



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered  
November 18, 2024

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

RE: CCN: 245067  
Cycle Start Date: October 18, 2024

Dear Administrator:

On November 14, 2024, 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.

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

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



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
October 30, 2024

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

RE: CCN: 245067  
Cycle Start Date: October 18, 2024

Dear Administrator:

On October 18, 2024, 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:

The Emeralds At Faribault LLC

October 30, 2024

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- 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](mailto: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 January 18, 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 April 18, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the

The Emeralds At Faribault LLC

October 30, 2024

Page 3

Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

[https://mdhprovidercontent.web.health.state.mn.us/ltr\\_idr.cfm](https://mdhprovidercontent.web.health.state.mn.us/ltr_idr.cfm)

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

[https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

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

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, 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](mailto:Melissa.Poepping@state.mn.us)



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October 30, 2024

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

Re: Event ID: XD2S11

Dear Administrator:

The above facility survey was completed on October 18, 2024 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,

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

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00571</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/18/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE EMERALDS AT FARIBAULT LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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2 000	<p><b>Initial Comments</b></p> <p style="text-align: center;"><b>*****ATTENTION*****</b></p> <p style="text-align: center;"><b>NH LICENSING CORRECTION ORDER</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b> On 10/16/24, 10/17/24, and 10/18/24 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.</p> <p>The following complaints were reviewed:</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>11/01/24</b>
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00571</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/18/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE EMERALDS AT FARIBAULT LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	<p>Continued From page 1</p> <p>HH50679482C (MN00107317). NO licensing orders were issued.</p> <p>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.</p>	2 000		

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

PRINTED: 11/14/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE EMERALDS AT FARIBAULT LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>On 10/16/24, 10/17/24, and 10/18/24 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.</p> <p>The following complaint was reviewed H50679482C (MN00107317) with a deficiencies cited at F849.</p> <p>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.</p> <p>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.</p>	F 000		
F 849 SS=D	<p>Hospice Services CFR(s): 483.70(n)(1)-(4)</p> <p>§483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.</p>	F 849		11/1/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>11/01/2024</b>
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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.

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

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NAME OF PROVIDER OR SUPPLIER  <b>THE EMERALDS AT FARIBAULT LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021</b>		
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F 849	Continued From page 1  §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate	F 849		

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NAME OF PROVIDER OR SUPPLIER  <b>THE EMERALDS AT FARIBAULT LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021</b>		
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F 849	<p>Continued From page 2</p> <p>course of hospice care, including the determination to change the level of services provided.</p> <p>(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.</p> <p>(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.</p> <p>(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.</p> <p>(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.</p> <p>(K) A delineation of the responsibilities of the</p>	F 849		

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F 849	<p>Continued From page 3</p> <p>hospice and the LTC facility to provide bereavement services to LTC facility staff.</p> <p>§483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.</p> <p>The designated interdisciplinary team member is responsible for the following:</p> <ul style="list-style-type: none"> <li>(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.</li> <li>(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.</li> <li>(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.</li> <li>(iv) Obtaining the following information from the hospice: <ul style="list-style-type: none"> <li>(A) The most recent hospice plan of care specific to each patient.</li> <li>(B) Hospice election form.</li> </ul> </li> </ul>	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE EMERALDS AT FARIBAULT LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021</b>		
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F 849	<p>Continued From page 4</p> <p>(C) Physician certification and recertification of the terminal illness specific to each patient.</p> <p>(D) Names and contact information for hospice personnel involved in hospice care of each patient.</p> <p>(E) Instructions on how to access the hospice's 24-hour on-call system.</p> <p>(F) Hospice medication information specific to each patient.</p> <p>(G) Hospice physician and attending physician (if any) orders specific to each patient.</p> <p>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.</p> <p>§483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure the necessary coordination of services between the facility and the hospice agency for 1 of 3 residents (R2) reviewed for hospice services.</p> <p>Findings include:</p> <p>R1's admission minimum data set (MDS) dated 9/16/24, indicated intact cognition with diagnoses of cancer, malnutrition, and depression. R1 required moderate assist with transfers and</p>	F 849	<p>R1 has passed away</p> <p>Like residents have had their Hospice Services reviewed to ensure coordination of care between the facility and hospice agency. Coordination of care may include in resident medical record; Medication list with a list of medication-specific hospice covered medications, a care plan, goals for care, hospice certification, the hospice election form, hospice aide visits and hospice</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  <b>THE EMERALDS AT FARIBAULT LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021</b>		
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F 849	<p>Continued From page 5</p> <p>maximal assist with toileting, bathing, and dressing. R1 was at risk for pressure ulcers but had not pressure ulcers. R1 had pressure relieving device in bed and chair and received medication or ointment to skin. R1 was on hospice.</p> <p>On 10/17/24 at 4:00 p.m., R1's medical record lacked current medication list with a list of medication-specific hospice covered medications, a care plan, goals for care, hospice certification, the hospice election form, hospice aide visits and hospice orders.</p> <p>During an interview on 10/17/24, hospice RN (HRN-A), stated the hospice was handling R1's pressure issues and had not been giving R1's comprehensive assessments to the facility because she did not know she had to. HRN-A stated the facility was the main care giver for the resident and should have an integrated care plan for resident, so everyone knew what was going on with the resident. It was an important part of care for the resident. HRN-A stated she would check in with the floor nurse as she wrote her note in the resident's hard hospice chart. HRN-A did not have access to the facilities electronic medical record (EMR).</p> <p>During an interview on 10/17/24 and 10/18/24, director of nursing (DON) stated the facility has reached out to the hospice agency (HA-A) via email, phone, and fax for copies of R1's hospice care plan and visit notes. HA-B sends their notes weekly and their interdisciplinary group meetings every two weeks. DON stated this has been a problem for the facility and HA-A. On 10/18/24 during a clarification interview DON stated there needed to be an integrated care plan and open</p>	F 849	<p>orders.</p> <p>DON or designee will educate appropriate staff along with Hospice Services to ensure coordination of care between the facility and hospice services.</p> <p>DON or designee will complete Audits complete weekly x 4 and as needed. Audits will be reviewed during QAPI.</p>	

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE EMERALDS AT FARIBAULT LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021</b>		
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F 849	<p>Continued From page 6</p> <p>communication for the hospice resident so everyone knew what was going on with the resident. DON stated it was his expectation the HRNs would update the nurse managers, DON, social worker (SW) or Administrator before leaving the facility, not just check in with the floor nurses.</p> <p>During an interview on 10/18/24 at 10:00 a.m., Administrator stated it was her expectation for the HRNs to update the nurse managers, DON, SW, or herself before leaving the facility. Furthermore, Administrator stated all hospice agencies have access to their EMR and if needed assistance with this they should address situation with her.</p> <p>Review of the Hospice facility's policy dated 11/2023, indicted the following: -It was the responsibility of the hospice agency to coordinate the resident's care as it relates to the terminal illness and related conditions, including: A. Determining the appropriate hospice plan. B. Changing the level of services provided when it was deemed appropriate. C. Providing medical direction, nursing, and clinical management of the terminal illness. D. Providing spiritual, bereavement and/or psychosocial counseling as needed. E. Provide medical supplies, durable medical equipment, and medications necessary for the palliation of pain and symptoms. -It was the responsibility of the facility staff to notify the hospice provider and primary care provider about a significant change in the resident's condition or situations requiring a revision of the plan of care. -The hospice agency will provide the facility staff with a copy of the hospice plan of care and scheduled visits. Hospice staff will communicate</p>	F 849		

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F 849	<p>Continued From page 7 and coordinate care with the interdisciplinary team.</p> <p>The facility Hospice contract dated 5/1/24, indicated coordination of care between the facility and Hospice included Hospice would maintain adequate records of each authorization of Hospice admission. The Hospice in consultation with the facility, will develop and agree upon a coordinated plan of care which was consistent with the unique needs of the resident. Hospice will assume responsibility for determining the appropriate course of hospice care, including level of services provided.</p> <p>-3.2 (b) Communication of initial plan of care. A plan of care will be promptly developed for each resident and a copy of plan of care will be provided to facility.</p> <p>-4.3 (a) Facility shall coordinate with hospice in developing a plan of care and shall designate an individual to serve on the IDG.</p> <p>(d) facility shall coordinate with hospice regarding management to ensure continuity of communication and easy access to ongoing information.</p> <p>-5.4 Hospice will provide facility with written documentation of communication between facility and hospice wither in hard copy or electronic format, depending on the structure of the facility's documentation system, to ensure the needs of the resident are addressed and met 24 hours per day and facility agrees it will at all times abide by this communication process.</p>	F 849		