Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 3, 2025

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

RE: CCN: 245067
Cycle Start Date: January 22, 2025

Dear Administrator:

On February 27, 2025, the Minnesota Department of Health 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.

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
January 30, 2025

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

RE: CCN: 245067
Cycle Start Date: January 22, 2025

Dear Administrator:

On January 22, 2025, a survey was completed at your facility by the Minnesota Department of Health 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:

- 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 22, 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 July 22, 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

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.

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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January 30, 2025

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

Re: Event ID: 84ZE11

Dear Administrator:

The above facility survey was completed on January 22, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any 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

An equal opportunity employer

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00571	A. BUILDING: ____ B. WING ____	C **01/22/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 1/16/25, 1/21/25 and 1/22/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were reviewed: H50674961C (MN109786) and H50675921C	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/08/25

Minnesota Department of Health

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2 000	Continued From page 1 (MN110109). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		

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	245067	A. BUILDING ______ B. WING ______	C 01/22/2025

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

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F 000	INITIAL COMMENTS On 1/16/25, 1/21/25 and 1/22/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H50674961C (MN109786) and H50675921C (MN110109) with a deficiency cited at F609 and F610. 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 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 609		2/8/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 02/08/2025

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.

F 609 Continued From page 1

serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to ensure allegation of a potential drug diversion was recognized and reported to the state agency (SA), reviewed for misappropriation of property.

Finding s included:

R1's admission Minimum Data Set (MDS) dated 1/10/25, identified R1 was cognitive and had a diagnosis of narcolepsy (a rare neurological condition that makes people very sleepy during the day and can cause them to fall asleep suddenly).

R1's order summary dated 1/6/25, identified an order for methylphenidate long acting (LA) (a stimulant medication to help with narcolepsy) 20 mg capsule to be given every day in the morning for narcolepsy.

F 609

The Administrator and/or designee will ensure training and education is conducted on the proper actions to take for alleged or suspected abuse. On 1/16/25 - 1/20/25, staff education with all nursing staff was conducted on medication administration, process for counting of narcotics/controlled substances, and logging in medication upon delivery from pharmacy. In addition, all facility staff were educated and trained on vulnerable adult, abuse and timely reporting. An additional in-service training on misappropriation of property relating to vulnerable adult/abuse, drug diversion, and abuse prevention was held on Tuesday, 2/4/25. The Administrator and Director of Nursing educated staff on the definition of a vulnerable adult and ensuring staff understand all residents in

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

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F 609	Continued From page 2 R1's Medication Administration Record (MAR) dated 1/6/25, identified R1 did not receive methylphenidate extended release (ER) 20 mg capsule as indicated by the number, "5" documented that indicated to see progress note. It was documented from 1/6/25 to 1/20/25, that R1 received his methylphenidate daily as indicated by nurse initials. R1's progress note dated 1/9/25 at 1:45 p.m., identified physical therapy (PT) went in R1's room to find R1 unresponsive to verbal and tactile stimuli. Writer was called and found R1 unresponsive, nystagmus (eyes rolled back in head), and experiencing involuntary jerking of bilateral arms. R1 had change in mental status and was unable to say his name and where he was. Writer notified primary and got the green light to send him to the hospital. 911 called and R1 was taken to the hospital. All parties notified. R1's ED (emergency department) progress note dated 1/9/25, at 1:54 p.m., identified during physical therapy (PT) R1 had a syncopal episode witnessed by staff. R1 was diagnosed with syncope (a brief loss of consciousness, or fainting, that occurs when blood flow to the brain is reduced) and collapse (a sudden loss of consciousness). Discharge instructions identified to follow up with provider and return if symptoms worsen. R1's progress note dated 1/9/25 at 6:00 p.m., R1 was returned via ambulance at 6:00 p.m. and was transferred to bed. R1 came back alert and orientated x 3. No significant findings found. No new orders given. When asked if R1 remembered what caused him to go to the	F 609	the facility are considered to be vulnerable adults. The Administrator and Director of Nursing educated on timely reporting with suspected/alleged abuse, types of abuse, and the proper communication to report abuse. The Administrator and/or designee, will conduct weekly audits x4, monthly audits x2 and report to QAPI committee for further evaluation and recommendation on vulnerable adult abuse reporting policy and procedure.	

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F 609	Continued From page 3	F 609		

hospital R1 stated he didn't remember a thing.

R1's progress note dated 1/10/25 at 1:54 p.m., identified R1 was sent to the ED for decreased level of responsiveness...

R1's hospital lab results dated 1/10/25 at 4:59 p.m., identified R1's inhouse rapid urine drug screen collected at 6:46 p.m., did not detect methamphetamine or amphetamines. The threshold concentrations used for amphetamines and methamphetamines was 500 ng/ml respectively.

R1's ED course summary dated 1/10/25, identified R1 presented to the ED with intermittent episodes of confusion. EMS (emergency medical services) was called because R1 had one of what sounds to be his typical narcolepsy episode. R1's MAR from his nursing facility was reviewed and it does appear that he had been receiving his methylphenidate. It is possible he needed a dose adjustment on this medication. I did also consider possible drug diversion, given family stated that R1 had been on this dose of medication for quite some time and had been stable. At 5:10 p.m., amphetamine not detected...which was somewhat unexpected for R1 who was supposed to be receiving methylphenidate, including this morning. At 5:29 p.m., discussed with pharmacist and agree, would anticipate positive test for amphetamines on UDS (urine drug screen) if R1 was being given his medications appropriately. This does raise the concern for diversion of medications. At 6:52 p.m., R1's family was notified about the urine drug screen results, as well as my concern that we are not seeing an anticipated false positive for amphetamines in the setting of methylphenidate which was reportedly

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F 609	Continued From page 4	F 609		

administered per MAR provided by nursing home, including this morning. Family would like to send confirmatory blood test; aware this is a send out test and this will take several days. At 6:56 p.m., emergency department registered nurse (EMRN)-A called and spoke with nurse for R1 at the Emeralds. Informed her of concern due to negative amphetamine results in urine drug screen although R1 was prescribed methamphetamines. Facility nurse stated she will email this information to their DON.

R1's discharge summary dated 1/10/25, identified R1's urine drug screen was negative for amphetamines, which is unexpected if you are taking methylphenidate. A confirmatory test will be sent and takes several days to come back. Please ensure that your medications are being administered as prescribed. This would likely be causing your increased episodes related to narcolepsy and cataplexy (sudden muscle weakness that occurs while a person is awake).

R1's progress note dated 1/10/25 at 10:34 p.m., identified R1 came from hospital at around 9:45 p.m., lab showed that R1's urine screen was negative for amphetamines which showed that R1 has not been taking methylphenidate. Further identified R1 was seen for the following diagnoses altered mental status, unspecified altered mental status, narcolepsy and cataplexy.

During an interview on 1/16/25 at 2:37 p.m., R1 was lying in bed and stated he was not sure if he was getting his medication for his narcolepsy and indicated he had been on that medication for years. R1 stated he normally took a white capsule. R1 stated if he doesn't take it, he would be sleeping. R1 further stated he never knows

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F 609		F 609		

Continued From page 5
when the narcolepsy would hit him, but when he does fall asleep, he had been told its very hard to wake him. R1 further indicated he has had several ED trips since being in the facility and was not sure what he was at the ED for.

During an interview on 1/21/25 at 2:45 p.m., via phone EDRN-A stated on 1/10/25 R1 was in the ED and the ED staff were very concerned that R1 had not been receiving his narcolepsy medication while at the nursing home due to R1's symptoms he was exhibiting and the negative urine drug screen that was performed. EDRN-A stated there was no way R1 could have been getting the medication because the urine test would have showed it. EDRN-A indicated she had called the facility and spoke to a nurse on 1/10/25 around 6:30 p.m., to report the ED's suspicions of drug diversion and the facility nurse told me they had no one on call and would notify their DON by email and follow up with this.

During an interview on 1/22/25 at 11:23 a.m., via phone licensed practical nurse (LPN)-A stated he was the nurse responsible for R1 on the evening of 1/10/25. LPN-A indicated when R1 came back from the hospital he read R1's hospital discharge summary that indicated R1 was potentially not receiving his narcolepsy medication and confirmed he put a progress note in R1's record indicating this. LPN-A stated he did not report this to anyone because the supervisor at the facility was aware of this already.

During a return phone call interview on 1/26/25, at 9:31 a.m., LPN-A indicated she was the nurse manager for R1 and was made aware that R1 potentially was not receiving his narcolepsy medication on 1/11/25, when she read R1's

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F 609	Continued From page 6	F 609		

1/10/25 progress note that indicated a hospital urine drug screen test did not show that R1 was receiving his narcolepsy medication. LPN-A immediately called the administrator to report it and was told to call the DON and report it. LPN-A called the DON on 1/11/25 at 2:24 p.m. and informed him R1's hospital urine drug screen was negative for amphetamines which showed R1 was not getting his medications. DON had directed LPN-A ensure the narcolepsy medication was in the lock box of the medication cart and to check PCC to ensure it was signed out after verifying it was given all days except for 1/6/25 due to not having a prescription. LPN-A stated she was not given any further instruction to investigate a drug diversion. LPN-A further indicated R1's family members had concerns R1 was not getting his narcolepsy medication due to his syncope episodes requiring ED visits, the family indicated he had been stable on this medication for quite some time with no syncope episodes. LPN-A stated with any allegations of drug diversion she would immediately report to the DON and administrator which she stated she did.

During an interview on 1/21/25 at 3:30 p.m., interim director of nursing (IDON) verified through R1's medical record that R1's urine drug screen test results from the hospital dated 1/10/25, were negative for methylphenidate and the ED notes identified potential drug diversion for R1. DON indicated he had not reported this potential drug diversion to the state.

During an interview on 1/22/25 at 9:08 a.m., the administrator stated the nurse that took the call from the hospital on 1/10/25 about R1's narcolepsy medication not being in his system on

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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) COMPLETION DATE
F 609	Continued From page 7 1/10/25 would be an allegation of potential drug diversion and should have been reported immediately to the DON or myself and was not. Administrator further stated this should have been reported to the state agency immediately and the investigation would have immediately followed and had not been done. The facility policy, "Abuse Prohibition/Vulnerable Adult Policy" reviewed 3/24, identified Policy interpretation and implementation, 1. All staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin (including suspicious bruises, skin tears, or other injuries), misappropriation of resident property, or involuntary seclusion. A completed incident report will be routed per facility procedure. 2. A Supervisor will be notified immediately and will assess the situation to determine if any emergency treatment or action is required. Immediately, upon learning of the incident, staff will take necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated...Incidents that must be reported to MDH include...g. Misappropriation of resident property ...How and when to report to the Minnesota Department of Health (MDH)/ Office of Health Facility Complaints (OHFC)...3. If the suspected Neglect, Exploitation, or Misappropriation of resident property did not result in serious bodily injury, the reports must be made within 24 hours.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse,	F 610		2/8/25

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	245067	A. BUILDING ______ B. WING ______	C 01/22/2025

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F 610	Continued From page 8 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to put a protection plan in place and thoroughly investigate an allegation of drug diversion for 1 of 1 resident (R1), reviewed for misappropriation of property. Finding s included: R1's admission Minimum Data Set (MDS) dated 1/10/25, identified R1 was cognitive and had a diagnosis of narcolepsy (a rare neurological condition that makes people very sleepy during the day and can cause them to fall asleep suddenly). R1's order summary dated 1/6/25, identified an order for methylphenidate long acting (LA) (a stimulant medication to help with narcolepsy) 20 mg capsule to be given every day in the morning for narcolepsy.	F 610	The Administrator and/or designee will ensure training and education is conducted on the proper actions to take for alleged or suspected abuse. On 1/16/25 - 1/20/25, staff education with all nursing staff was conducted on medication administration, process for counting of narcotics/controlled substances, and logging in medication upon delivery from pharmacy. In addition, all facility staff were educated and trained on vulnerable adult, abuse and timely reporting. An additional in-service training on misappropriation of property relating to vulnerable adult/abuse, drug diversion, and abuse prevention was held on Tuesday, 2/4/25. The Administrator and Director of Nursing educated staff on the definition of a vulnerable adult and ensuring staff understand all residents in	

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F 610	Continued From page 9 R1's Medication Administration Record (MAR) dated 1/6/25, identified R1 did not receive methylphenidate extended release (ER) 20 mg capsule as indicated by the number, "5" documented that indicated to see progress note. It was documented from 1/6/25 to 1/20/25, that R1 received his methylphenidate daily as indicated by nurse initials. R1's progress note dated 1/9/25 at 1:45 p.m., identified physical therapy (PT) went in R1's room to find R1 unresponsive to verbal and tactile stimuli. 911 called and R1 was taken to the hospital. All parties notified. R1's ED (emergency department) progress note dated 1/9/25, at 1:54 p.m., identified during physical therapy (PT) R1 had a syncopal episode witnessed by staff. R1 was diagnosed with syncope (a brief loss of consciousness, or fainting, that occurs when blood flow to the brain is reduced) and collapse (a sudden loss of consciousness). Discharge instructions identified to follow up with provider and return if symptoms worsen. R1's progress note dated 1/9/25 at 6:00 p.m., R1 was returned via ambulance at 6:00 p.m. and was transferred to bed. R1 came back alert and orientated x 3. No significant findings found. No new orders given. When asked if R1 remembered what caused him to go to the hospital R1 stated he didn't remember a thing. R1's progress note dated 1/10/25 at 1:54 p.m., identified R1 was sent to the ED for decreased level of responsiveness.	F 610	the facility are considered to be vulnerable adults. The Administrator and Director of Nursing educated on timely reporting with suspected/alleged abuse, types of abuse, and the proper communication to report abuse. In addition, further discussion regarding this education included completion of a thorough investigation in relation to misappropriation of property per policy. The Administrator and Director of Nursing will ensure a protection plan is in place for resident/vulnerable adult and any like residents while investigation is being completed. IDT holds stand up at 9:30am Monday through Friday - during this time, discussion is had but not limited to residents who are transferred to hospital, bed holds, along with missed medications and/or treatments. IDT holds stand down at 2:00pm Monday through Friday to discuss outstanding items and task completion with follow up from morning meeting. Administrator and Director of Nursing will ensure nurse to nurse reports have been conducted with residents transferred out to hospital in addition to review hospital progress notes. If any member of IDT find suspected diversion noted, Administrator and Director of Nursing will follow up promptly with calling hospital to talk through current findings regarding any misappropriation of property in relation to suspected drug diversion. The Administrator and/or designee, will conduct weekly audits x4, monthly audits x2 and report to QAPI committee for	

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F 610	Continued From page 10 R1's ED course summary dated 1/10/25, identified R1 presented to the ED with intermittent episodes of confusion. EMS (emergency medical services) was called because R1 had one of what sounds to be his typical narcolepsy episode. R1's MAR from his nursing facility was reviewed and it does appear that he had been receiving his methylphenidate. It is possible he needed a dose adjustment on this medication. I did also consider possible drug diversion, given family stated that R1 had been on this dose of medication for quite some time and had been stable. At 5:10 p.m., amphetamine not detected...which was somewhat unexpected for R1 who was supposed to be receiving methylphenidate, including this morning. At 5:29 p.m., discussed with pharmacist and agree, would anticipate positive test for amphetamines on UDS (urine drug screen) if R1 was being given his medications appropriately. This does raise the concern for diversion of medications. At 6:52 p.m., R1's family was notified about the urine drug screen results, as well as my concern that we are not seeing an anticipated false positive for amphetamines in the setting of methylphenidate which was reportedly administered per MAR provided by nursing home, including this morning. Family would like to send confirmatory blood test; aware this is a send out test and this will take several days. At 6:56 p.m., emergency department registered nurse (EMRN)-A called and spoke with nurse for R1 at the Emeralds. Informed her of concern due to negative amphetamine results in urine drug screen although R1 was prescribed methamphetamines. Facility nurse stated she will email this information to their DON. The facility documentation did not identify a protection plan for R1 and like residents from	F 610	further evaluation and recommendation on vulnerable adult abuse reporting policy and procedure.	

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F 610	Continued From page 11	F 610		

potential drug diversion and did not include investigation activities as to why R1's drug screen would not be positive for amphetamine as per the hospital notations.

During an interview on 1/21/25 at 2:45 p.m., via phone EDRN-A stated on 1/10/25 R1 was in the ED and the ED staff were very concerned that R1 had not been receiving his narcolepsy medication while at the nursing home due to R1's symptoms he was exhibiting and the negative urine drug screen that was performed. EDRN-A stated there was no way R1 could have been getting the medication because the urine test would have showed it. EDRN-A indicated she had called the facility and spoke to a nurse on 1/10/25 around 6:30 p.m., to report the ED's suspicions of drug diversion and the facility nurse told me they had no one on call and would notify their DON by email and follow up with this.

During an interview on 1/16/25 at 2:37 p.m., R1 was lying in bed and stated he was not sure if he was getting his medication for his narcolepsy and indicated he had been on that medication for years. R1 stated he normally took a white capsule. R1 stated if he doesn't take it, he would be sleeping. R1 further indicated he has had several ED trips since being in the facility and was not sure what he was at the ED for.

During an interview on 1/22/25 at 11:23 a.m., via phone licensed practical nurse (LPN)-A stated he was the nurse responsible for R1 on the evening of 1/10/25. LPN-A stated he did not report the potential drug diversion as indicated by the hospital discharge summary to anyone because the supervisor at the facility was aware.

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F 610	Continued From page 12 During a return phone call interview on 1/26/25, at 9:31 a.m., LPN-A indicated she was the nurse manager for R1 and was made aware that R1 potentially was not receiving his narcolepsy medication on 1/11/25, when she read R1's 1/10/25, progress note that indicated a hospital urine drug screen test did not show that R1 was receiving his narcolepsy medication. LPN-A stated she immediately called the administrator to report it and was told to call the DON and report it. LPN-A stated she called the DON on 1/11/25 at 2:24 p.m., and informed him R1's hospital urine drug screen was negative for amphetamines which showed R1 was not getting his medications. DON directed LPN-A to ensure the narcolepsy medication was in the lock box of the medication cart and to check PCC to ensure it was signed out after verifying it was given all days except for 1/6/25 due to not having a prescription. LPN-A stated she was not given any further instruction to investigate a drug diversion. During an interview on 1/21/25 at 3:30 p.m., interim director of nursing (IDON) verified through R1's medical record that R1's urine drug screen test results from the hospital dated 1/10/25, were negative for methylphenidate and the ED notes identified potential drug diversion for R1. DON indicated he had not put a protection plan in place or thoroughly investigate the potential drug diversion. During an interview on 1/22/25 at 9:08 a.m., the administrator stated the nurse that took the call from the hospital on 1/10/25 about R1's narcolepsy medication not being in his system on 1/10/25 would be an allegation of potential drug diversion and should have been reported immediately to the DON or myself and was not.	F 610		

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F 610	Continued From page 13 Administrator further stated this should have been reported to the state agency immediately and the investigation would have immediately followed and had not been done. The facility policy, "Abuse Prohibition/Vulnerable Adult Policy" reviewed 3/24, identified Policy interpretation and implementation, 1. All staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin (including suspicious bruises, skin tears, or other injuries), misappropriation of resident property, or involuntary seclusion. A completed incident report will be routed per facility procedure. 2. A Supervisor will be notified immediately and will assess the situation to determine if any emergency treatment or action is required. Immediately, upon learning of the incident, staff will take necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated...Incidents that must be reported to MDH include...g. Misappropriation of resident property...How and when to report to the Minnesota Department of Health (MDH)/ Office of Health Facility Complaints (OHFC)...3. If the suspected Neglect, Exploitation, or Misappropriation of resident property did not result in serious bodily injury, the reports must be made within 24 hours.	F 610		