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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
August 5, 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 July 19, 2024, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On July 19, 2024, the situation of immediate jeopardy to potential health and safety cited at F695 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

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

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of

payment for new admissions is effective August 20, 2024, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 20,2024, (42 CFR 488.417 (b)).

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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 19, 2024. This prohibition is not subject to appeal. 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.

If you have not achieved substantial compliance by August 20, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Emeralds At St Paul Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 20, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80

Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require 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 Sections 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.

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 "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, Licensing and Certification Program 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 DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to

conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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://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 5, 2024

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

Re: Event ID: NJP811

Dear Administrator:

The above facility survey was completed on July 19, 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 07/19/2024

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 7/15/24 to 7/19/24, 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 complaint was reviewed: H52955720C (MN00104841) with a deficiency issued at F695 and F838. The survey resulted in an Immediate Jeopardy (IJ) at F695 when the facility failed to timely respond to ventilator alarms for 1 of 3 residents (R1) when R1's ventilator alarmed intermittently on 7/11/24 from 3:19 a.m. to 5:47 a.m., 237 times. The alarms indicated high pressure in the ventilator or an obstruction in the ventilation system. The IJ began on 7/11/24, and the immediacy was removed on 7/19/24. The above findings constituted substandard quality of care, and an extended survey was conducted from 7/18/24 to 7/19/24. 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	F 000		

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

Electronically Signed | 08/14/2024

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 000	Continued From page 1	F 000		
	regulations has been attained.			
F 695 SS=J	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to timely respond to ventilator alarms for 1 of 3 residents (R1) reviewed for response to ventilator alarms. This resulted in an immediate jeopardy (IJ) for R1 when R1's ventilator alarmed intermittently on 7/11/24 from 3:19 a.m. to 5:47 a.m., 237 times, for an alarm that indicated high pressure in the ventilator or an obstruction in the ventilation system. The IJ began on 7/11/24 at 3:19 a.m., when R1's ventilator alarmed intermittently on 7/11/24, 237 times between 3:19 a.m., and 5:47 a.m., without staff response. The director of nursing (DON), facility owner, and senior nurse consultant were notified of the IJ on 7/18/24 at 1:31 p.m. The IJ was removed 7/19/24 at 2:28 p.m., but noncompliance remained at the lower scope and severity level of a D which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:	F 695	R1 remains at the facility. R1 remains medically stable with no respiratory distress. R1’s care plan was reviewed and updated to reflect ventilator-dependent when asleep. R1’s ventilator alarm has been appropriately responded to. Full house audit was completed with like residents who require ventilator support, and all maintain their health status baseline and no signs of respiratory distress. Respiratory Therapy Policy reviewed and remained current. Education initiated with RN, LPN, Nurse	8/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 695	Continued From page 2 R1's face sheet, undated indicated R1 admitted to the facility with diagnosis of chronic respiratory failure and dependence upon a ventilator when she is sleeping. R1's quarterly Minimum Data Set dated 6/18/24, indicated R1 was moderately cognitively impaired. R1's care plan dated 12/19/23 indicated R1 had chronic respiratory failure with ventilator dependence. The interventions included monitor for cyanosis, shortness of breath, increased respirations, and difficulty coughing up sputum. The care plan indicated R1 was ventilator-dependent related to chronic respiratory failure, but lacked mention R1 was ventilator-dependent only when asleep. R1's Physician's Orders dated 12/16/23, indicated R1 used a ventilator with oxygen to keep oxygen saturations greater than 90%. R1's ventilator report for 7/11/24 from 3:19 a.m. to 5:47 a.m., indicated R1's ventilator alarmed for high inspiratory pressure. The ventilator alarm self-corrected for most of the alarms without measuring the number of seconds the ventilator alarmed. The ventilator report indicated alarm times were lengthier than a few seconds and identified the following: At 4:07 a.m., the ventilator alarmed for 114 seconds. At 4:10 a.m., the ventilator alarmed for 115 seconds. At 4:13 a.m., the ventilator alarmed for 81 seconds.	F 695	Managers, Respiratory Therapist and NAR's who work the vent unit regarding procedure for ventilator response to alarms specific to the outside alarm box being "ON", answering alarms, assessing resident, equipment malfunction, utilization of walkie talkies, etc. Staff education occurs prior to the start of their assigned shift until completed. 3 Audits of ventilator alarm responses continue per removal plan of weekly x 4 weeks, then monthly x 2 months, then PRN depending on audit results. Audits specific to outside alarm being "ON", resident utilizing vent, and vent alarm times. QAPI will review audit results and recommend continued audit schedule. Respiratory Therapist/Designee is responsible party.	

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F 695	Continued From page 3 At 4:16 a.m., the ventilator alarmed for 141 seconds. At 4:20 a.m., the ventilator alarmed for 785 seconds (13 minutes). At 4:38 a.m., the ventilator alarmed for 695 seconds (11 minutes). At 4:57 a.m., the ventilator alarmed for 1288 seconds (21 minutes). At 5:19 a.m., the ventilator alarmed for 92 seconds. At 5:33 a.m., the ventilator alarmed for 82 seconds. At 5:40 a.m., the ventilator alarmed for 339 seconds (5 minutes). At 5:47 a.m., the ventilator alarmed for 566 seconds (9 minutes). At 5:59 a.m., the ventilator was disconnected as R1 was up for the day. On 7/15/24 at 12:05 p.m., R1's family member (FM)-A stated a video indicated R1's ventilator alarmed on 7/11/24 from approximately 3:00 a.m., to about 6:00 a.m. without staff attention. On 7/15/24 at 4:47 p.m., respiratory therapist (RT)-A stated R1 required a ventilator at night because of her weight and her chronic respiratory failure. If a ventilator alarmed for high ventilator pressure, staff should check on the resident as it could mean the ventilator was obstructed with a mucus plug, the resident was not able to breathe, or was in respiratory distress. "Every alarm should be treated as an emergency." The facility was not doing audits on ventilator alarms nor on how long staff took to respond to each of the alarms. She was not aware R1's alarms were not answered. The RT department checked the ventilator settings	F 695		

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F 695	Continued From page 4	F 695		

every working shift and reviewed the alarm settings.

On 7/16/24 at 10:13 a.m., licensed practical nurse (LPN)-A stated she worked on 7/11/24, night shift and was assigned to R1. If a typical ventilator patient's alarm went off it was an emergency, but not R1, as she was more stable than the rest of the ventilator residents. If R1's was going off for 10 minutes, it was not an emergency, but staff should still check on her. At 12:48 p.m., LPN-A stated there were times she could not hear alarms if she was working on other hallways. LPN-A acknowledged she didn't check R1's alarms on 7/11/24 and had worked other times with only two nurses but was unable to identify dates.

During a subsequent interview on 7/17/24 at 11:12 a.m., LPN-A stated on 7/11/24, during the night there was a new admission, and all four working staff were in that resident's room together. She was sure she heard alarms that night when she was walking down the hall, but there were other alarms going off too, and there were only two nurses working that night. No one told her R1's alarm was going off. "I don't know what happened that night. Maybe other residents were more critical."

On 7/16/24 at 10:33 a.m., the director of nursing (DON) stated a ventilator should not alarm for greater than 10 minutes without staff looking at it, as the resident could die. Other staff didn't hear the alarm going off for so long.

On 7/16/24 at 11:28 a.m., registered nurse (RN)-B stated if a ventilator alarmed more than 5 minutes

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F 695	Continued From page 5	F 695		

the resident would be in respiratory distress, and more than 10 minutes, the resident could be deceased. If a ventilator alarmed, it should be assessed. He did not respond to R1's alarms on 7/11/24, as R1 was assigned to LPN-A.

On 7/16/24 at 11:55 a.m., nurse practitioner (NP)-A stated R1 required nocturnal ventilation related to obesity hypoventilation syndrome (a condition in which severely overweight people fail to breathe rapidly or deeply enough resulting in low oxygen levels and high carbon dioxide levels) and it was not feasible nursing staff didn't hear the alarms for hours.

On 7/16 24 at 1:57 p.m., R1 stated she did not know how long the ventilator alarms went off on 7/11/24, as she was asleep at the time.

On 7/16/24 at 2:21 p.m., RN-A stated he worked night shift on 7/11/24. He did not respond to R1's alarms as he was working with other residents, and R1 was assigned to LPN-A. At approximately 3:00 a.m. to 3:30 a.m., all four staff working that night were in one room with one resident who was in respiratory crisis. If R1 was sleeping when the ventilator alarmed, R1 might not know she was in respiratory trouble. There was a night, 7/14/24, he worked with 17 ventilated residents as was the only nurse on the floor for approximately four hours.

On 7/17/24 at 11:28 a.m., during a subsequent interview the DON stated the facility had 15 ventilator-dependent residents on 7/11/24, who required two nurses and two nursing assistants for care, but would staff three nurses for 16

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	245295	A. BUILDING _____ B. WING _____	C 07/19/2024

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F 695	Continued From page 6 ventilator-dependent residents. The DON stated with fewer than 16 ventilator-dependent residents two nurses was enough and safe. The facility had not reviewed ventilator alarm response times prior to this incident, there was no policy for answering ventilator alarms, and he did not know the ventilator-dependent residents were not mentioned in the acuity section of the facility assessment. On 7/17/24 at 11:51 a.m., RT-B stated if a ventilator alarm persisted to go off, staff should investigate. If a ventilator alarmed for 11 minutes, R1 was not getting the required air volume, and R1 would not be getting enough air to the lungs. A single high-pressure alarm could indicate a cough, but, "No one coughs for two and half hours." There was an alarm for 1288 seconds, or 21 minutes, and staff should have checked to see what was going on. There were codes on R1's ventilator report which indicated the alarm escalated to three higher levels, indicating more emergent need because the alarms were not answered timely. He spoke to the DON on 7/15/24 about R1's alarms, and the DON told him staff might have been in another room. On 7/18/24 at 12:39 p.m., RT-B stated he did not think the machine malfunctioned on 7/11/24, "The alarms are there for a reason." The Facility Assessment dated 11/22/23, indicated the acuity of the residents was based upon the activities of daily living (ADLs) of each resident, and whether the resident was independent, required the assistance of 1-2 staff for assistance, or was fully dependent upon staff for ADL assistance. Additionally, the FA identified resident mobility as a measure of acuity based upon whether the resident was independent, required an	F 695		

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F 695	Continued From page 7 assistive device, or was, "In a chair most of the time." The FA lacked ventilator-dependent resident consideration to determine resident acuity. The Respiratory Therapy Policy dated 5/20/2, directed respiratory therapy services were for the assessment, treatment and monitoring of patients with deficiencies or abnormalities of pulmonary function. Respiratory therapy services included coughing, deep breathing, nebulizer treatments, assessing breath sounds, and mechanical ventilation which must be provided by a respiratory therapist or trained respiratory nurse. The policy stated a respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws. The policy stated nurses who performed respiratory therapy services would complete competencies for pre-assessment/evaluation of respirations and lung sounds, set up, administration and clean-up of nebulizer and post-assessment/ evaluation of respirations and lung sounds. The policy did not address how staff should manage ventilator alarms. A ventilator policy was requested, but not provided. The immediate jeopardy that began on 7/11/24, was removed on 7/19/24, after it was verified nursing staff and respiratory therapists were educated about the policies and procedures for ventilator care and response to ventilator alarms, with the expectation staff would answer ventilator alarms within two minutes. R1's care plan was	F 695		

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F 695	Continued From page 8 reviewed and updated to ensure her ventilator needs were identified. The facility ordered walkie talkies to ensure timely access to assistance from other units' staff as needed. Facility staff was educated to ensure one staff was always available to monitor ventilator alarms. A third nurse was added to third shift to ensure adequate nurse to resident care ratios. Audits for response to ventilator alarms were implemented. The noncompliance remained at the lower scope and severity level of a D-isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm, that is not immediate jeopardy.	F 695		
F 838 SS=E	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions,	F 838		8/19/24

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F 838	Continued From page 9 physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an	F 838		

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F 838	Continued From page 10 all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify in the facility assessment (FA) protocol related to the acuity for day-to-day operations and for emergencies for fifteen ventilator-dependent residents. Additionally, the facility failed to review the FA annually. Findings include: Review of the facility assessment tool dated 11/22/23, indicated the acuity of the residents was based upon the activities of daily living (ADLs) of each resident, whether the resident was independent, required the assistance of 1-2 staff, or was fully dependent upon staff for ADL assistance. Additionally, the FA identified resident mobility as a measure of acuity based upon whether the resident was independent, required an assistive device, or was, "In a chair most of the time." The FA lacked ventilator-dependent residents in the consideration to determine resident acuity. On 7/17/24 at 11:28 a.m., during an interview the director of nursing (DON) acknowledged the FA lacked mention of the ventilator-dependent residents in the acuity section. The DON further stated the staffing for the second floor, where the vent-dependent residents lived, required two nurses during the night shift, but staffing would increase to three nurses if there were 16 residents with ventilators. 7/18/24 at 5:02 p.m., during an interview the regional nurse consultant. (RNC) stated she was	F 838	F838 Facility assessment has been updated to reflect day to day operations of acuity to staffing and reviewed. Facility Administrator educated to Facility Assessment regulation specific to annual review/revisions and acuity for day-to-day operations specific to ventilator unit. Facility will audit annually for facility review and revisions as needed along for accuracy. QAPI will review audit results and recommend continued audit schedule. Administrator/Designee is responsible party.	

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F 838	Continued From page 11 not aware the facility assessment didn't contain acuity for the vent-dependent residents and was not aware the FA was not reviewed annually.	F 838		

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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: From 7/15/24 to 7/19/24, 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 order(s)	2 000		

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2 000	Continued From page 1 (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed. H52955720C (MN 00104841) with a licensing order issued at 0240. 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	2 000		

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2 000	Continued From page 2 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 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		