DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 4, 2024

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

RE: CCN: 245295
Cycle Start Date: July 19, 2024

Dear Administrator:

On August 5, 2023, we notified you a remedy was imposed. On August 26, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 19, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 20, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 5, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 19, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 8, 2024

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

RE: CCN: 245295
Cycle Start Date: July 19, 2024

Dear Administrator:

On August 5, 2024, we informed you of imposed enforcement remedies.

On July 29, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety.The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

Also on July 29, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY
On July 26, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

Also on July 27, 2024, the situation of immediate jeopardy to potential health and safety cited at F660 was removed. However, continued non-compliance remains at the lower scope and severity of D.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 20, 2024 will remain.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 20, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 20, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of August 5, 2024, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 19, 2024.

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. If you have not already provided the 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 July 19, 2024. 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.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 19, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ 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://forms.web.health.state.mn.us/form/NHDisputeResolution

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 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,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 8, 2024

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

Re: Event ID: EQV511

Dear Administrator:

The above facility survey was completed on July 29, 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,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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 07/29/2024

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 7/9/24, 7/10/24, 7/25/24, 7/26/24 and 7/29/24, an 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: H52955142C (MN00104456) H52954730C (MN00104199) H52955464C (MN00104698) with deficiencies issued at F689. The survey resulted in an Immediate Jeopardy (IJ) to resident health and safety. An IJ (F689) began on 7/6/24 when the facility failed to assess, monitor for potential life-threatening side effects and drug interactions, along with implementing interventions and follow facility policy to ensure the safety of 2 of 2 residents (R1, R6) who were reported to use crack cocaine on the facility smoking patio. The director of nursing and administrator were notified of the IJ on 7/25/24 at 5:10 p.m. and was removed on 7/26/24. The above findings constituted substandard quality of care. An extended survey for his provider was just completed on 7/19/24 for a previous abbreviated survey. The provider verified there were no changes or updates to their process since 7/19/24 so the extended was not completed. 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/16/2024

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.

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 07/29/2024

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	Continued From page 1 the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		8/19/24

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 07/29/2024

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 609	Continued From page 2 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to report allegations of verbal and emotional abuse immediately (within two hours) to the State Agency (SA) for 1 of 4 residents (R10) reviewed for abuse. Findings include: R10's quarterly Minimum Data Set (MDS) dated 5/14/24 indicated moderate cognitive impairment. On 6/28/24 a progress note written by the facility administrator indicated R10's family member (FM)-A was no longer allowed in the facility due to reports of staying overnights, threatening other residents, soliciting money from residents for hair services. The notes further indicated FM-A became irate, was seen in the main lobby shouting and pointing her finger, and ran up to R10 and shoved him in to a table whereby R10 fell backwards into a chair. Additionally, the note indicated FM-A grabbed R10 by both of his wrists, and left the facility with R10. FM-A proceeded to another resident and then took R10 to the street corner. The note indicate police were called and an officer and two staff escorted R10 back in to the facility, and R10's legal guardian was updated. On 7/10/24 at 5:24 p.m., the administrator stated FM-A was in the facility on 6/27/24, and performed hair services on another resident and only half-completed the service. FM-A then tried to charge that resident money for the work. She didn't think the incident was reportable because	F 609	R10 remains in the facility. Facility filed OHFC on 7/10/2024. All residents within the facility are free from abuse, neglect, and/or exploitation The facilities Abuse Prohibition/Vulnerable Adult Policy was reviewed and remains current. Education provided to Administrator on the facilities Abuse Prohibition/Vulnerable Adult Policy specific to incidents to report and how/when to report to state agencies. The facility will audit reported OHFC reports to ensure timely reporting weekly x 4 weeks, then monthly x 2 months, then PRN depending on audit results. QAPI will review audit results and recommend continued audit schedule. Administrator/Designee is responsible party.	

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 07/29/2024

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 609	Continued From page 3 the police were called right away and didn't consider reporting a family member abuse of a resident. "I guess it possibly is an assault. In the moment, I didn't think of it. Looking back, I should have reported it." The facility's Abuse Prohibition/Vulnerable Adult Policy dated 3/24 directed abuse, inappropriate treatment, and financial exploitation would be reported to the Minnesota Department of Health The policy further indicated abuse would be reported no later than two hours after forming the suspicion of abuse, and exploitation would be reported within 24 hours.	F 609		
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 observation, interview and document review, the facility failed to assess, monitor for side effects and drug interactions, implement interventions and follow facility policy to ensure the safety of 2 of 3 residents (R1, R6) who were reported to use crack cocaine "all weekend" on the facility smoking patio. This resulted in an immediate jeopardy (IJ) for R1 and R6 and had the potential to affect 20 other residents who were identified at risk for illicit drug use.	F 689	R1 remains at the facility. R1's orders were updated to reflect monitoring or use of illegal substances. R1's care plan was reviewed and updated to reflect history and current substance use. R1 was educated on the risk and benefits of substance use. R1 was educated on the substance use policy. R1's provider and pharmacist were updated of residents substance use. R1 continues with ACP and hospice services. R6 discharged from the facility on	8/19/24

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 07/29/2024

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 689	Continued From page 4 The IJ began on 7/6/24 when R1 and R6 were seen smoking crack cocaine on the facility patio and were not assessed or monitored for potential life-threatening side effects and drug interactions. The director of nursing and administrator were notified of the IJ on 7/25/24 at 5:10 p.m. The IJ was removed 7/26/24, but noncompliance remained at the lower scope and severity level of an D which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's quarterly Minimum Data Set (MDS) dated 6/5/24 indicated severe cognitive impairment. R1 was her own decision-maker. R1's Face Sheet printed 7/12/24, lacked family or friends listed in her contact information to help make decisions and listed R1 as the responsible party for her own care and admitted to the facility 12/3/23 with intraabdominal and pelvic mass. R1's Smoking Evaluation dated 6/12/24 indicated R1 was a safe smoker and could keep her smoking materials stored in her personal belongings. The evaluation indicated R1 had cognitive loss, used oxygen, and was educated to remove and store oxygen prior to smoking. R1's care plan dated 3/4/24, lacked indication R1 had a history of smoking marijuana or other illicit substances. R1's Provider Orders printed 7/9/24 lacked directions about monitoring or use of illegal	F 689	7/23/2024 Residents with a history of and/or current substance use were reviewed to ensure orders, care plan, risk and benefits were all current. These like-residents provider and pharmacist were notified of residents history of and/or current substance use. These like-residents were educated on the facilities substance use policy. The facilities Substance Use Policy was reviewed and remains current Staff education provided regarding illegal/illicit drug use and appropriate policies/procedures related to illegal/illicit drug use. The facility will audit new admissions to identify if they have a history of and/or current substance use, to determine appropriate monitoring orders, care plan, risk and benefits, provider and pharmacist notification, etc. weekly x 4 weeks, monthly x 2 months, then PRN based on audit results (following removal plan audit frequency). The facility will audit 2 like-residents per week to ensure orders are in place, care plan updated, providers and pharmacist notified, and risk vs benefits completed weekly x 4 weeks, monthly x 2 months, then PRN based on audit results (following removal plan audit frequency). Facility will complete substance use quiz with 3 staff members weekly x 4 weeks, monthly x 2 months,	

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 07/29/2024

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 689	Continued From page 5 substances. R1 provider orders included paroxetine (Paxil, an antidepressant) dated 2/23/24, Dilaudid (a narcotic pain medication) dated 4/3/24, and gabapentin (an anticonvulsant used to treat seizures and nerve pain) dated 2/22/24. On 3/28/24 a progress note indicated R1 was educated about the facility substance use policy regarding the use of marijuana. On 4/16/24 a progress note indicated R1 was seen smoking marijuana on the smoking patio and refused to give the marijuana or smoking materials to the social worker (SW). R1 was updated on the facility substance use policy. The facility Substance Use Policy dated 6/23, specified illegal or illicit non-prescribed substances or paraphernalia were not allowed on the facility premises and staff would confiscate any illegal or illicit substance or paraphernalia. On 5/30/24 a progress note indicated social services met with R1 after R1 was seen exchanging money and a bag with another resident, R2. R1 denied the behavior but admitted use of marijuana. On 7/5/24 a progress note indicated R1 was seen smoking "crack out of a small pipe," and R1 stated she would do whatever she wanted. The progress notes further indicated social service staff re-educated R1 about the substance use policy, offered substance use support, and informed R1 she was banned from smoking on the smoking patio with other residents. R1 continued to smoke on the patio regardless of social services staff	F 689	then PRN based on audit results to show staff competencies (following removal plan audit frequency). QAPI will review audit results and recommend continued audit schedule. Director of Social Services/Designee is responsible party.	

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 07/29/2024

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 689	Continued From page 6 asking her not to. On 7/8/24 a progress note indicated R1 and another resident (R6) were "smoking crack all weekend" on the smoking patio (7/6/24 and 7/7/24) and were seen "purchasing drugs across the street from the facility." The progress note indicated R1 confirmed smoking crack with the other resident, and "[R6] sold it to her." R1's room was searched, and "nine broken glass crack pipes" were taken from her room because drug paraphernalia was not allowed on campus per the Substance Use Policy. R6's admission MDS dated 6/18/24 did not include a cognitive assessment as R6 refused to participate, but indicated R6 was an independent decision-maker. R6's Face Sheet printed 7/12/24, indicated R6 admitted to the facility with diagnoses of osteomyelitis (inflammation of the bone), and a history of frost bite. R6's care plan dated 6/19/24 indicated R6 smoked in the facility and was noted to smoke marijuana in the facility. The care plan further indicated R6 had a history and diagnosis of substance use. R6's Provider Orders printed 7/9/24, lacked directions about monitoring or use of illegal substances. R6's provider orders included Oxycodone (a narcotic pain medication) dated 6/11/24, lisinopril (a medication used to treat high blood pressure and heart failure) dated 7/9/24, and gabapentin dated 6/11/24.	F 689		

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 07/29/2024

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 689	Continued From page 7	F 689		

On 7/5/24 a progress note indicated R6 was seen "smoking a white substance out of a small pipe," and R1 admitted to using drugs.

On 7/9/24 a progress note indicated R6 and another resident (R1) were "seen smoking crack all weekend" on the smoking patio and were "seen purchasing drugs across the street from the facility." R6 denied smoking crack and denied selling it to the other resident. Staff searched R6's room and found a marijuana pipe and a pocketknife.

On 7/9/24 at 2:27 p.m., during an interview anonymous reporter (AR)-B stated R1 used marijuana, and used both marijuana and crack on the smoking patio. "You can smell the marijuana." AR-B stated R1 smoked "crack cocaine" on the patio or by the facility front door. AR-B stated, "It's just known she uses and she does it on the patio."

On 7/9/24 at 2:55 p.m., during an interview nursing assistant (NA)-A stated R1, "Puts something in a little glass pipe and smokes it outside," with other residents, and had seen it. NA-A denied reporting it to administration.

On 7/25/24 at 11:58 a.m., in a subsequent interview NA-A stated she did not report drug use because she didn't know she needed to because, "Everyone knew already."

On 7/9/24 at 4:17 p.m., during an interview NA-F stated a lot of the residents smoked marijuana, and residents from the apartment building across the street sat in front of the facility with facility residents. She has seen, "Stuff is exchanged

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 07/29/2024

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 689	Continued From page 8 from one hand to another, and you know it is something illegal by the way they act." On 7/25/24 at 11:37 a.m., in a subsequent interview NA-F stated she didn't report drug use to administration because, "They [administration] knew people were smoking marijuana. Nobody said what we were supposed to do." On 7/9/24 at 4:49 p.m., during an interview the administrator stated during her investigation several residents reported seeing R6 buy drugs across the street from the facility in the previous two days on 7/6/24 and 7/7/24. Further, the administrator stated R1 admitted to using crack cocaine and R6 sold it to her. "All we can do is ask if we can search, remove it if we find it, and re-educate the resident. If I actually saw them using [drugs] I would call the police." The administrator stated she suggested R1 relocate to a different facility as R1 was known to use illicit drugs. The administrator stated residents told a social services staff they saw drug deals and crack smoked on the patio, R1 has always purchased marijuana and, "Wouldn't put it past her to share." The Substance Use policy dated 6/2023, indicated staff should confiscate illegal or illicit substances or paraphernalia, and if any amount of illicit substance was found, staff would contact police for instructions on how to handle it. On 7/10/24 at 9:20 a.m., during an interview social services designee (SS)-A stated R1 reported to her she bought drugs from R6 and could do what she wanted. SS-A stated R1 had a friend across the street who staff suspected was selling drugs to R1, and had come to facility twice in the prior two	F 689		

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 07/29/2024

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 689	Continued From page 9 days. SS-A stated the administrator banned this friend from the facility. SS-A stated she offered R1 drug treatment, but R1 declined. Further, SS-stated if staff saw drug deals, it had not been reported to her. SS-A stated she asked administrative staff for supervised smoking for R1 and R6 and was told there was no staff available for that intervention, or for supervised leaves of absence for either resident. SS-A acknowledged knowing R1 and R6 smoked crack on the patio no longer qualified them as safe smokers. SS-A further acknowledged another resident, R6, was the resident who smoked crack cocaine with R1, but R1 did not acknowledge buying drugs from R6. SS-A stated R1 had less money than she used to, and wasn't buying anything other than drugs. On 7/25/24 at 9:58 a.m., during a subsequent interview SS-A stated when drug use was suspected facility interventions included room searches, staff removed drug paraphernalia, and resident re-education. SS-A stated the facility asked residents to smoke marijuana on the public sidewalk instead of on the facility grounds but resident met people from across the street and bought drugs from them. SS-A stated the facility staff told residents they were not allowed to smoke cannabis on the patio, but the facility policy did not indicate that. SS-A stated she did not report drug use to administration right away, but puts a note in the medical records, re-educates the residents and then updates the nurse manager and the administrator. On 7/10/24 at 10:44 a.m., during an interview pharmacist (PH)-A stated he was not aware of illicit drug use by either R1 or R6. PH-A stated if	F 689		

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 07/29/2024

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 689	Continued From page 10 either R1 or R6 were using crack cocaine or marijuana, the pharmacist should have been notified as there could be contraindications or side effects with other medications. The pharmacist should have been notified due to potential drug interactions, including death, and amphetamines could worsen resident health conditions. R6 could have negative interactions between crack cocaine and Oxycodone which could make R6 more high, or have addiction results, and the reaction between crack cocaine and gabapentin could be increased sedation. "Those two would be a big concern." R6 used lisinopril for elevated blood pressure, but if R6 was not taking his medications as he often refused, his blood pressure could elevate and he could have heart problems, drug interactions, and death. R1 could have similar sedating effects from using crack cocaine and gabapentin together, and if R1 used paroxetine with crack cocaine she could have increased anxiety, depression, and suicidal thoughts. On 7/10/24 at 12:13 p.m., during an interview R6 stated, "Don't be asking me no questions about drugs." On 7/10/24 at 1:33 p.m., during an interview nurse practitioner (NP)-B stated she was not informed R6 was using illicit drugs. Staff should have informed her of suspected drug use so she would know what was safe to prescribe and, "If they knew on Friday, they should have called on Friday." On 7/10/24 at 2:05 p.m., during an interview the director of nursing (DON) stated when staff knew residents were using drugs, staff should report it to	F 689		

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 07/29/2024

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 689	Continued From page 11	F 689		

their supervisors, try to remove the drugs safely, and report it to the provider and family members. He was unsure if the pharmacist was notified about R1's and R6's drug use. On 7/5/24 staff was educated about checking on R1 every hour to monitor for adverse effects of drug use, intoxication, and to notify the provider right away if drug use was suspected. He did not have a copy of the education provided, nor a list of which staff was educated on 7/5/24, and acknowledged the orders for hourly checks started on 7/10/24. He expected staff to pass the information to other staff during report, but acknowledged he did not add the information to the report sheet. He acknowledged police were not notified of crack cocaine use on the property. Nursing staff was likely not wanting to get involved in the drug issue. If the pharmacist was not informed about illicit drug use, there could be reactions to some medications. He denied knowledge of any other residents other than R1 and R6 using marijuana or crack cocaine.

On 7/25/24 at 2:11 p.m., during a subsequent interview the DON stated he was not told about the drug use until 7/8/24, and did not know why staff did not report it to him over the weekend. The DON stated there was no indication staff assessed R1 and R6 after the reported drug use, the provider was notified, or medications were held.

On 7/10/24 at 2:11 p.m., during an interview NP-A stated she was notified of R1's crack cocaine use on 7/5/24, and acknowledged R1 used crack cocaine previously.

On 7/10/24 at 3:20 p.m., during an interview the administrator stated the police were now notified

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 07/29/2024

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 689	Continued From page 12 about R1's and R6's crack cocaine use in the facility. She would have expected to see a care plan for both residents about it, providers updated, the pharmacists, and responsible parties updated. The administrator stated the policy indicated the provider would be notified and the police were notified if drugs other than cannabis was found. Additionally, the administrator acknowledged the policy lacked instruction to notify the pharmacist. On 7/10/24 at 12:48 p.m., during an interview AR-A stated he saw R1 and R6 smoke marijuana in their rooms and on the smoking patio, and on 7/4/24 he saw them "smoke crack cocaine" on the smoking patio. AR-A further stated he witnessed R6 wheel his wheelchair up to a car in the street to buy drugs. "[R6] goes every day between two and three p.m., to buy drugs. Everyone knows." On 7/10/24 at 1:58 p.m., during an interview R1 stated she did use crack cocaine, didn't care if it interacted with her other medications, and would do it if she wanted. She admitted to smoking crack cocaine on the smoking patio. On 7/10/24 at 4:49 p.m., during an interview AR-C stated R6 was on the patio smoking crack and was known to go to a nearby hospital, "Hustling people for money." AR-C stated she requested supervised outings for R6 but was told there was no staff or family to take R6 out. AR-C stated R6 was deemed a safe cigarette smoker, but was not assessed for smoking illicit drugs on the patio, "It is not safe for other residents on the patio." AR-B stated other residents were trying to stay drug-free and using drugs, marijuana, or crack on the patio near them could trigger relapse to using again.	F 689		

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 07/29/2024

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 689	Continued From page 13 Additionally, AR-C stated administrative staff was aware of many marijuana users in the facility. AR-C stated R6 got drugs from the shelter where he used to live and wanted to go back to R6 for that reason. AR-C further stated other residents were trying to maintain sobriety, and could be triggered to use drugs again if others were using drugs around them. On 7/25/24 at 9:25 a.m., during a subsequent interview AR-C stated the facility had no interventions in place to prevent drug use and further stated all she was allowed to do was re-educate the residents about it. The administration identified on 7/25/24, at 12:05 p.m. identified they had approximately 20 current residents who had a history of drug abuse and were potentially at risk for relapse for drug abuse. Although the facility was aware R1 and R6, were smoking and using illicit drugs in which broken crack pipes were found in R1's room and staff were aware this was occurring. The facility had not assessed or monitored these resident for potential life-threatening side effects and drug interactions when using these drugs. In addition the facility had not implemented interventions to mitigate the risk of residents purchasing and bringing these drugs back to the facility even though the facility identified approximately 20 residents in their facility had a history of drug abuse and were potentially at risk for a relapse. The facility's Substance Use Policy dated 6/23 directed due to negative health side effects from mixing some prescribed medications with alcohol	F 689		

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 07/29/2024

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 689	Continued From page 14 and/or illegal substances, a resident who the facility has a reasonable suspicion or believe has been using alcohol or illegal substances will be subject to the policy. The policy directed illegal or illicit non-prescribed substances or paraphernalia were not allowed on the facility premises. The policy directed care plans should include risks of leaving the facility without notification, signs and symptoms of use, and risk of overdose. The policy further directed staff to review medication administration records and orders for medications that are contraindicated with substance use, call physician or NP, and document notification. The policy directed social services staff would revise the resident plan of care focus for Substance Use and Disorders. The policy lacked direction to notify the pharmacist of suspected or known drug use. The immediate jeopardy that began on 7/6/24, was removed on 7/26/24 at 5:00 p.m., when the facility updated R1's orders and the care plan was updated to include monitoring and reflect history and use of smoking marijuana and substances. R1 was educated on the risks and benefits of substance use and re-educated on the substance use policy. Additionally R1's physician and pharmacy consultant were notified of R1's substance use and like residents were reviewed to ensure orders were in place, care plans updated, providers and pharmacist were notified and the risk versus benefits completed. Additionally, staff education was completed on signs of intoxication and how to respond along with notification to the hospice provider. This was verified through observation, interview and document review.	F 689		

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 _____	07/29/2024

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) 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 7/9/24, 7/10/24, 7/25/24, 7/26/24 and 7/29/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure.	2 000		

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 _____	07/29/2024

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) COMPLETE DATE
2 000	Continued From page 1 The following complaints were reviewed during the survey: The following complaints were reviewed: H52955142C (MN00104456) H52954730C (MN00104199) H52955464C (MN00104698) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		