P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a

Electronically delivered
June 24, 2021

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

RE: CCN: 245295
Cycle Start Date: June 9, 2021

Dear Administrator:

On June 9, 2021, 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 immediate jeopardy (Level J), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On June 4, 2021, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office forimposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the</u>

following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Emeralds At St Paul Llc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 9, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's

Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day

period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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 06/09/2021

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	F 000		

On 6/8/21 and 6/9/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.

The following complaints were found to be SUBSTANTIATED:
H5295210C (MN73507, MN73523), with a deficiency cited at F689 past non-compliance and does NOT require a plan of correction

The following complaints were found to be UNSUBSTANTIATED:
H5295211C (MN64680) with no deficiencies
H5295212C (MN73576) with no deficiencies

The survey resulted in an Immediate Jeopardy (IJ) at F689. The IJ began on 6/3/21, when R1 eloped from a basement door that was not alarmed with a wander guard (WG) alarm, was missing for 1.5 hours and was found walking on the side of Interstate 35 E by police. The administrator and director of nursing (DON) were notified of the IJ for R1 on 6/8/21 at 4:30 p.m. The facility immediately implemented correction action on 6/4/21, and F689 is being issued at past non-compliance.

The above findings constituted substandard quality of care, and an extended survey was conducted on 6/9/21.

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

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

Electronically Signed | | 07/01/2021

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 000	Continued From page 1 verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the safety interventions for elopement were implemented for 1 of 3 residents (R1) reviewed for elopement. This failure resulted in an immediate jeopardy (IJ) when R1 eloped from a basement door that was not alarmed with a wander guard (WG) alarm. The facility had implemented corrective action so the deficient practice is being issued at past non-compliance. The IJ began on 6/3/21, when R1 eloped from the facility and was missing for 1.5 hours and was found walking on the side of Interstate 35 East by police. The facility administrator and director of nursing (DON) were notified of the IJ at 4:25 p.m. on 6/8/21. The facility implemented immediate corrective action on 6/4/21, prior to the start of the survey and was issued as past non-compliance.	F 689	Past noncompliance: no plan of correction required.	7/1/21

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F 689	Continued From page 2	F 689		

Findings include:

R1's quarterly Minimum Data Set (MDS) dated 5/13/21, identified R1 was severely cognitively impaired with a Brief Mental Status (BIMS) score of 8. He had a medical diagnosis of unspecified sequelae of cerebral infarction (stroke). R1 required an assist of 1 with activities of daily living (ADLs). He ambulated independently with the use of a cane. R1 was a standby assist of 1 for transfers. The MDS indicated R1 did not have any behavior where he wandered.

R1's admission elopement risk assessment dated 12/20/20, identified R1 had a score of 5 (0-14 was no risk and over 15 indicated a risk for elopement).

R1's care plan with revision date of 3/16/21, did not address wandering as an identified concern.

Nursing progress notes dated 4/16/21, at 1:14 p.m. identified R1 attempted to elope from the facility. R1 was on the elevator and attempted to exit through the back part of the elevator and follow staff into the kitchen. R1 was easily redirected back to the nursing floor. R1 was immediately put on 15 minute checks for seven days, his care plan was reviewed and updated, a WG (device worn on the ankle or wrist that would sound when a resident went through a door that had a WG alarm system) was placed on R1's ankle, and an elopement evaluation was re assessed and the assessment identified him as high risk for elopement.

Nursing progress notes dated 5/22/21, 9:49 p.m. identified R1 attempted to elope from the facility.

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F 689	Continued From page 3	F 689		

R1 eloped outside of the building through the back door on the first floor. The wander-guard sounded, the receptionist followed R1 out the door. Staff approached R1 who refused to reenter the building at that time. 911 was then called and police officers were able to convince R1 to return inside the facility. R1 was immediately put on 15-minute checks, his care plan was reviewed and updated, and an elopement assessment was completed with a score of 13 which indicated low risk, however additional assessment notes in the elopement assessment identified him as a high risk due to elopement events. R1 was placed on 15-minute checks for seven days and after seven days the 15 minute checks were removed without further attempts from R1 to elope. The WG remained on his ankle.

Nursing progress notes dated 6/3/21, 7:17 p.m. identified a call was received from Regions Hospital at approximately 4:30 p.m. The progress note indicated R1, was found wondering by the state patrol. Location unclear. The note indicated the emergency room social worker noted R1 was not harmed and did not seem distressed. R1 reportedly told police that he was walking home. R1 was appropriately dressed for the weather and wore a light sweater and sweat pants. Nursing home facility staff were unaware R1 was gone from the building.

The facility investigative report dated 6/3/21, identified the administrator saw R1 at 2:07 p.m. in the facility lobby on her way to a meeting. R1 was last seen on the facility lobby security camera at 3:09 p.m. Regions Hospital called the facility at 4:30 p.m. to inform them that R1 was found walking on Interstate 35 E by police. R1 was

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F 689	Continued From page 4	F 689		

taken to the emergency room for evaluation. The facility was unaware R1 had eloped. The outdoor temperature on 6/3/21, was 90 degrees Fahrenheit. The facility investigative report was not able to conclude how R1 left the building.

During an interview on 6/8/21, at 1:31 p.m. the social services manager (SS) reported that R1 had been in a wheel chair since his admission in December. R1 was reassessed for elopement risk after the elopement events on 4/16/21 and 5/22/21. SS reported if a resident eloped or made an attempt to elope, a resident would go on 15-minute check for seven days and then the check would be discontinued if a resident did not make any further attempts to elope. R1 progressed with his therapy and became ambulatory with the use of a cane and liked to get on the elevators. It was not unusual for R1 to be off of the nursing unit. SS indicted R1 was allowed to be in the lobby, on other floors of the facility, and in the fenced in outdoor courtyard because he had a WG on and exit doors would alarm if R1 attempted to leave. When asked how R1 left the building the SS said the management team speculated that R1 left the building through the basement door. The SS said the basement had an exit door with a WG alarm that was not functional and would not alarm in response if a WG bracelet passed through it. The elevator required an access code be entered in order for the elevator to go down into the basement, however if someone pushed the elevator button while in the basement the elevator it will override the need for a code. The SS stated it is unlikely that R1 knew the elevator code.

During an interview on 6/8/21, at 1:37 p.m. the maintenance director said the WG was a good

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F 689	Continued From page 5 system that didn't require maintenance but needed to be checked to make sure the system worked with routine tests. The maintenance director checked the WG system one time per week. The receptionist also checked it two times per week. The maintenance director believed the basement door was the only way that R1 could have gotten out of the building without detection. He identified the basement door that leads to the alleyway had a WG system but that it had not been plugged in and had not likely been armed for at least a year. He knew R1 and indicated, he was able to move around the facility freely. The maintenance director did not feel like R1 tried to exit the building. During an interview on 6/8/21, at 1:44 p.m. the DON indicated that R1 was most commonly found in the lobby but was able to go outside too into the courtyard. The DON identified the facility had a receptionist in the lobby 24 hours a day and kept an eye on R1 when he was in the lobby. She stated that R1 like to wander but she was unsure if he tried to get out of the building or just wandered out. The DON stated R1 rode the elevator frequently and on 6/3/21, R1's WG had been checked per his care plan and functioned appropriately. On 6/3/21, at approximately 4:30 p.m. the facility received a call from Regions Hospital that R1 was found walking about 1.5 miles away on Interstate 35 E and was brought to the hospital by police for an assessment. R1 was evaluated and sent back to the facility. The DON believed he must have gotten out of the building through the basement door. She identified it was discovered there is an alarm on the basement exit door that was not activated at the time of R1's elopement.	F 689		

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F 689	Continued From page 6	F 689		

During an interview on 6/8/21, at 2:30 p.m. the administrator stated the facility received a call on 6/3/21, from the ER at Regions Hospital. No time given by the administrator. R1 was found by the state patrol and brought into Regions Hospital for evaluation. The administrator started the last time she saw R1 was on 6/3/21, at 2:07 p.m. on her way to a meeting. An elopement assessment of R 1 was done upon his return on 6/3/21, and was put on a 1:1 supervision where a staff member was with him at all times until his discharge. Education began with staff on 6/3/21. The WG system was also checked to ensure it functioned. Signs were placed at the elevator to instruct staff to wait for the elevator if they have pressed to button. Through the investigation it was found the basement door did not have an active wander guard alarm on the door. The facility thought a code was needed to access the basement however if someone from the basement called the elevator to the basement and someone was on the elevator at the time of the call, the elevator would go straight to the basement. The facility was not certain but felt this may have been how R1 eloped from the basement.

The facility elopement guideline and policy last revised in November of 2017. defined elopement as, "that situation where a resident with impaired decision-making ability, who is oblivious to his/her own safety, needs and therefore at risk of injury outside the confines of the facility, had left the facility without knowledge of staff." All residents are evaluated at admission to establish elopement risk. All residents at risk for elopement are assessed quarterly and as needed. "Only the administrator (or designee) may authorize disabling the alarm system and is

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F 689	Continued From page 7 responsible for the method of monitoring for residents' safety and resetting the alarm." The past noncompliance immediate jeopardy began on 6/3/21. The immediate jeopardy was removed and the deficient practice corrected by 6/4/21, after the facility implemented a systemic plan that included the following actions: When R1 returned to the facility he was placed on 1 to 1 supervision, R1 was transferred to a sister facility with a secured locked unit on 6/4/21. The Quality Assurance Performance and Improvement (QAPI) notes dated 6/4/21, identified the facility management team met and the following were completed; all other residents with wander-guards were evaluated to ensure their wander-guards were working and care plans were updated. The facility reviewed policy on elopement and no changes were needed. The alarm on basement door was activated. Signs were placed by elevators to indicate if the elevator is called to stay and wait for the elevator. Stop signs were placed on the doors to remind staff not to have residents follow staff out the door. All staff were educated on the elopement guidelines (policy), everyone's responsibility to respond to a door alarm, not to clear the door alarm until it was confirmed no residents were missing, nursing staff to check wander guard placement, if alarm did not work to contact the administrator. Education was done by 6/4/21, with all staff. Staff that were not present on 6/4/21, were educated prior to the start of their next shift or via phone. Staff interviews were conducted on 6/8/21, from approximately 2:00 p.m. to 4:00 p.m. with staff that included; RN's LPN's NA's, social services	F 689		

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F 689	Continued From page 8 staff, front desk staff and physical therapy staff. Staff identified education was provided to them about the elopement policy, staff's responsibility when the WG alarms sound and what to do if a resident cannot be found. Review of the facility education entitled Elopements dated 6/3/21 and 6/4/21, confirmed the facility implemented corrective action and therefore this will be cited at past noncompliance. Observation of sign on 6/8/21, between 2:00 p.m. and 4:00 p.m. were verified on 6/8/21.	F 689		

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
June 24, 2021

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

Re: Event ID: YIXN11

Dear Administrator:

The above facility survey was completed on June 9, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

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 ____	C **06/09/2021**

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/8/21 and 6/9/21, an abbreviated and extended survey was completed at your facility to conduct a complaint investigation. Your facility was found IN compliance for state licensure. The following complaint was found to be SUBSTANTIATED:	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 07/01/21

Minnesota Department of Health

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 ______	C 06/09/2021

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2 000	Continued From page 1 H5295210C (MN73507, MN73523). No state licensing orders were issued The following complaints were found to be UNSUBSTANTIATED: H5295211C (MN64680) with no deficiencies H5295212C (MN73576) with no deficiencies Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents.	2 000		