Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 10, 2025

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

RE: CCN: 245067
Cycle Start Date: March 12, 2025

Dear Administrator:

On April 9, 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

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April 10, 2025

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

Re: Reinspection Results
Event ID: NXM312

Dear Administrator:

On April 9, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 12, 2025. At this time these correction orders were found corrected.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2025

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

RE: CCN: 245067
Cycle Start Date: March 12, 2025

Dear Administrator:

On March 12, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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:

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 June 12, 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 September 12, 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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Electronically delivered
March 14, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: NXM311

Dear Administrator:

The above facility was surveyed on March 11, 2025 through March 12, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

Please feel free to call me with any questions.

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

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 03/12/2025

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 3/11/25-3/12/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed. H50679406C (MN00111246) with a licensing order issued at 0875 and 0270. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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

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2 000	Continued From page 2 state form. 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.	2 000		
2 270	MN Rule 4658.0090 Use of Oxygen A nursing home must develop and implement policies and procedures for the safe storage and use of oxygen. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to obtain an order for oxygen for one of seven residents (R1) who was on continuous oxygen. Findings include: R1's face sheet indicated R1 was admitted to the facility on 2/25/25 with a primary diagnosis of acute cystitis with hematuria. R1's additional diagnoses included chronic obstructive pulmonary disease, covid-19, chronic respiratory failure, dependence on supplemental oxygen, chronic obstructive pulmonary disease with exacerbation, and obstructive sleep apnea. R1 was discharged from the facility on 3/4/25. R1's admission hospital medical records indicated R1 was admitted to the hospital from 2/17/25 to 2/25/25 due to covid-19, urinary tract infection, and encephalopathy. R1 was to resume home regimen including oxygen as needed to	2 270	Corrected	3/24/25

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2 270	Continued From page 3 keep oxygen saturation from eighty-eight percent to ninety-four percent. R1 was on two liters of oxygen via nasal cannula. R1's progress note dated 2/25/25, indicated R1 was admitted to the facility and used two liters of supplemental oxygen. R1's Brief Interview for Mental Status (BIMS) assessment dated 2/25/25, indicated R1 scored eight, which indicated R1 was moderately cognitively impaired. R1's care plan dated 2/25/25, indicated R1 had an alteration in oxygen, gas exchange, and respiratory status. Interventions included staff to monitor oxygen saturations as ordered and as needed, monitor and document on respiratory status, keep the provider informed of changes, and monitor for cyanosis, accessory muscle use, shortness of breath, increased respirations, and difficulty coughing up sputum. R1's Admission Data Collection Assessment dated 2/25/25, indicated R1 required supplemental oxygen. R1's Minimum Data Set (MDS) dated 2/27/25, indicated R1 used continuous oxygen therapy. R1's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated February and March 2025, indicated R1 did not have an order for supplemental oxygen use. During an interview on 3/12/25 at 10:56 a.m., the director of nursing (DON) stated R1 was on continuous supplemental oxygen. The oxygen orders were not in the discharge orders but were "hidden" in the history and physical from the	2 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE EMERALDS AT FARIBAULT LLC	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

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2 270	Continued From page 4 provider. DON stated those orders did not translate to R1's MAR and TAR. During an interview on 3/12/25 at 11:39 a.m., registered nurse (RN)-A stated he knew if a resident was supposed to be on supplemental oxygen by looking at the resident's MAR and TAR. The MAR and TAR would indicate how many liters of oxygen a resident was supposed to be on. RN-A stated if the resident did not have an order for supplemental oxygen, he would look at the facility's standing orders, apply supplemental oxygen if the standing order parameters allowed, and then he would contact the provider. RN-A stated R1 was on continuous supplemental oxygen. An admission orders policy was requested, and none was received. SUGGESTED METHOD OF CORRECTION: The facility could review policies and procedures related to oxygen orders. The Director of Nursing (or designee) should conduct measurable audits on residents have current orders for oxygen and bring to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	2 270		
2 875	MN Rule 4658.0520 Subp. 2 I Adequate and Proper Nursing Care; Monitor TPR Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as	2 875		3/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 03/12/2025

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2 875	Continued From page 5	2 875		

indicated by the resident's condition but at least weekly.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the facility failed to immediately assess a resident after a change in condition for one of one resident (R1). License practical nurse (LPN)-A noticed a change in condition at 8:00 a.m. on 3/4/25, started taking vital signs at 10:30 a.m., and emergency medical services (EMS) was not called until 11:33 a.m.

Corrected

Findings include:

R1's face sheet indicated R1 was admitted to the facility on 2/25/25 with a primary diagnosis of acute cystitis with hematuria. R1's additional diagnoses included chronic obstructive pulmonary disease, acute kidney failure, hallucinations, chronic respiratory failure, dependence on supplemental oxygen, and chronic obstructive pulmonary disease with exacerbation. R1 was discharged from the facility on 3/4/25.

R1's admission hospital medical records indicated R1 was admitted to the hospital from 2/17/25 to 2/25/25 due to covid-19, urinary tract infection, and encephalopathy. It was noted during her admission that her skin was warm and dry. No skin concerns were noted.

R1's Initial Data Collection assessment dated 2/25/25, indicated R1's skin was dry and pale but was not cyanotic, oily, mottled, jaundiced, or clear. There were eleven bruises, and their locations noted, and one area of redness noted. No other skin concerns were noted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE EMERALDS AT FARIBAULT LLC	**500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021**

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2 875	Continued From page 6	2 875		

R1's Brief Interview for Mental Status (BIMS) assessment dated 2/25/25, indicated R1 scored eight, which indicated R1 was moderately cognitively impaired.

R1's care plan dated 2/25/25, indicated R1 had alterations in skin integrity. Staff was to monitor skin integrity daily during cares, monitor for skin breakdown for signs/symptoms of infection and to report to the provider, and document on skin condition and keep the provider informed of changes.

R1's Provider Orders for Life-Sustaining Treatment (POLST) dated 2/25/25, indicated R1 requested resuscitation to be attempted. R1 requested full medical treatment if necessary. The POLST was signed by R1, but not by the provider.

R1's Minimum Data Set (MDS) dated 2/27/25, indicated R1 had one or more unhealed pressure ulcers, but no other skin concerns noted.

R1's Skin Evaluation and Skin Risk Factors assessment dated 2/27/25, did not indicate R1 had a gray tint to her skin.

R1's progress note dated 3/4/25 at 11:18 a.m., indicated R1's vital signs were unstable, a change of condition was noted, and R1 was not responding to stimuli. R1's pulse was ranging from the fifties to one hundred and twenty beats per minute, blood pressure was seventy-three over forty-nine, reparations were twenty-six breaths per minute, and her oxygen was at eighty-two percent on two liters of oxygen. The nursing staff raised R1's oxygen to four liters of oxygen via nasal cannula. R1 was breathing

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2 875	Continued From page 7	2 875		

heavily and was not responding to verbal commands or sternal rubs. It was recommended that R1 be sent to the emergency department for further evaluation. FM-B was present in the facility at the time.

R1's progress note dated 3/4/25 at 12:00 p.m., indicated the writer was notified that R1's blood pressure was seventy-three over forty-nine, pulse was ranging from fifty-five, one hundred-eight, one hundred thirty-eight, and forty-nine. R1's respirations were twenty-six breaths per minute with shallow breathing, temperature was ninety-seven point four, and her oxygen was eighty-two percent on two liters of oxygen but increased to eighty-nine percent on four liters of oxygen. R1 was hard to arouse. The nursing staff performed a sternal rub and R1 was heard moaning in a low voice and was able to respond with eyebrow movement when asked how she was doing. The writer of the progress note called FM-B, updated him on the status of R1, and recommended R1 be sent to the emergency department. FM-B reported that he was on his way to the facility to discharge R1 home with hospice services, not to send R1 to the emergency department, and FM-B would have R1 evaluated once she was discharged. The writer called FM-B again to update R1's POLST to do not resuscitate (DNR) if he was not approving to send R1 to the emergency department, but FM-B was already at the facility and wanted to keep R1 a full code. FM-B later approved to send R1 to the emergency department.

R1's progress note dated 3/4/25 at 12:40 p.m., indicated at about 12:21 p.m. the writer gave a report to a nurse in the emergency department. R1 had a bed bath between 7:00 a.m. and 8:00

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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
2 875	Continued From page 8 a.m. that morning. R1 was noted to be sleepy and snoring, but that she typically sleeps in the morning. FM-B informed staff not to send R1 to the hospital or activate EMS as R1 was going to be discharged on hospice that day. FM-B indicated he was on his way to the facility, arrived four minutes later, refused to change R1's code status, and then approved of R1 going to the emergency department. The assigned RN indicated R1 was at her baseline prior to the change in condition, prompting an assessment, follow up call to the provider, family, the interdisciplinary team (IDT), and EMS. R1's progress note dated 3/4/25 at 1:06 p.m., indicated R1 was responsive the entire time before R1 was taken via EMS by sternal rub and speaking with R1. R1 would respond by moaning and raising eyebrows when writer would ask questions. Writer went into R1's room and RN-A was getting R1's vital signs. R1's temperature was ninety-seven point three and oxygen was eighty-two precent on two liters of oxygen. Nursing staff increased R1's oxygen to three liters of oxygen via nasal cannula and oxygen saturation remained under ninety percent, so nursing staff increased oxygen to four liters of oxygen via nasal cannula and oxygen saturations raised to ninety percent. R1's pulse ranged from the forties to one hundred-thirty beats per minute. R1's pulse would increase quickly at eighty beats per minute, to one hundred-twenty beats per minute, and then sixty beats per minute. The nursing staff took blood pressures and pulse from the beginning to when R1 left with EMS. The following vitals signs were in order from the beginning: blood pressure sixty-eight over thirty-nine with pulse seventy three beats her minute, blood pressure sixty-four over thirty-five with pulse eighty beats per minute, blood	2 875		

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	00571	A. BUILDING: ______ B. WING ______	C 03/12/2025

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2 875	Continued From page 9	2 875		

pressure seventy-three over forty-nine with pulse fifty beats per minute, blood pressure seventy-eight over forty-two with pulse seventy-five beats per minute, blood pressure seventy-one over forty-one with pulse fifty-two beats per minute, blood pressure fifty-one over thirty-one with pulse eighty-two beats per minute, blood pressure fifty-six over twenty-nine with pulse seventy-eight beats per minute, and blood pressure sixty over thirty-seven with pulse seventy-nine beats per minute. R1 was transferred to the hospital via EMS.

R1's vital sign documentation indicated blood pressures ranging from one hundred-twelve over sixty-one to one hundred eighty-nine over seventy-seven. R1's oxygen ranged from eighty-nine percent on oxygen via nasal cannula to ninety-six percent via nasal cannula. R1's pulse ranged from sixty-nine beats per minute to one hundred nine beats per minute. R1's respirations ranged from fourteen breaths per minute to twenty breaths per minute. R1's temperatures range from ninety-six point three to ninety-eight point zero.

R1's EMS report indicated the facility called EMS on 3/4/25 at 11:33 p.m., and arrived at the facility on 11:38 a.m. where R1 had shallow respirations. Staff stated R1 had been unresponsive for about four hours before calling EMS. Staff also stated R1 was transitioning back home that same day and was going on hospice, but family had been in the room requesting R1 to be a full code. R1 had been laying down and was on four liters of oxygen when she is normally only on two liters of oxygen. The report stated R1 was given a sternal rub which R1 responded with a moan, but did not open her eyes or talk. No skin abnormalities noted.

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2 875	Continued From page 10 R1's hospital medical records dated 3/4/24, indicated R1 presented to the emergency department by EMS for evaluation of decreased level of consciousness. R1 had been unresponsive for four hours. R1 would occasionally groan but was not speaking. R1 presented with agonal respirations, lethargic, minimally responsive, but no skin concerns. R1's blood pressure at the facility was seventy over twelve but increased to one hundred-thirty over sixty on the way to the hospital. Medical records indicated R1 was going on hospice to get better in-home services so R1 could leave the facility. During this admission, R1 was intubated, and was transferred to another hospital via EMS. R1's medical records dated 3/4/25, indicated R1 presented to the intensive care unit (ICU) with shock. R1 was too critically ill to participate in any cares. During her admission, R1 had acute encephalopathy, septic shock due to UTI, severe acute kidney injury due to acute tubular necrosis in setting of septic shock, and acute on chronic hypoxemic and hypercapnic respiratory failure. R1 was still in the hospital as of 3/11/25. During an interview on 3/11/25 at 2:20 p.m., family member (FM)-A stated R1 was still in the transitional care unit (TCU) at the hospital. Hospital staff removed R1's intubation tube on 3/9/25. An interview was attempted with FM-B on 3/11/25 at 2:38 p.m. and 3:14 p.m. but was not successful. During an interview on 3/11/25 at 3:21 p.m., LPN-A stated she has been working at the facility for about four weeks. LPN-A stated when R1 was	2 875		

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2 875	Continued From page 11 first admitted to the facility on 2/25/25, LPN-A had completed her admission assessment. LPN-A noted no skin concerns or discoloration at that time. On 3/3/25, LPN-A had seen R1 while working with R1's roommate and R1 was sleeping and did not have any skin discoloration or concerns at that time. On 3/4/25 around 7:00 a.m. or 8:00 a.m., FM-A was visiting and LPN-A stated R1 is usually awake during the night, and sleeps most of the day. FM-A stated R1 was to be discharged on hospice that same day. LPN-A stated she noticed R1's facial coloring was not at her baseline. LPN-A stated that she had mentioned R1's gray tint to FM-A but FM-A stated R1 had looked "like that before". LPN-A stated she considered that to be a change of condition. LPN-A stated she was not concerned about R1 because FM-A stated R1 had "looked like this before". LPN-A stated R1 would respond to her by raising her eyebrows or by moaning, but R1 did not open her eyes or talk. R1's baseline was talking and opening her eyes. LPN-A told FM-A that she would be talking to the interdisciplinary team (IDT) in their morning meeting about R1's condition. LPN-A stated the IDT meeting ended "around 10:30 a.m." and had asked the NA's to get a set of vital signs from R1 but could not recall the name of the NA. RN-A was in R1's room while the NA was attempting to get R1's vital signs. RN-A had left R1's room and it was only LPN-A and one of the NA's in R1's room at the time. LPN-A stated she would perform sternal rubs on R1 and R1 would respond by raising her eyebrows and moaning quietly. When R1's blood pressure was low, R1 would not respond at all but still had a pulse. RN-A told LPN-A that registered nurse (RN)-C had talked to FM-B and FM-B did not want R1 sent to the emergency department right away and that he would be at the facility in a "couple of minutes". Once FM-B got to the facility,	2 875		

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2 875	Continued From page 12	2 875		

the facility staff were able to call EMS. When EMS got to the facility, LPN-A gave report stating R1 was responsive by raising her eyebrows and moaning quietly. LPN-A stated she told EMS that R1 had a gray tint to her face for "about four hours". LPN-A stated she also told another EMS staff that R1 had been in this condition for four hours. LPN-A stated any resident who had a gray tint to their face or body would be concerning.

During an interview on 3/11/25 at 3:53 p.m., FM-A stated she did not tell licensed practical nurse (LPN)-A that R1 facial color had been gray or that a gray facial color was R1's baseline.

During an interview on 3/11/25 at 4:24 p.m., RN-A stated on the morning of 3/4/25, he saw the nursing assistants (NA's) give R1 a bed bath and she was very sleepy. RN-A stated her baseline was being very tired due to being awake at night and sleeping during the day. RN-A could not recall what time he saw the NA's give R1 her bed bath. R1 would make a moaning sound during her bed bath. R1's blood pressure was low. R1 was "not really responding at all". RN-A state he kept getting R1's vital signs and got the crash cart ready in case R1 did not have a pulse. RN-A stated RN-C called FM-B, updated him on R1's condition, and had recommended she be sent to the emergency department for further evaluation. FM-B said he was only "minutes" away from the facility and to wait to call EMS. When FM-B got to the facility, he wanted EMS called right away. When EMS got to the facility, R1 was not responsive, but had a pulse and blood pressure.

During an interview on 3/12/25 at 8:11 a.m., RN-C stated herself and LPN-A admitted R1 into the facility. RN-C stated she could not recall R1's facial color when she admitted. On 3/4/25, R1

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2 875	Continued From page 13 was going to be discharging home on hospice services. Around 11:00 a.m., RN-C was called into R1's room by RN-A and LPN-A and said R1's vitals were not "ok". RN-C noticed that R1 was sleeping. RN-C noted her oxygen saturation to be low, so the RN-C increased R1's oxygen via nasal cannula. RN-C did not look or assess R1's facial coloring. RN-C called FM-B and gave an update on R1's condition and had recommended R1 be sent out to the emergency department for further evaluation. FM-B said that he was on his way to the facility and not to call EMS until he got to the facility. RN-C walked back into R1's room and FM-B had arrived and said that R1 needed to be sent to the emergency department right away. EMS was called and EMS suggested to get the crash cart if needed. RN-C asked FM-B wanted to change R1's POLST code to DNR instead of her full code. FM-B did not want to change R1's code status. EMS arrived and transferred R1 to the emergency department. RN-C gave a nurse-to-nurse report to the hospital nurse and the hospital nurse stated R1 had been unconscious for four hours in which RN-C said that was not true because when staff at the facility did a sternal rub, R1 would moan and raise her eyebrows. RN-C stated she would expect when a licensed nursing staff noticed a change in condition, they would immediately call and update the provider. If they get ahold of the provider, they would give their recommendations and follow the providers orders. If they did not get ahold of the provider, there are instances where they could send the resident to the hospital without a provider's orders. RN-C stated it would not be appropriate to wait two hours or more to assess a residents change in condition. RN-C stated if she saw a resident have a gray facial color that was not at the resident's baseline, she would call EMS right away. RN-C stated if the license nurses	2 875		

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waited over two hours to assess a resident's change in condition, the facility failed.

During an interview on 3/12/25 at 8:29 a.m., the director of nursing (DON) stated on 3/4/25 RN-A told the DON that R1 had a bed bath in the morning but could not recall the time that took place. DON stated RN-A went to give R1 her medications and check her vitals "around 11:00 a.m." DON stated RN-A called him because he was not in the facility at the time. RN-C called FM-B and FM-B stated he did not want the facility to send R1 to the hospital for further evaluation until he got to the facility in a couple of minutes. When FM-B got to the facility, he said that he wanted the facility to call EMS and send her to the hospital. DON stated he got to the facility before R1 left the facility. DON stated R1 did not look "like herself" and there was "definitely" a change in condition. DON stated the EMS as well as the nurses were all in R1's room so he did not get to see R1's facial color. DON stated he would expect when a licensed nurse saw a change in condition in a resident, the nurse would notify the provider and family right away. If the resident did have a change in condition, the assessments should be done immediately. When a resident had a gray facial color that was outside her baseline, the licensed staff should have assessed right away, and it would not be appropriate to wait three to four hours to assess.

During an interview on 3/12/25 at 9:10 a.m., the administrator stated at the IDT meeting on 3/4/25 the IDT had talked about R1 being discharged that day, but nothing about the condition she was in. The administrator stated if a licensed nurse noticed a resident had a change in condition, she would expect the nurse to notify the provider, update vitals, and contact the resident's

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representative. The administrator stated she spoke with LPN-A after the incident and asked what she had meant by saying R1 had been unresponsive for four hours prior to EMS being called, LPN-A stated she meant to say that she was sleeping, not unresponsive. The administrator stated she did immediate education with LPN-A.

During an interview on 3/12/25 at 9:39 a.m., medical director (MD)-A stated when she saw R1, she was minimally responsive to pain. R1 was not talking but her vitals were stable. MD-A stated the family was going to put R1 on hospice to get R1 more resources and help but not transition to end of life care by discontinuing treatments. MD-A stated when she did labs on R1, R1's creatinine was nine. MD-A stated R1's creatinine indicated how well the kidneys were functioning. MD-A stated R1 was put on a ventilator because R1 was not responsive. MD-A was unsure if R1's outcome would have changed if she would have gone to the hospital four hours prior.

During an interview on 3/12/25 at 10:56 a.m., DON stated the facility did education with LPN-A on 3/4/25 after the incident. DON stated the facility also did education with all the licensed nurses working at the time about assessing a resident after a change in condition.

During an email correspondence on 3/12/25 at 11:26 a.m., the administrator stated when a license staff notices a change in condition for a resident, a head-to-toe assessment should be completed along with notifying the provider of changes.

LPN-A's personnel file included a signed LPN Care Coordinator description indicating LPN-A

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would be responsible for monitoring residents for changes in their condition and to report those changes to the RN. LPN-A was hired at the facility on 1/29/25. Included in the personnel file was an "educational moment" dated 3/12/25 that stated on 3/4/25 LPN-A had told the paramedic that R1's color changed four hours prior to EMS arrival. The document stated this would be considered a change in condition that would have required an immediate intervention and notification to the provider for the change in R1's medical status. It would be required to immediately communicate any change of resident condition to the appropriate parties in real-time. LPN-A did not have any additional corrective actions during her employment.

The facility's Notification of Changes policy dated 3/2024, indicated nurses and other care staff were educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's provider, to ensure best outcomes of care for the resident.

Suggested Method of Correction: The Directior of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents with a change receive appropriate care and assessments for a change in condition. The director of nursing or designee, could conduct education and training on appropriate care and assessments for a change in resident condition.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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F 000	INITIAL COMMENTS On 3/11/25-3/12/25, 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 complaints were reviewed. H50679406C (MN00111246) with a deficiency issued at F684 and F695 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 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		3/24/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 03/23/2025

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

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Based on interview and record review, the facility failed to immediately assess a resident after a change in condition for one of one resident (R1). License practical nurse (LPN)-A noticed a change in condition at 8:00 a.m. on 3/4/25, started taking vital signs at 10:30 a.m., and emergency medical services (EMS) was not called until 11:33 a.m.

Findings include:

R1's face sheet indicated R1 was admitted to the facility on 2/25/25 with a primary diagnosis of acute cystitis with hematuria. R1's additional diagnoses included chronic obstructive pulmonary disease, acute kidney failure, hallucinations, chronic respiratory failure, dependence on supplemental oxygen, and chronic obstructive pulmonary disease with exacerbation. R1 was discharged from the facility on 3/4/25.

R1's admission hospital medical records indicated R1 was admitted to the hospital from 2/17/25 to 2/25/25 due to covid-19, urinary tract infection, and encephalopathy. It was noted during her admission that her skin was warm and dry. No skin concerns were noted.

R1's Initial Data Collection assessment dated 2/25/25, indicated R1's skin was dry and pale but was not cyanotic, oily, mottled, jaundiced, or clear. There were eleven bruises, and their locations noted, and one area of redness noted. No other skin concerns were noted.

R1's Brief Interview for Mental Status (BIMS) assessment dated 2/25/25, indicated R1 scored eight, which indicated R1 was moderately cognitively impaired.

F 684

On 3/4/25, DON conducted on-spot education to facility staff regarding the difference between sleeping and unresponsive. Education provided also consisted of change in condition and facility policy/process.
R1 does have medical history of the following diagnoses, but not limited to, acute cystitis with hematuria, generalized weakness, sundowner’s, hallucinations (visual and auditory), OSA, hypertension, chronic respiratory failure, chronic obstructive pulmonary disease, BMI 60.0-69.9, morbid obesity, recent positive test of COVID-19, and other signs and symptoms involving cognitive functions and awareness.
On 3/4/25, DON and Administrator reviewed policy/procedures/protocols for timely physician notification of change in condition. DON further educated nurses on completing a full assessment for potential change in condition and notification to provider/resident representative.
DON and Administrator have current facility process in place for the following:
Administrator or designee will send out 24 hour report each morning for all management to review before stand up.
Change of condition is discussed daily at stand up with IDT along with at stand down/afternoon touch base.
DON and Administrator will conduct weekly audits x4, monthly audits x2 and report to QAPI committee for further evaluation and recommendation on quality of care in relation to change in condition and timely notification to physician,

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F 684	Continued From page 2	F 684	resident representative, DON and Administrator.	

R1's care plan dated 2/25/25, indicated R1 had alterations in skin integrity. Staff was to monitor skin integrity daily during cares, monitor for skin breakdown for signs/symptoms of infection and to report to the provider, and document on skin condition and keep the provider informed of changes.

R1's Provider Orders for Life-Sustaining Treatment (POLST) dated 2/25/25, indicated R1 requested resuscitation to be attempted. R1 requested full medical treatment if necessary. The POLST was signed by R1, but not by the provider.

R1's Minimum Data Set (MDS) dated 2/27/25, indicated R1 had one or more unhealed pressure ulcers, but no other skin concerns noted.

R1's Skin Evaluation and Skin Risk Factors assessment dated 2/27/25, did not indicate R1 had a gray tint to her skin.

R1's progress note dated 3/4/25 at 11:18 a.m., indicated R1's vital signs were unstable, a change of condition was noted, and R1 was not responding to stimuli. R1's pulse was ranging from the fifties to one hundred and twenty beats per minute, blood pressure was seventy-three over forty-nine, reparations were twenty-six breaths per minute, and her oxygen was at eighty-two percent on two liters of oxygen. The nursing staff raised R1's oxygen to four liters of oxygen via nasal cannula. R1 was breathing heavily and was not responding to verbal commands or sternal rubs. It was recommended that R1 be sent to the emergency department for further evaluation. FM-B was present in the

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F 684	Continued From page 3 facility at the time. R1's progress note dated 3/4/25 at 12:00 p.m., indicated the writer was notified that R1's blood pressure was seventy-three over forty-nine, pulse was ranging from fifty-five, one hundred-eight, one hundred thirty-eight, and forty-nine. R1's respirations were twenty-six breaths per minute with shallow breathing, temperature was ninety-seven point four, and her oxygen was eighty-two percent on two liters of oxygen but increased to eighty-nine percent on four liters of oxygen. R1 was hard to arouse. The nursing staff performed a sternal rub and R1 was heard moaning in a low voice and was able to respond with eyebrow movement when asked how she was doing. The writer of the progress note called FM-B, updated him on the status of R1, and recommended R1 be sent to the emergency department. FM-B reported that he was on his way to the facility to discharge R1 home with hospice services, not to send R1 to the emergency department, and FM-B would have R1 evaluated once she was discharged. The writer called FM-B again to update R1's POLST to do not resuscitate (DNR) if he was not approving to send R1 to the emergency department, but FM-B was already at the facility and wanted to keep R1 a full code. FM-B later approved to send R1 to the emergency department. R1's progress note dated 3/4/25 at 12:40 p.m., indicated at about 12:21 p.m. the writer gave a report to a nurse in the emergency department. R1 had a bed bath between 7:00 a.m. and 8:00 a.m. that morning. R1 was noted to be sleepy and snoring, but that she typically sleeps in the morning. FM-B informed staff not to send R1 to	F 684		

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the hospital or activate EMS as R1 was going to be discharged on hospice that day. FM-B indicated he was on his way to the facility, arrived four minutes later, refused to change R1's code status, and then approved of R1 going to the emergency department. The assigned RN indicated R1 was at her baseline prior to the change in condition, prompting an assessment, follow up call to the provider, family, the interdisciplinary team (IDT), and EMS.

R1's progress note dated 3/4/25 at 1:06 p.m., indicated R1 was responsive the entire time before R1 was taken via EMS by sternal rub and speaking with R1. R1 would respond by moaning and raising eyebrows when writer would ask questions. Writer went into R1's room and RN-A was getting R1's vital signs. R1's temperature was ninety-seven point three and oxygen was eighty-two precent on two liters of oxygen. Nursing staff increased R1's oxygen to three liters of oxygen via nasal cannula and oxygen saturation remained under ninety percent, so nursing staff increased oxygen to four liters of oxygen via nasal cannula and oxygen saturations raised to ninety percent. R1's pulse ranged from the forties to one hundred-thirty beats per minute. R1's pulse would increase quickly at eighty beats per minute, to one hundred-twenty beats per minute, and then sixty beats per minute. The nursing staff took blood pressures and pulse from the beginning to when R1 left with EMS. The following vitals signs were in order from the beginning: blood pressure sixty-eight over thirty-nine with pulse seventy three beats her minute, blood pressure sixty-four over thirty-five with pulse eighty beats per minute, blood pressure seventy-three over forty-nine with pulse fifty beats per minute, blood pressure

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seventy-eight over forty-two with pulse seventy-five beats per minute, blood pressure seventy-one over forty-one with pulse fifty-two beats per minute, blood pressure fifty-one over thirty-one with pulse eighty-two beats per minute, blood pressure fifty-six over twenty-nine with pulse seventy-eight beats per minute, and blood pressure sixty over thirty-seven with pulse seventy-nine beats per minute. R1 was transferred to the hospital via EMS.

R1's vital sign documentation indicated blood pressures ranging from one hundred-twelve over sixty-one to one hundred eighty-nine over seventy-seven. R1's oxygen ranged from eighty-nine percent on oxygen via nasal cannula to ninety-six percent via nasal cannula. R1's pulse ranged from sixty-nine beats per minute to one hundred nine beats per minute. R1's respirations ranged from fourteen breaths per minute to twenty breaths per minute. R1's temperatures range from ninety-six point three to ninety-eight point zero.

R1's EMS report indicated the facility called EMS on 3/4/25 at 11:33 p.m., and arrived at the facility on 11:38 a.m. where R1 had shallow respirations. Staff stated R1 had been unresponsive for about four hours before calling EMS. Staff also stated R1 was transitioning back home that same day and was going on hospice, but family had been in the room requesting R1 to be a full code. R1 had been laying down and was on four liters of oxygen when she is normally only on two liters of oxygen. The report stated R1 was given a sternal rub which R1 responded with a moan, but did not open her eyes or talk. No skin abnormalities noted.

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R1's hospital medical records dated 3/4/24, indicated R1 presented to the emergency department by EMS for evaluation of decreased level of consciousness. R1 had been unresponsive for four hours. R1 would occasionally groan but was not speaking. R1 presented with agonal respirations, lethargic, minimally responsive, but no skin concerns. R1's blood pressure at the facility was seventy over twelve but increased to one hundred-thirty over sixty on the way to the hospital. Medical records indicated R1 was going on hospice to get better in-home services so R1 could leave the facility. During this admission, R1 was intubated, and was transferred to another hospital via EMS.

R1's medical records dated 3/4/25, indicated R1 presented to the intensive care unit (ICU) with shock. R1 was too critically ill to participate in any cares. During her admission, R1 had acute encephalopathy, septic shock due to UTI, severe acute kidney injury due to acute tubular necrosis in setting of septic shock, and acute on chronic hypoxemic and hypercapnic respiratory failure. R1 was still in the hospital as of 3/11/25.

During an interview on 3/11/25 at 2:20 p.m., family member (FM)-A stated R1 was still in the transitional care unit (TCU) at the hospital. Hospital staff removed R1's intubation tube on 3/9/25.

An interview was attempted with FM-B on 3/11/25 at 2:38 p.m. and 3:14 p.m. but was not successful.

During an interview on 3/11/25 at 3:21 p.m., LPN-A stated she has been working at the facility for about four weeks. LPN-A stated when R1 was

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F 684	Continued From page 7 first admitted to the facility on 2/25/25, LPN-A had completed her admission assessment. LPN-A noted no skin concerns or discoloration at that time. On 3/3/25, LPN-A had seen R1 while working with R1's roommate and R1 was sleeping and did not have any skin discoloration or concerns at that time. On 3/4/25 around 7:00 a.m. or 8:00 a.m., FM-A was visiting and LPN-A stated R1 is usually awake during the night, and sleeps most of the day. FM-A stated R1 was to be discharged on hospice that same day. LPN-A stated she noticed R1's facial coloring was not at her baseline. LPN-A stated that she had mentioned R1's gray tint to FM-A but FM-A stated R1 had looked "like that before". LPN-A stated she considered that to be a change of condition. LPN-A stated she was not concerned about R1 because FM-A stated R1 had "looked like this before". LPN-A stated R1 would respond to her by raising her eyebrows or by moaning, but R1 did not open her eyes or talk. R1's baseline was talking and opening her eyes. LPN-A told FM-A that she would be talking to the interdisciplinary team (IDT) in their morning meeting about R1's condition. LPN-A stated the IDT meeting ended "around 10:30 a.m." and had asked the NA's to get a set of vital signs from R1 but could not recall the name of the NA. RN-A was in R1's room while the NA was attempting to get R1's vital signs. RN-A had left R1's room and it was only LPN-A and one of the NA's in R1's room at the time. LPN-A stated she would perform sternal rubs on R1 and R1 would respond by raising her eyebrows and moaning quietly. When R1's blood pressure was low, R1 would not respond at all but still had a pulse. RN-A told LPN-A that registered nurse (RN)-C had talked to FM-B and FM-B did not want R1 sent to the emergency department right away and that he would be at the facility in a	F 684		

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"couple of minutes". Once FM-B got to the facility, the facility staff were able to call EMS. When EMS got to the facility, LPN-A gave report stating R1 was responsive by raising her eyebrows and moaning quietly. LPN-A stated she told EMS that R1 had a gray tint to her face for "about four hours". LPN-A stated she also told another EMS staff that R1 had been in this condition for four hours. LPN-A stated any resident who had a gray tint to their face or body would be concerning.

During an interview on 3/11/25 at 3:53 p.m., FM-A stated she did not tell licensed practical nurse (LPN)-A that R1 facial color had been gray or that a gray facial color was R1's baseline.

During an interview on 3/11/25 at 4:24 p.m., RN-A stated on the morning of 3/4/25, he saw the nursing assistants (NA's) give R1 a bed bath and she was very sleepy. RN-A stated her baseline was being very tired due to being awake at night and sleeping during the day. RN-A could not recall what time he saw the NA's give R1 her bed bath. R1 would make a moaning sound during her bed bath. R1's blood pressure was low. R1 was "not really responding at all". RN-A state he kept getting R1's vital signs and got the crash cart ready in case R1 did not have a pulse. RN-A stated RN-C called FM-B, updated him on R1's condition, and had recommended she be sent to the emergency department for further evaluation. FM-B said he was only "minutes" away from the facility and to wait to call EMS. When FM-B got to the facility, he wanted EMS called right away. When EMS got to the facility, R1 was not responsive, but had a pulse and blood pressure.

During an interview on 3/12/25 at 8:11 a.m., RN-C stated herself and LPN-A admitted R1 into the

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F 684	Continued From page 9 facility. RN-C stated she could not recall R1's facial color when she admitted. On 3/4/25, R1 was going to be discharging home on hospice services. Around 11:00 a.m., RN-C was called into R1's room by RN-A and LPN-A and said R1's vitals were not "ok". RN-C noticed that R1 was sleeping. RN-C noted her oxygen saturation to be low, so the RN-C increased R1's oxygen via nasal cannula. RN-C did not look or assess R1's facial coloring. RN-C called FM-B and gave an update on R1's condition and had recommended R1 be sent out to the emergency department for further evaluation. FM-B said that he was on his way to the facility and not to call EMS until he got to the facility. RN-C walked back into R1's room and FM-B had arrived and said that R1 needed to be sent to the emergency department right away. EMS was called and EMS suggested to get the crash cart if needed. RN-C asked FM-B wanted to change R1's POLST code to DNR instead of her full code. FM-B did not want to change R1's code status. EMS arrived and transferred R1 to the emergency department. RN-C gave a nurse-to-nurse report to the hospital nurse and the hospital nurse stated R1 had been unconscious for four hours in which RN-C said that was not true because when staff at the facility did a sternal rub, R1 would moan and raise her eyebrows. RN-C stated she would expect when a licensed nursing staff noticed a change in condition, they would immediately call and update the provider. If they get ahold of the provider, they would give their recommendations and follow the providers orders. If they did not get ahold of the provider, there are instances where they could send the resident to the hospital without a provider's orders. RN-C stated it would not be appropriate to wait two hours or more to assess a residents change in condition. RN-C stated if she	F 684		

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saw a resident have a gray facial color that was not at the resident's baseline, she would call EMS right away. RN-C stated if the license nurses waited over two hours to assess a resident's change in condition, the facility failed.

During an interview on 3/12/25 at 8:29 a.m., the director of nursing (DON) stated on 3/4/25 RN-A told the DON that R1 had a bed bath in the morning but could not recall the time that took place. DON stated RN-A went to give R1 her medications and check her vitals "around 11:00 a.m." DON stated RN-A called him because he was not in the facility at the time. RN-C called FM-B and FM-B stated he did not want the facility to send R1 to the hospital for further evaluation until he got to the facility in a couple of minutes. When FM-B got to the facility, he said that he wanted the facility to call EMS and send her to the hospital. DON stated he got to the facility before R1 left the facility. DON stated R1 did not look "like herself" and there was "definitely" a change in condition. DON stated the EMS as well as the nurses were all in R1's room so he did not get to see R1's facial color. DON stated he would expect when a licensed nurse saw a change in condition in a resident, the nurse would notify the provider and family right away. If the resident did have a change in condition, the assessments should be done immediately. When a resident had a gray facial color that was outside her baseline, the licensed staff should have assessed right away, and it would not be appropriate to wait three to four hours to assess.

During an interview on 3/12/25 at 9:10 a.m., the administrator stated at the IDT meeting on 3/4/25 the IDT had talked about R1 being discharged that day, but nothing about the condition she was

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F 684	Continued From page 11 in. The administrator stated if a licensed nurse noticed a resident had a change in condition, she would expect the nurse to notify the provider, update vitals, and contact the resident's representative. The administrator stated she spoke with LPN-A after the incident and asked what she had meant by saying R1 had been unresponsive for four hours prior to EMS being called, LPN-A stated she meant to say that she was sleeping, not unresponsive. The administrator stated she did immediate education with LPN-A. During an interview on 3/12/25 at 9:39 a.m., medical director (MD)-A stated when she saw R1, she was minimally responsive to pain. R1 was not talking but her vitals were stable. MD-A stated the family was going to put R1 on hospice to get R1 more resources and help but not transition to end of life care by discontinuing treatments. MD-A stated when she did labs on R1, R1's creatinine was nine. MD-A stated R1's creatinine indicated how well the kidneys were functioning. MD-A stated R1 was put on a ventilator because R1 was not responsive. MD-A was unsure if R1's outcome would have changed if she would have gone to the hospital four hours prior. During an interview on 3/12/25 at 10:56 a.m., DON stated the facility did education with LPN-A on 3/4/25 after the incident. DON stated the facility also did education with all the licensed nurses working at the time about assessing a resident after a change in condition. During an email correspondence on 3/12/25 at 11:26 a.m., the administrator stated when a license staff notices a change in condition for a resident, a head-to-toe assessment should be	F 684		

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F 684	Continued From page 12 completed along with notifying the provider of changes. LPN-A's personnel file included a signed LPN Care Coordinator description indicating LPN-A would be responsible for monitoring residents for changes in their condition and to report those changes to the RN. LPN-A was hired at the facility on 1/29/25. Included in the personnel file was an "educational moment" dated 3/12/25 that stated on 3/4/25 LPN-A had told the paramedic that R1's color changed four hours prior to EMS arrival. The document stated this would be considered a change in condition that would have required an immediate intervention and notification to the provider for the change in R1's medical status. It would be required to immediately communicate any change of resident condition to the appropriate parties in real-time. LPN-A did not have any additional corrective actions during her employment. The facility's Notification of Changes policy dated 3/2024, indicated nurses and other care staff were educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's provider, to ensure best outcomes of care for the resident.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		3/24/25

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practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to obtain an order for oxygen for one of seven residents (R1) who was on continuous oxygen.

Findings include:

R1's face sheet indicated R1 was admitted to the facility on 2/25/25 with a primary diagnosis of acute cystitis with hematuria. R1's additional diagnoses included chronic obstructive pulmonary disease, covid-19, chronic respiratory failure, dependence on supplemental oxygen, chronic obstructive pulmonary disease with exacerbation, and obstructive sleep apnea. R1 was discharged from the facility on 3/4/25.

R1's admission hospital medical records indicated R1 was admitted to the hospital from 2/17/25 to 2/25/25 due to covid-19, urinary tract infection, and encephalopathy. R1 was to resume home regimen including oxygen as needed to keep oxygen saturation from eighty-eight percent to ninety-four percent. R1 was on two liters of oxygen via nasal cannula.

R1's progress note dated 2/25/25, indicated R1 was admitted to the facility and used two liters of supplemental oxygen.

R1's Brief Interview for Mental Status (BIMS) assessment dated 2/25/25, indicated R1 scored eight, which indicated R1 was moderately cognitively impaired.

Provider's Plan of Correction (F 695):

DON conducted education with nursing staff regarding O2 orders in relation to standing orders. DON and Administrator will review all-like residents with COPD an ensure they have assessment in place for O2 utilization if needed.
DON and Administrator will ensure new residents admitting to facility who do not have oxygen orders upon admission from discharging provider, to call and clarify if residents have history of oxygen utilization or needing oxygen orders.
DON and Administrator will conduct weekly audits x4, monthly audits x2 and report to QAPI committee for further evaluation and recommendation on residents with continuous oxygen and history of COPD.

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R1's care plan dated 2/25/25, indicated R1 had an alteration in oxygen, gas exchange, and respiratory status. Interventions included staff to monitor oxygen saturations as ordered and as needed, monitor and document on respiratory status, keep the provider informed of changes, and monitor for cyanosis, accessory muscle use, shortness of breath, increased respirations, and difficulty coughing up sputum.

R1's Admission Data Collection Assessment dated 2/25/25, indicated R1 required supplemental oxygen.

R1's Minimum Data Set (MDS) dated 2/27/25, indicated R1 used continuous oxygen therapy.

R1's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated February and March 2025, indicated R1 did not have an order for supplemental oxygen use.

During an interview on 3/12/25 at 10:56 a.m., the director of nursing (DON) stated R1 was on continuous supplemental oxygen. The oxygen orders were not in the discharge orders but were "hidden" in the history and physical from the provider. DON stated those orders did not translate to R1's MAR and TAR.

During an interview on 3/12/25 at 11:39 a.m., registered nurse (RN)-A stated he knew if a resident was supposed to be on supplemental oxygen by looking at the resident's MAR and TAR. The MAR and TAR would indicate how many liters of oxygen a resident was supposed to be on. RN-A stated if the resident did not have an order for supplemental oxygen, he would look at

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 03/12/2025

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) COMPLETION DATE
F 695	Continued From page 15 the facility's standing orders, apply supplemental oxygen if the standing order parameters allowed, and then he would contact the provider. RN-A stated R1 was on continuous supplemental oxygen. An admission orders policy was requested, and none was received.	F 695		