOC not required at the I state form. PLEASE DISREGATOURTH COLUMN "PROVIDER'S PLATOURTH COLUMN" PROVIDER'S PLATOURTH COLUMN TO FEDE THIS WILL APPEA	Although no plan of correction ate Statutes/Rules, please RRECTED" in the box ou must then indicate in the ensure process, under the date, the date your orders will be electronically submitting to artment of Health. The facility and therefore a signature is bottom of the first page of	2 000			1/31/22
2 090	Motion Subp. 2. Range of that is directed towa through positioning implemented and motion comprehensive results of nursing services development of a nursing services developme	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which h a limited range of motion e treatment and services to notion and to prevent further	2 093			1/31/22
	by:	ent is not met as evidenced on, interview, and document		Based on observation, interview, and	d	

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2 895	Continued From pa	ige 3	2 895		
	extremity (BUE) pa home exercise pro- consistently implem was received, to re	ailed to ensure bilateral upper ssive range of motion (PROM) gram (HEP) exercises were nented and palmar hand splint store,maintain and prevent otion for 1 of 1 resident (R1) ctures.		document review, the facility did nensure bilateral upper extremity (Epassive range of motion (PROM) exercise program (HEP) exercises consistently implemented and pall hand splint was received, to restormaintain and prevent loss of rangemotion for 1 of 1 resident (RI) revicent ractures.	BUE) home s were mar re, e of
	assessment, dated intact cognition and other behaviors. R' activities of daily liv contractures, and r with bed mobility, to with transfers and pambulate. The MDS including history of immune system disaffecting communic	mum Data Set (MDS) 4/26/21, identified R1 had I demonstrated no delusions or I had functional limitations in ing (ADL), bilateral hand equired extensive assistance bileting, eating; total assistance bersonal hygiene. R1 did not S further identified diagnosis multiple sclerosis (MS) (An becase causing nerve damage cation between brain and rest basis and chronic pain		All residents are screened at the tradmission and quarterly to evaluar range of motion deficits. When a trade plan for the range of motion deficition been formulated, it will be brought nurse manager (NM) and/or direct nursing (DON) to review. Together therapy, NM and/or DON will plan education, update care plans and recommendations on the treatment administration record.	te for therapy t has t to the tor of r, staff place
	Range of Motion da exercises, repetitio staff were to compl recommendations of completed three tin daily basis by nursi included; shoulder arm raise, arm turn	Therapy Toolkit Passive ated 4/23/21; identified types of ns, and times per day nursing ete to BUE. Therapy specified PROM exercises be nes to each BUE site on a ng staff. PROM exercises blade, front arm raise, side is, making a fist, finger spread, w bend, forearm turns, and		All staff will be educated in the pro- related to therapy recommendatio importance of increasing or keeping resident function. The director of nursing or designed conduct random audits to ensured screening and implementation of restorative maintenance plans.	ns, the ng
	Encounter Note (s)	ional Therapy Treatment dated 4/29/21, indicated plans ar hand splint at next session		Audits will be completed weekly x	4,

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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2 895	Continued From pa	ge 4	2 895			
	on 5/3/21. R1 had follow-up sessions scheduled with occupational therapy (OT) on 5/5/21, 5/10/21, 5/12/21, 5/14/21, 5/18/21, 5/21/21; trialing of palmar hand splints did not occur at any of these visits. Review of Occupational Therapy OT Evaluation and Plan of Treatment Note (s) dated 6/9/21, indicated R1 had been receiving HEP of ROM of BUE by nursing daily, therefore would not need to address contracture impairment at visit, as functional maintenance program (FMP) already was in place.			monthly x 2 and results will be rep the Quality Assurance and Proces Improvement Committee for furth and recommendations.	SS	
	On 1/10/22, at 11:00 a.m. R1 was observed sitting in her wheelchair in room. R1's third, fourth, and fifth finger of both hands; was observed to appear tight, rigid, and curled inwards toward palm of hands. R1 was observed to not have a palmar splint in place to either hand. When R1 tried to extend her fingers, she could extend the first and second fingers,but third-fifth fingers remained flexed on both hands. Palms of both hands observed to be pink in color with fingernail indentation, skin remained intact. R1 indicated being aware of having therapy exercises to BLE's, but not to her BUE's.					
	occupational therapheen fitted for and usplint. OT-A indicated Occupational Theraphees from 4/28/21 had been fitted for a hand splint around confirm the exact distaff were provided Passive Range of N	on 1/10/22 at 12:16 p.m. pist (OT)-A indicated R1 had received bilateral palmar hand ted when reviewing apy Treatment Encounter and 4/29/21, she believed R1 and received bilateral palmar that time, but could not ate. OT-A indicated nursing Occupational Therapy Toolkit Motion sheets, a written or nursing staff to follow for				

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2 895	Continued From page 5		2 895			
2 095	R1's BUE, which had been given to nursing staff prior to fitting of hand splints. OT-A indicated when recommendations were provided, nursing staff were informed, and recommendations were placed in nursing therapy book. OT-A indicated exercises for BUE PROM HEP should be located in R1's room, either taped to the wall or pinned to bulletin board, and nursing staff were informed to review. OT-A indicated R1 had an evaluation on 6/9/21 for wheelchair positioning and BUE contractures. OT-A indicated R1 had no changes with contractures, so visit was primarily focused on wheelchair. When interviewed on 1/10/22, at 2:05 p.m. nursing assistant (NA)-A indicated she was aware of R1's care needs. NA-A indicated that all NAs were provided daily a facility NA task list consisting of each resident's care needs to be completed for each shift working. NA-A was observed during interview to retrieve a copy of NA task list titled "East," updated 1/6/22, which indicated R1's care needs for NA staff to complete during 1/10/22 shift. Review of task list noted to have PROM exercises for BLE's, did not indicate any exercises for BUE. NA-A indicated all NAs document completion of resident's cares in EMR (Electronic Medical Record) system.					
	Review of R1's care EMAR system did r PROM to BUE, only remembering R1 halong ago, unable to asked. NA-A indica complete any cares or removing splints for bilateral hand cofrom what she coulwith wearing BUEs	e needs provided by NAs in not indicate for NAs to perform to BLE. NA-A indicated ad hand splints at one time recall how long ago when ated that she had not had to for R1 that included applying to BUE's, nor any exercises ontractures. NA-A indicated d remember R1 was complian				

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2 895	brace to BLE. NA-type of exercises, a removal needed for writer NA unit commask lists included in provided by NA-A, receive any therapy application and ren R1 did not have an or splint application the EMR system. In needing to be compleach resident's roo exercises in R1's reexercises to be for to look around R1's plints, finding BLE unable to located puring an interview licensed practical in being aware of any application and renindicated if nursing residents receiving recommendations, be placed in nursin proceeded to look for R1's exercise removal recommendations, be placed in nursin proceeded to look for R1's exercise removal recommendations, be placed in nursin proceeded to look for R1's exercise removal recommendations, be placed in nursing proceeded to look for R1's exercise removal recommendation and rening PROM thera application and rening therapists discussin nurse on unit and to new written orders	A indicated being aware of and brace application and r R1's BLE. NA-A showed munication book, paper sheet n book. Paper sheet task list verified R 1 was not listed to y exercises for BUE's or splint noval. NA-A confirmed that y therapy exercises for BUE's and removal by aides listed in NA-A indicated all exercises pleted were posted on wall in m. NA-A showed writer from to be completed, verified BLE's only. NA-A proceeded s room for palmar hand is braces and back brace but halmar hand splints. You 1/10/22 at 2:30 p.m. hurse (LPN)-A indicated not therapy exercises or splint noval for R1's BUE's. LPN-A was to complete anything for therapy services; orders, and exercise hand-outs would g therapy binder. LPN-A through nursing therapy binder egimen, splint application and andations. LPN-A indicated apy exercises, brace	2 895			

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2 895	therapy orders and continued care. No book with new writt recommendations place copy of thera on the DON's desk care plan based on which triggered nur complete in EMAR not being aware of for R1's BUE contrathrough review of Edid not have any th BUE's. On 1/10/22, at 2:57 reviewed occupation encounter notes frowerified an error has hand splints. OT-AR1 would trial palm which did not occur back order. OT-AR1 would trial palm which did not occur back order. OT-AR1 on follow-up list BUE exercises were or in R1's room, conursing therapy both During an interview physical therapist (Therapy OT Evaluation and Pland contractures. Evaluation and Pland contractures. Evaluation and Pland contractures.	recommendations for ursing to update unit therapy	2 895			

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2 895	Continued From parecommendations of indicated for nursin BUE range of motion with all exercises in exercise hand-out woon bulletin board be therapy recommend. Facility policy titled Long Term Care Promanagement," under to maintain or improfurther decline through the maintain or interventions used; staff training regards splint wear schedul general treatment pof the splint wear and treatment sessions examples, terminol guide for types use. SUGGESTED MET The director of nurse review/revise policies implementation of resource proper asses being implemented staff on the policies for evaluating and representation of the developed, with the brought to the facilic Committee for review.	form, dated 1/11/2 g and NA staff to come (ROM) program dicated on form. It was placed by PT-ehind R1's bed, as dation book. "Remedy Therapy ogramming: UE Come of the compairments a compairment of the compairments of the compairment o	complete n once daily A copy of A and OT-A s well as in / Services contracture al of program and prevent be or range program nsure proper uded ning process on olint fit and n, as well as removal; assessment part of the entation cation, splint ECTION: could s related to ervices, could // ventions are re-educate A system ent id be audits being				

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2 895	·	ge 9 R CORRECTION: Twenty-one	2 895			

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