DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 31, 2024

Administrator
The Emeralds At St Paul LLC
420 Marshall Avenue
Saint Paul, MN 55102

RE: CCN: 245295
Cycle Start Date: November 14, 2024

Dear Administrator:

On December 24, 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.

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

December 31, 2024

Administrator
The Emeralds At St Paul LLC
420 Marshall Avenue
Saint Paul, MN 55102

Re: Reinspection Results
Event ID: 4G4G12

Dear Administrator:

On December 24, 2024 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 November 14, 2024. 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
December 2, 2024

Administrator
The Emeralds At St Paul LLC
420 Marshall Avenue
Saint Paul, MN 55102

RE: CCN: 245295
Cycle Start Date: November 14, 2024

Dear Administrator:

On November 14, 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);

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

- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by February 14, 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 May 14, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING _____ B. WING _____	C 11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT ST PAUL LLC	420 MARSHALL AVENUE SAINT PAUL, MN 55102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 11/13/24 & 11/14/24, 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. The following complaints were reviewed: H52951154C (MN108178) & H52951193C (MN108069) with a deficiency cited at F755. 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 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		12/15/24

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

Electronically Signed | 12/05/2024

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

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F 755	Continued From page 1 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician orders and failed to identify and report medication errors according to facility policy for 3 of 3 (R1, R2, R3) residents reviewed for medication administration. Findings include: R1 R1's admission Minimum Data Set (MDS) assessment dated 10/18/24, indicated R1 admitted on 10/11/24 with diagnoses including unspecified pain and had intact cognition. R1 received scheduled pain medication, received PRN (as needed) pain medication, and took	F 755	R1 went to hospital on 11/12/2024 and gave up bed hold at facility on 11/20/2024. R2 and R3 remain at the facility. R2 and R3's medication ordered were reviewed and provider(s) contacted for clarification of orders. All like-residents' medications were reviewed and provider(s) contacted if clarification of orders were needed. The facility's policies on Medication Administration Procedures and Medication Error Procedure were reviewed without changes.	

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F 755	Continued From page 2 opioid (a drug classification including some medications for pain relief) medication. R1's care plan included an alteration in comfort dated 10/13/24, with intervention of pain medication as ordered by MD (physician). R1's physician orders included an order for oxycodone HCl (oxycodone hydrochloride, an opioid drug used to treat moderate to severe pain) oral tablet 5 mg (milligrams) with start date 10/17/24 and discontinue date 11/6/24. Instructions were "give 5 mg by mouth every 6 hours as needed for pain, (max of 3 doses a day)." R1's physician orders included an order for oxycodone HCl oral tablet 5 mg with start date 11/8/24. Instructions were "give 5 mg by mouth every 4 hours as needed for pain max of 15 mg a day." R1's medication administration record (MAR) for October and November 2024, identified administrations of the oxycodone outside of the ordered daily maximums including: - On 10/23/24 at 12:04 a.m., 8:19 a.m., 4:04 p.m., and 11:49 p.m. Four doses were administered for a total of 20 mg of oxycodone. - On 10/27/24 at 2:46 a.m., 8:40 a.m., 3:30 p.m., and 9:56 p.m. Four doses were administered for a total of 20 mg of oxycodone. - On 11/9/24 at 12:13 a.m., 5:10 a.m., 9:08 a.m., 3:37 p.m., and 8:30 p.m. Five doses were administered for a total of 25 mg of oxycodone. - On 11/10/24 at 5:35 a.m., 11:56 a.m., 4:40 p.m., and 9:41 p.m. Four doses were administered for a total of 20 mg of oxycodone. - On 11/11/24 at 5:13 a.m., 9:15 a.m., 1:18 p.m.,	F 755	Education to all licensed nursing staff initiated specific to checking the order against the MAR to ensure correct amount administered, along with review of the Medication Administration Procedures and Medication Error Procedure policies. DON or designee will conduct random resident medication order/administration audits weekly x 4 weeks, then monthly x 2 months, then PRN based on audit results. QAPI will review audit results and recommend continued audit schedule.	

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F 755	Continued From page 3	F 755		

and 8:40 p.m. Four doses were administered for a total of 20 mg of oxycodone.

In an interview on 11/14/24 at 11:56 p.m., licensed practical nurse (LPN)-A stated residents who are cognitively intact ask for their PRN medications. LPN-A noted PRN medications have time frames for how frequently that can be administered. He noted some PRN medications have a maximum daily dose that can be given and he would look at the administration record to calculate how much had been given recently to determine if the maximum had been reached.

In an interview on 11/14/24 at 12:13 p.m., registered nurse (RN)-A stated for PRN medications there are time frames of how frequently the medication is allowed to be administered and the MAR would tell you if you tried to administer it too soon after the previous dose. RN-A noted some PRN medications have a maximum amount that could be administered and staff have to check the MAR to see how the amount of the medication that had already been administered. She stated if someone wanted PRN pain medication but the maximum allowable administrations had already been reached she would assess the resident and contact the provider to ask about other options.

In an interview on 11/14/24 at 12:24 p.m., clinical manager (CM)-A stated for PRN medications the MAR would say if the dose shouldn't exceed a certain amount and nurses can see on the administration record how many times a medication has been given and how much medication was administered. CM-A noted the information was in the electronic health record's medication administration charting system, but it

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F 755	Continued From page 4 would not pop up with an alert for administering medication in excess of an ordered total amount or total doses, though it would if nurses administered the medication too early. Nurses would have to look at the administration record to determine the total doses or amount already given. CM-A noted if the total available dose had been exceeded and someone wanted a PRN pain medication staff should contact the provider to see what they want to do. CM-A noted she expected staff to administer medications in accordance with physician orders. In an interview on 11/14/24 at 2:06 p.m., LPN-A confirmed R1's current PRN oxycodone order stated it could be given every four hours as needed with a maximum of 15 mg a day. LPN-A stated staff "can give a maximum of three doses in 24 hours because that equals 15 mg total" and noted it would be a medication error if R1 was given four doses in one day. In an interview on 11/14/24 at 2:15 pm., RN-B stated R1 took oxycodone every four hours as needed and noted the order said there was a 15 mg maximum of the medication in a day which "means she can only have three in a day." RN-B confirmed R1 received five doses on 11/9/24, four doses on 11/10/24, and four doses on 11/11/24 and "she shouldn't have had fourth and fifth doses." RN-B stated those doses should have been reported as medication errors. In an interview on 11/14/24 at 2:31 p.m., CM-A stated for R1 excessive doses of the medication could be given if staff weren't reading the fine print of the order. CM-A noted R1 receiving fourth or fifth doses of the medication was a medication error and "that is too much medication. I would	F 755		

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F 755	Continued From page 5 expect nurses to follow the provider orders." CM-A stated four or five doses should not be administered, per what the order said it was over the maximum dose, and she was not aware R1 had been receiving extra pain medication. CM-A identified the breakdown in the process as the lack of an alert in the charting system notifying nurses the maximum daily administration had been reached. CM-A stated the provider should have been notified and it should have been reported to herself and the director of nursing (DON). CM-A stated R1 had not received the medication in accordance with physician orders. In an interview on 11/14/24 at 3:21 p.m., nurse practitioner (NP)-A stated he worked for a rehabilitation and pain management practice and managed and prescribed R1's oxycodone. NP-A stated R1's oxycodone was to be given as needed for a maximum of three doses a day only and noted many things factor into how orders are written. NP-A noted "when we prescribe narcotics, the first thing first is safety. If safety is not first, then we might be doing harm and not good to the patients." NP-A stated he was not aware R1 had received excess doses. NP-A stated "the nurse that is giving it is not following the order. That is not acceptable." NP-A stated nurses have to follow the order and if her pain was increasing, he should be notified and giving excess doses of the medication was "a safety concern." NP-A stated preventing addiction was one concern with the administration of narcotics like oxycodone and staff giving excess medication was "not good" and "they should contact me." In an interview on 11/14/24 at 3:59 p.m., the DON stated medications should be administered as	F 755		

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F 755	Continued From page 6 written in physician orders. The DON stated for a 5 mg medication with a maximum dose of 15 mg per day there would be a maximum of three doses that could be given. If more than three doses were given it would be a medication error. The DON identified administration of medication beyond a maximum daily total dose or number of administrations as a medication error, "that would be going above provider orders, nurses can't do that." The DON stated he was not previously aware that R1 had received excess doses of PRN oxycodone. The DON that it was possible the nurses administering the medication "were not looking back" at when R1 had last received the medication and "looking at the orders accurately to see she can only receive so many on that day." The DON stated if R1 was asking for pain medication and the full daily dose had already been given, nurses should call the physician. The DON stated he did not think the charting system had a way of alerting nurses when a daily administration maximum was reached but thought "it would be a lot safer to have something like that instead of relying on a person under pressure." R2 R2's admission MDS dated 11/5/25, indicated R2 admitted on 10/30/24 with diagnoses including heart failure, pain, and gastrostomy status (presence of a surgical opening into the stomach). R2 received scheduled pain medication and took diuretic (a class of medications that reduce fluid build-up in the body) medication. R2's care plan included an alteration in comfort dated 9/6/24, with intervention of pain medication as ordered by MD.	F 755		

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F 755	Continued From page 7 R2's physician orders included an order for furosemide (a diuretic) oral tablet 20 mg with start date 11/1/24. Instructions were "give 20 mg via G-tube [gastrostomy tube, a tube inserted through the abdomen into the stomach] in the morning for edema [fluid build-up]." R2's physician orders included an order for gabapentin (an anti-epileptic medication also used to treat nerve pain) oral capsule 300 mg with start date 9/4/24. Instructions were "give 600 mg via G-tube three times a day related to pain, unspecified" with administrations scheduled at 6:00 a.m., 4:00 p.m., and 8:00 p.m. daily. R2's medication administration record (MAR) for November 2024, identified scheduled administrations of the furosemide and gabapentin. R3's MAR lacked documentation of the scheduled administrations of furosemide 20 mg and gabapentin 600 mg on 11/6/24 at 6:00 a.m. Documentation for these administrations was blank with no indication the medications were administered or documented reasons the medications were not administered. R3 R3's facesheet dated 11/14/24, indicated R3 admitted on 8/9/24. R3 had diagnoses including acute and chronic respiratory failure (a condition where blood has too much carbon dioxide or not enough oxygen), unspecified viral hepatitis B, quadriplegia (paralysis affecting the body from the neck down), locked-in state (neurologic condition where someone is aware but cannot move or communicate due to paralysis), disorder of the autonomic nervous system, hypertension,	F 755		

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F 755	Continued From page 8 dysphagia following cerebral infarction (difficulty swallowing after a stroke), gastroesophageal reflux disease (GERD, acid reflux), gastrostomy status, and tracheostomy status (presence of an artificial opening in the windpipe/trachea to help with breathing). R3's care plan included a risk for aspiration related to presence of a feeding tube dated 8/13/24, with intervention to administer tube feedings as ordered and free water and tube flush per facility protocol. R3's nutrition care plan dated 8/12/24, identified R2's nutritional status was nothing by mouth and he received tube feedings. Interventions included tube feeding and flushes per physician orders, medication per physician orders, and medication for gastrointestinal upset per physician orders. R3's physician orders included the following: - Order for ammonium lactate external cream 12% (a skin cream) with start date 10/4/24. Instructions were to apply to affected areas topically two times a day for dry itchy skin. - Order for aspirin oral tablet chewable 81 mg with start date 10/5/24. Instructions were to give 81 mg via G-tube one time a day related to hypertension. - Order for carboxymethylcellulose sodium ophthalmic solution (lubricating eye drops) with start date 10/4/24. Instructions were to instill one drop in both eyes four times a day for dry eyes. - Order for Claritin oral tablet 10 mg (an antihistamine) with start date 10/5/24. Instructions were to give 10 mg via G-tube one time a day for hay fever. - Order for entecavir oral tablet 0.5 mg (an antiviral medication) with start date 10/5/24.	F 755		

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	245295	A. BUILDING _____ B. WING _____	C 11/14/2024

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F 755	Continued From page 9 Instructions were to give one tablet via G-tube one time a day related to unspecified viral hepatitis B. - Order for enteral feed (tube feeding) order with start date 8/9/24. Instructions were free water flushes (water administered through a feeding tube) of 50 ml every three hours. - Order for gabapentin oral tablet 600 mg with start date 10/4/24. Instructions were to give 600 mg via G-tube three times a day related to disorder of the autonomic nervous system, give with feeding. - Order for glycopyrrolate 1 mg (a medication that helps reduce respiratory secretions) tablet with start date 10/4/24. Instructions were to give 1 tablet via G-tube two times a day related to tracheostomy status. - Order for guaifenesin oral liquid 100 mg/5 milliliters (ml) (a medication that helps to thin respiratory secretions) with start date 10/4/24. Instructions were to give 20 ml via G-tube three times a day related to tracheostomy status. - Order for lansoprazole oral suspension 3 mg/ml (a medication to reduce stomach acid) with start date 10/5/24. Instructions were to give 10 ml via G-tube one time a day for GERD related to dysphagia following cerebral infarction. - Order for Miralax oral powder 17 grams/scoop (a laxative medication) with start date 10/5/24. Instructions were to give 17 grams via G-tube one time a day for constipation. - Order for white petrolatum-mineral oil ophthalmic ointment (a lubricating eye ointment) with start date 10/4/24. Instructions were to instill 0.25 inches in both eyes four times a day for dry eyes. Review of R3's MAR dated months of October and November 2024, identified scheduled	F 755		

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F 755	Continued From page 10 administrations of the above listed medications. R3's MAR lacked documentation of scheduled administrations as follows: - On 10/25/24 at 6:00 a.m.: aspirin oral tablet chewable 81 mg, Claritin oral tablet 10 mg, entecavir oral tablet 0.5 mg, lansoprazole oral suspension 10 ml, Miralax oral powder 17 grams, glycopyrrolate tablet 1 mg, gabapentin oral tablet 600 mg, guaifenesin oral liquid 20 ml, and free water flush 50 ml - On 11/8/24 at 8:00 a.m.: ammonium lactate external cream, carboxymethylcellulose sodium ophthalmic solution, and white petrolatum-mineral oil ophthalmic ointment - On 11/8/24 at 9:00 a.m.: free water flush 50 ml - On 11/10/24 at 3:00 a.m.: free water flush 50 ml - On 11/10/24 at 6:00 a.m.: aspirin oral tablet chewable 81 mg, Claritin oral tablet 10 mg, Entecavir oral tablet 0.5 mg, lansoprazole oral suspension 10 ml, Miralax oral powder 17 grams, glycopyrrolate 1 mg tablet, gabapentin oral tablet 600 mg, guaifenesin oral liquid 20 ml, and free water flush 50 ml. Documentation for these administrations was blank with no indication the medications were administered or documented reasons the medications were not administered. During Interview and Observation on 11/14/24 at 2:41 p.m. of medication cart with certified nurse manager (CM-A), CM-A reported that the medication for R2 was still in the package and was missed. Upon review of R3's medication was unsure about R3's over the counter medication, but confirmed there were anticipated to be missed. In an interview on 11/14/24 at 3:59 p.m., the DON stated medications should be administered as written in physician orders. The DON noted	F 755		

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F 755	Continued From page 11	F 755		

nurses know what medications to administer because they have an electronic MAR that tells them what medication is due and when it is due. The DON stated if the documentation on the MAR was blank, he believed the corresponding medication administration had been missed. The DON stated he was not able to confirm medications were administered in accordance with physician orders if the documentation on the MAR was blank. He noted a missed administration of a medication would constitute a medication error, should be reported, and the physician should be notified.

Facility policy titled IIB1: Administration Procedures for All Medications dated May 2022, included: "Review 5 Rights (3) times: 1) Prior to removing the medication package/container from the cart/drawer; a. Check MAR/TAR for order. b. Note any allergies or contraindications the resident may have prior to drug administration. c. If unfamiliar with the medication, consult a drug reference, manufacturer package insert, or pharmacist for more information. d. Check for vital signs, other tests to be done during/prior to medication administration. e. Prepare resident for medication administration. 2) Prior to removing the medication from the container a. Check the label against the order on the MAR. b. Note any supplemental labeling that applies (fractional tablet, multiple tablets, volume of liquid, shake well, give with another medication, etc.). c. Due to the complexity and length/amount of instructions, some medications may be labeled "use as directed." Refer to the MAR for instruction details. 3) After the dose has been prepared and before returning the medication to storage ... L. If resident refuses medication, document refusal on MAR or TAR. Research refusals for possibility of

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F 755	Continued From page 12 dry mouth, resident reluctance, development of swallowing difficulty. M. When administering an "as needed" (PRN) medication, document reason for giving, observe for medication actions/reactions and record [on the PRN effectiveness sheet/nurse's notes] ... P. Notification of Physician/Prescriber 1) Persistent refusals. 2) Held medications for pulse, blood pressure, low or high blood sugar, or other abnormal test results, vital signs, resulting in medications being held. 3) Suspected adverse drug reactions." Facility policy titled Medication Error Procedure dated 1/2020, included "Medication errors should be assessed, documented, and reported according to federal and/or state guidelines as appropriate. Medication errors will be rectified according to standard of practice and the facilities pharmacy policy for preventing and detecting adverse consequences and medication errors ... When a medication error occurs, the person responsible for the error or the person finding the error will complete the Medication Error Reconciliation Report ... 2.) Contact the Medical Provider to inform them of the error a.) Give Description of the Error b.) Document provider comments and follow-up 3.) Notify resident/family/POA 4.) Notify Pharmacist if error is the result of a Pharmacy Error; document pharmacy follow-up 5.) Document Medication Error in the Medical Record."	F 755		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 2, 2024

Administrator
The Emeralds At St Paul LLC
420 Marshall Avenue
Saint Paul, MN 55102

Re: State Nursing Home Licensing Orders
Event ID: 4G4G11

Dear Administrator:

The above facility was surveyed on November 13, 2024 through November 14, 2024 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:

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

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
	00913	A. BUILDING: _____ B. WING _____	11/14/2024

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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 11/13/24 & 11/14/24, 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 orders 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: H52951154C (MN108178) & H52951193C (MN108069) with a licensing order issued at 1545. 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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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		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the	21545		12/15/24

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21545	Continued From page 3 physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician orders and failed to identify and report medication errors according to facility policy for 3 of 3 (R1, R2, R3) residents reviewed for medication administration. Findings include: R1 R1's admission Minimum Data Set (MDS) assessment dated 10/18/24, indicated R1 admitted on 10/11/24 with diagnoses including unspecified pain and had intact cognition. R1 received scheduled pain medication, received PRN (as needed) pain medication, and took opioid (a drug classification including some medications for pain relief) medication. R1's care plan included an alteration in comfort	21545	Corrected.	

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21545	Continued From page 4 dated 10/13/24, with intervention of pain medication as ordered by MD (physician). R1's physician orders included an order for oxycodone HCl (oxycodone hydrochloride, an opioid drug used to treat moderate to severe pain) oral tablet 5 mg (milligrams) with start date 10/17/24 and discontinue date 11/6/24. Instructions were "give 5 mg by mouth every 6 hours as needed for pain, (max of 3 doses a day)." R1's physician orders included an order for oxycodone HCl oral tablet 5 mg with start date 11/8/24. Instructions were "give 5 mg by mouth every 4 hours as needed for pain max of 15 mg a day." R1's medication administration record (MAR) for October and November 2024, identified administrations of the oxycodone outside of the ordered daily maximums including: - On 10/23/24 at 12:04 a.m., 8:19 a.m., 4:04 p.m., and 11:49 p.m. Four doses were administered for a total of 20 mg of oxycodone. - On 10/27/24 at 2:46 a.m., 8:40 a.m., 3:30 p.m., and 9:56 p.m. Four doses were administered for a total of 20 mg of oxycodone. - On 11/9/24 at 12:13 a.m., 5:10 a.m., 9:08 a.m., 3:37 p.m., and 8:30 p.m. Five doses were administered for a total of 25 mg of oxycodone. - On 11/10/24 at 5:35 a.m., 11:56 a.m., 4:40 p.m., and 9:41 p.m. Four doses were administered for a total of 20 mg of oxycodone. - On 11/11/24 at 5:13 a.m., 9:15 a.m., 1:18 p.m., and 8:40 p.m. Four doses were administered for a total of 20 mg of oxycodone. In an interview on 11/14/24 at 11:56 p.m., licensed practical nurse (LPN)-A stated residents	21545		

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21545	Continued From page 5 who are cognitively intact ask for their PRN medications. LPN-A noted PRN medications have time frames for how frequently that can be administered. He noted some PRN medications have a maximum daily dose that can be given and he would look at the administration record to calculate how much had been given recently to determine if the maximum had been reached. In an interview on 11/14/24 at 12:13 p.m., registered nurse (RN)-A stated for PRN medications there are time frames of how frequently the medication is allowed to be administered and the MAR would tell you if you tried to administer it too soon after the previous dose. RN-A noted some PRN medications have a maximum amount that could be administered and staff have to check the MAR to see how the amount of the medication that had already been administered. She stated if someone wanted PRN pain medication but the maximum allowable administrations had already been reached she would assess the resident and contact the provider to ask about other options. In an interview on 11/14/24 at 12:24 p.m., clinical manager (CM)-A stated for PRN medications the MAR would say if the dose shouldn't exceed a certain amount and nurses can see on the administration record how many times a medication has been given and how much medication was administered. CM-A noted the information was in the electronic health record's medication administration charting system, but it would not pop up with an alert for administering medication in excess of an ordered total amount or total doses, though it would if nurses administered the medication too early. Nurses would have to look at the administration record to determine the total doses or amount already	21545		

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21545	Continued From page 6 given. CM-A noted if the total available dose had been exceeded and someone wanted a PRN pain medication staff should contact the provider to see what they want to do. CM-A noted she expected staff to administer medications in accordance with physician orders. In an interview on 11/14/24 at 2:06 p.m., LPN-A confirmed R1's current PRN oxycodone order stated it could be given every four hours as needed with a maximum of 15 mg a day. LPN-A stated staff "can give a maximum of three doses in 24 hours because that equals 15 mg total" and noted it would be a medication error if R1 was given four doses in one day. In an interview on 11/14/24 at 2:15 pm., RN-B stated R1 took oxycodone every four hours as needed and noted the order said there was a 15 mg maximum of the medication in a day which "means she can only have three in a day." RN-B confirmed R1 received five doses on 11/9/24, four doses on 11/10/24, and four doses on 11/11/24 and "she shouldn't have had fourth and fifth doses." RN-B stated those doses should have been reported as medication errors. In an interview on 11/14/24 at 2:31 p.m., CM-A stated for R1 excessive doses of the medication could be given if staff weren't reading the fine print of the order. CM-A noted R1 receiving fourth or fifth doses of the medication was a medication error and "that is too much medication. I would expect nurses to follow the provider orders." CM-A stated four or five doses should not be administered, per what the order said it was over the maximum dose, and she was not aware R1 had been receiving extra pain medication. CM-A identified the breakdown in the process as the lack of an alert in the charting system notifying	21545		

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21545	Continued From page 7 nurses the maximum daily administration had been reached. CM-A stated the provider should have been notified and it should have been reported to herself and the director of nursing (DON). CM-A stated R1 had not received the medication in accordance with physician orders. In an interview on 11/14/24 at 3:21 p.m., nurse practitioner (NP)-A stated he worked for a rehabilitation and pain management practice and managed and prescribed R1's oxycodone. NP-A stated R1's oxycodone was to be given as needed for a maximum of three doses a day only and noted many things factor into how orders are written. NP-A noted "when we prescribe narcotics, the first thing first is safety. If safety is not first, then we might be doing harm and not good to the patients." NP-A stated he was not aware R1 had received excess doses. NP-A stated "the nurse that is giving it is not following the order. That is not acceptable." NP-A stated nurses have to follow the order and if her pain was increasing, he should be notified and giving excess doses of the medication was "a safety concern." NP-A stated preventing addiction was one concern with the administration of narcotics like oxycodone and staff giving excess medication was "not good" and "they should contact me." In an interview on 11/14/24 at 3:59 p.m., the DON stated medications should be administered as written in physician orders. The DON stated for a 5 mg medication with a maximum dose of 15 mg per day there would be a maximum of three doses that could be given. If more than three doses were given it would be a medication error. The DON identified administration of medication beyond a maximum daily total dose or number of administrations as a medication error, "that would	21545		

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21545	Continued From page 8 be going above provider orders, nurses can't do that." The DON stated he was not previously aware that R1 had received excess doses of PRN oxycodone. The DON that it was possible the nurses administering the medication "were not looking back" at when R1 had last received the medication and "looking at the orders accurately to see she can only receive so many on that day." The DON stated if R1 was asking for pain medication and the full daily dose had already been given, nurses should call the physician. The DON stated he did not think the charting system had a way of alerting nurses when a daily administration maximum was reached but thought "it would be a lot safer to have something like that instead of relying on a person under pressure." R2 R2's admission MDS dated 11/5/25, indicated R2 admitted on 10/30/24 with diagnoses including heart failure, pain, and gastrostomy status (presence of a surgical opening into the stomach). R2 received scheduled pain medication and took diuretic (a class of medications that reduce fluid build-up in the body) medication. R2's care plan included an alteration in comfort dated 9/6/24, with intervention of pain medication as ordered by MD. R2's physician orders included an order for furosemide (a diuretic) oral tablet 20 mg with start date 11/1/24. Instructions were "give 20 mg via G-tube [gastrostomy tube, a tube inserted through the abdomen into the stomach] in the morning for edema [fluid build-up]." R2's physician orders included an order for	21545		

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21545	Continued From page 9 gabapentin (an anti-epileptic medication also used to treat nerve pain) oral capsule 300 mg with start date 9/4/24. Instructions were "give 600 mg via G-tube three times a day related to pain, unspecified" with administrations scheduled at 6:00 a.m., 4:00 p.m., and 8:00 p.m. daily. R2's medication administration record (MAR) for November 2024, identified scheduled administrations of the furosemide and gabapentin. R3's MAR lacked documentation of the scheduled administrations of furosemide 20 mg and gabapentin 600 mg on 11/6/24 at 6:00 a.m. Documentation for these administrations was blank with no indication the medications were administered or documented reasons the medications were not administered. R3 R3's facesheet dated 11/14/24, indicated R3 admitted on 8/9/24. R3 had diagnoses including acute and chronic respiratory failure (a condition where blood has too much carbon dioxide or not enough oxygen), unspecified viral hepatitis B, quadriplegia (paralysis affecting the body from the neck down), locked-in state (neurologic condition where someone is aware but cannot move or communicate due to paralysis), disorder of the autonomic nervous system, hypertension, dysphagia following cerebral infarction (difficulty swallowing after a stroke), gastroesophageal reflux disease (GERD, acid reflux), gastrostomy status, and tracheostomy status (presence of an artificial opening in the windpipe/trachea to help with breathing). R3's care plan included a risk for aspiration related to presence of a feeding tube dated 8/13/24, with intervention to administer tube	21545		

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21545	Continued From page 10 feedings as ordered and free water and tube flush per facility protocol. R3's nutrition care plan dated 8/12/24, identified R2's nutritional status was nothing by mouth and he received tube feedings. Interventions included tube feeding and flushes per physician orders, medication per physician orders, and medication for gastrointestinal upset per physician orders. R3's physician orders included the following: - Order for ammonium lactate external cream 12% (a skin cream) with start date 10/4/24. Instructions were to apply to affected areas topically two times a day for dry itchy skin. - Order for aspirin oral tablet chewable 81 mg with start date 10/5/24. Instructions were to give 81 mg via G-tube one time a day related to hypertension. - Order for carboxymethylcellulose sodium ophthalmic solution (lubricating eye drops) with start date 10/4/24. Instructions were to instill one drop in both eyes four times a day for dry eyes. - Order for Claritin oral tablet 10 mg (an antihistamine) with start date 10/5/24. Instructions were to give 10 mg via G-tube one time a day for hay fever. - Order for entecavir oral tablet 0.5 mg (an antiviral medication) with start date 10/5/24. Instructions were to give one tablet via G-tube one time a day related to unspecified viral hepatitis B. - Order for enteral feed (tube feeding) order with start date 8/9/24. Instructions were free water flushes (water administered through a feeding tube) of 50 ml every three hours. - Order for gabapentin oral tablet 600 mg with start date 10/4/24. Instructions were to give 600 mg via G-tube three times a day related to disorder of the autonomic nervous system, give	21545		

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21545	Continued From page 11 with feeding. - Order for glycopyrrolate 1 mg (a medication that helps reduce respiratory secretions) tablet with start date 10/4/24. Instructions were to give 1 tablet via G-tube two times a day related to tracheostomy status. - Order for guaifenesin oral liquid 100 mg/5 milliliters (ml) (a medication that helps to thin respiratory secretions) with start date 10/4/24. Instructions were to give 20 ml via G-tube three times a day related to tracheostomy status. - Order for lansoprazole oral suspension 3 mg/ml (a medication to reduce stomach acid) with start date 10/5/24. Instructions were to give 10 ml via G-tube one time a day for GERD related to dysphagia following cerebral infarction. - Order for Miralax oral powder 17 grams/scoop (a laxative medication) with start date 10/5/24. Instructions were to give 17 grams via G-tube one time a day for constipation. - Order for white petrolatum-mineral oil ophthalmic ointment (a lubricating eye ointment) with start date 10/4/24. Instructions were to instill 0.25 inches in both eyes four times a day for dry eyes. Review of R3's MAR dated months of October and November 2024, identified scheduled administrations of the above listed medications. R3's MAR lacked documentation of scheduled administrations as follows: - On 10/25/24 at 6:00 a.m.: aspirin oral tablet chewable 81 mg, Claritin oral tablet 10 mg, entecavir oral tablet 0.5 mg, lansoprazole oral suspension 10 ml, Miralax oral powder 17 grams, glycopyrrolate tablet 1 mg, gabapentin oral tablet 600 mg, guaifenesin oral liquid 20 ml, and free water flush 50 ml - On 11/8/24 at 8:00 a.m.: ammonium lactate external cream, carboxymethylcellulose sodium	21545		

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21545	Continued From page 12 ophthalmic solution, and white petrolatum-mineral oil ophthalmic ointment - On 11/8/24 at 9:00 a.m.: free water flush 50 ml - On 11/10/24 at 3:00 a.m.: free water flush 50 ml - On 11/10/24 at 6:00 a.m.: aspirin oral tablet chewable 81 mg, Claritin oral tablet 10 mg, Entecavir oral tablet 0.5 mg, lansoprazole oral suspension 10 ml, Miralax oral powder 17 grams, glycopyrrolate 1 mg tablet, gabapentin oral tablet 600 mg, guaifenesin oral liquid 20 ml, and free water flush 50 ml. Documentation for these administrations was blank with no indication the medications were administered or documented reasons the medications were not administered. During Interview and Observation on 11/14/24 at 2:41 p.m. of medication cart with certified nurse manager (CM-A), CM-A reported that the medication for R2 was still in the package and was missed. Upon review of R3's medication was unsure about R3's over the counter medication, but confirmed there were anticipated to be missed. In an interview on 11/14/24 at 3:59 p.m., the DON stated medications should be administered as written in physician orders. The DON noted nurses know what medications to administer because they have an electronic MAR that tells them what medication is due and when it is due. The DON stated if the documentation on the MAR was blank, he believed the corresponding medication administration had been missed. The DON stated he was not able to confirm medications were administered in accordance with physician orders if the documentation on the MAR was blank. He noted a missed administration of a medication would constitute a medication error, should be reported, and the physician should be notified.	21545		

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21545	Continued From page 13 Facility policy titled IIB1: Administration Procedures for All Medications dated May 2022, included: "Review 5 Rights (3) times: 1) Prior to removing the medication package/container from the cart/drawer; a. Check MAR/TAR for order. b. Note any allergies or contraindications the resident may have prior to drug administration. c. If unfamiliar with the medication, consult a drug reference, manufacturer package insert, or pharmacist for more information. d. Check for vital signs, other tests to be done during/prior to medication administration. e. Prepare resident for medication administration. 2) Prior to removing the medication from the container a. Check the label against the order on the MAR. b. Note any supplemental labeling that applies (fractional tablet, multiple tablets, volume of liquid, shake well, give with another medication, etc.). c. Due to the complexity and length/amount of instructions, some medications may be labeled "use as directed." Refer to the MAR for instruction details. 3) After the dose has been prepared and before returning the medication to storage ... L. If resident refuses medication, document refusal on MAR or TAR. Research refusals for possibility of dry mouth, resident reluctance, development of swallowing difficulty. M. When administering an "as needed" (PRN) medication, document reason for giving, observe for medication actions/reactions and record [on the PRN effectiveness sheet/nurse's notes] ... P. Notification of Physician/Prescriber 1) Persistent refusals. 2) Held medications for pulse, blood pressure, low or high blood sugar, or other abnormal test results, vital signs, resulting in medications being held. 3) Suspected adverse drug reactions." Facility policy titled Medication Error Procedure	21545		

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21545	Continued From page 14 dated 1/2020, included "Medication errors should be assessed, documented, and reported according to federal and/or state guidelines as appropriate. Medication errors will be rectified according to standard of practice and the facilities pharmacy policy for preventing and detecting adverse consequences and medication errors ... When a medication error occurs, the person responsible for the error or the person finding the error will complete the Medication Error Reconciliation Report ... 2.) Contact the Medical Provider to inform them of the error a.) Give Description of the Error b.) Document provider comments and follow-up 3.) Notify resident/family/POA 4.) Notify Pharmacist if error is the result of a Pharmacy Error; document pharmacy follow-up 5.) Document Medication Error in the Medical Record." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review/revise policies and procedures on scheduled and as needed medication administration. The administrator, DON, or designee could educate all staff on these policies and procedures. The administrator, DON, or designee could audit to ensure all staff members are administering both scheduled and as needed medications in accordance with physician orders and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21545		