



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 8, 2024

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

RE: CCN: 245295
Cycle Start Date: May 23, 2024

Dear Administrator:

On July 2, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

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



Protecting, Maintaining and Improving the Health of All Minnesotans

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July 8, 2024

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

Re: Reinspection Results
Event ID: NCJ212

Dear Administrator:

On July 2, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 23, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'M. Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 7, 2024

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

RE: CCN: 245295
Cycle Start Date: May 23, 2024

Dear Administrator:

On May 23, 2024, a survey was completed at your facility by the Minnesota Departments 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Nathan Schreier, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: nate.schreier@state.mn.us
Office: (651) 201-4348 Mobile (651) 392-2726

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 23, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 23, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the

The Emeralds At St Paul LLC

June 7, 2024

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dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2024
NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT ST PAUL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
E 000	Initial Comments On 5/20/24 -5/23/24 a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 5/20/24 - 5/23/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was IN NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52953776C (MN00101605) H52953774C (MN00101095) H52953775C (MN00101043) H52953778C (MN00100614) 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	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/13/2024

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			
F 554 SS=D	validate substantial compliance with the regulations has been attained. Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to perform a self-administration of medication assessment and obtain provider order to have medication left in room and self-administered for 1 of 1 (R46) resident reviewed for self-administration of medication. Findings included, R46's quarterly Minimum Data Set (MDS) assessment dated 2/26/24, indicated R46 was cognitively intact. Diagnoses included renal insufficiency5 diabetes, and Asthma. R46's care plan undated, indicated R46 chose to self-administer Arnuity Ellipta Aerosol Powder Breath Activated 200 MCG/ACT (Fluticasone Furoate) and PRN Proventil HFA Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate HFA). All other medication would be administered by nursing. R46's Self Administration of Medication Evaluation form dated 5/25/23 indicated R46 was approved to self-administer inhalation meds-meds taken orally by breathing in the	F 554	F554 – Resident Self-Admin Meds-Clinically Appropriate R46 had a new self-administration assessment completed to reflect ability to self-administer Sarna lotion, along with provider order to leave medication at bedside. R46's care plan reviewed and updated. All like-residents who self-administer medications have had self-administration assessments completed and provider orders reviewed to have medication left in room. All like-residents have the potential to be affected by this deficient practice. DON or designee to reeducate appropriate staff on self-administration of medications, self-administration assessments and to update provider orders to allow medications to be left in room. DON or designee to conduct audits weekly times 4 weeks, then monthly times 2 months.		6/30/24

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F 554	Continued From page 2 medication. R46's Order Summary dated 5/23/24 indicated an order written on 8/15/23 okayed R46 to self-administer inhalation medications. During an observation on 5/20/24 at 3:38 p.m., R46's had a bottle of Sarna lotion on the window seal, next to the bed. A follow up observation on 5/22/24 at 2:36 p.m., the bottle of Sarna lotion was still on window seal. During an interview on 5/22/2024 at 2:37 p.m., licensed practical nurse (LPN)-A, if a resident was approved for meds at bedside and self-administer then there would be a notification in the medication administration record (MAR) letting staff know. LPN-A confirmed R46's Sarna lotion was kept at bedside and used for the daily orders. LPN-A reviewed the MAR and reported there was nothing in the MAR that showed R46 could keep and self-medicate the Sarna lotion. LPN- A then walked down a different hallway, opposite the direction of R46. During an interview on 5/23/24 at 11:32 a.m. the pharmacy consultant stated they were unsure what requirements were needed for a resident to self-administer medication and keep it at bedside. During an interview on 5/23/24 at 11:59 a.m., registered nurse (RN)-A stated if medications were to be left at resident bedside there needed to be a self-administration of medication assessment (SAM) and a provider order to leave at bedside. RN-H stated R46 did not have a SAM or orders to self-administer or leave Sarna lotion at bedside.	F 554	Audit findings to be brought to QAPI for further review and recommendations.		

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F 554	Continued From page 3 During an interview on 5/23/24 at 2:00 p.m., the director of nursing (DON) stated and expectation the nurse would observe the medications given to R46 and then would return the medications to the medication cart unless a SAM and order were in place. Facility policy Self-Administration of Medication last revised 2/24, indicated a resident could self-administer medication if the SAM determined that self-administration was clinically appropriate.	F 554			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		6/30/24	

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F 580	Continued From page 4 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a physician was notified of elevated blood glucose results for 1 of 1 resident (R20) reviewed who had specific physician's orders with parameters for physician notification of high blood glucose results. Findings Include: R20's admission Minimum Data Set (MDS) dated 2/28/24, indicated R20 was cognitively intact, did not exhibit rejection of care during the assessment period, and diagnosis included	F 580	F580 – Notify of Changes (Injury/Decline/Room, etc.) (BG results) R20's blood glucose parameters have been reviewed and updated per physicians' orders. R20's care plan and updated. All like-residents blood glucose parameters have been reviewed and updated per physicians' orders. All like-residents have the potential to be affected by this deficient practice.		

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F 580	Continued From page 5 diabetes mellitus and peripheral vascular disease. R20 also received insulin seven days during the assessment period. R20's care plan printed 5/22/24, indicated a focus for potential for alteration in blood sugar related to diagnosis of diabetes with history of refusing blood sugar checks, and medications. Goals included R20's blood sugar would be maintained between 60 and 120. Interventions included resident and family education provided and to monitor resident for signs/symptoms of hyperglycemia and hypoglycemia. R20's face sheet printed 5/22/24, indicated R20's diagnosis included type 2 diabetes mellitus with ketoacidosis without coma and epilepsy without status epilepticus (a seizure with 5 minutes or more of continuous clinical and/or electrographic seizure activity or recurrent seizure activity without recovery between seizures). R20's physician order dated 5/3/2024, indicated blood sugars: notify nurse practitioner or physician if two blood glucose results are <75 or >350 in a 24 hour period and/or condition change, before meals and at bedtime related to related to type 2 diabetes mellitus with ketoacidosis without coma. R20's medication administration record (MAR) for 5/2024, indicated the following blood glucose readings: 5/9/24, evening blood glucose result was 594. 5/10/24, evening blood glucose was 450; bedtime blood glucose was 418. 5/11/24 evening blood glucose was 420; bedtime blood glucose was 460.	F 580	DON or designee to reeducate appropriate staff on notification of provider with changes in blood glucose. DON or designee to conduct audits weekly times 4 weeks, then monthly times 2 months. Audit findings to be brought to QAPI for further review and recommendations.		

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F 580	Continued From page 6 5/12/24, evening blood glucose was 368. 5/13/24 morning blood glucose was 440; evening blood glucose was 385. 5/14/24, morning blood glucose was 387; evening blood glucose was 591; and bedtime blood glucose was 369. 5/15/24, night blood glucose was 375. 5/16/24, evening blood glucose was 400 and bedtime blood glucose was 400. 5/17/24, morning blood glucose was 393; evening blood glucose was 434. 5/18/24, morning blood glucose was 357; evening blood glucose was 450; and bedtime blood glucose was 436. 5/20/24, evening blood glucose was 482. 5/21/24, evening blood glucose was 400. R20's progress notes dated 5/9/24, indicated BG >500, 5 units one time given per nurse practitioner (NP). R20's progress notes lacked documentation the physician was updated on the other dates indicated above, when R20's blood glucose results were elevated. R20's physician regulatory visit progress notes dated 5/17/2024, indicated type 2 diabetes mellitus with other circulatory complications. Multiple diabetic ketoacidosis (DKA, a life-threatening problem that affects people with diabetes. It occurs when the body starts breaking down fat at a rate that is much too fast. The liver processes the fat into a fuel called ketones, which causes the blood to become acidic) episodes: 12/26/23, 1/15/24, and 2/18/24. Also, with hypoglycemic episode on 4/7/24. Endocrinology was consulted.	F 580			

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F 580	Continued From page 7 R20's physician progress notes printed 5/24/24, indicated R20 was hospitalized 2/18/2024 - 2/22/2024, for evaluation of elevated blood sugar. During interview on 5/22/24 at 8:23 a.m., nurse manager, registered nurse (RN)-A stated R20 refused cares and medications often, however staff should have notified the provider with blood glucose results that were elevated per the physician orders. RN-A explained the facility utilized the nursing agency on the evening shift often and as a result the physician notification was not being completed for R20. RN-A also clarified as the nurse manager they were responsible to monitor R20's elevated glucose level and to ensure physician was updated per R20's physician order. R20's nurse practitioner was called on 5/22/24 at 8:48 a.m., with message left with answering service staff, however a return call was not received. During interview on 5/22/24 at 1:55 p.m., the director of nursing (DON) stated nursing staff should have notified the provider per the physician order with R20's elevated blood glucose results. DON further clarified that the agency staff also viewed the providers' orders when they on duty and were expected to follow the physician orders as prescribed. The facility policy on physician notification was requested but not received.	F 580			
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment.	F 584			6/30/24

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F 584	Continued From page 8 The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.	F 584			

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F 584	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a homelike environment for 1 of 1 residents (R65) reviewed who had enteral feeding liquid spilled on the bottom of the tube feeding pump pole and on the floor. Findings include: R65's significant change Minimum Data Set dated 3/13/24, included R65 was severely cognitively impaired, dependent on staff for all activities of daily living, had a diagnosis of traumatic brain injury, and indicated they had a feeding tube through which they received more than 50% of their nutrition. During observation and interview on 5/20/24 at 2:13 p.m., R65 was lying in bed in their room with tube feeding running and their representative present. The tube feeding pump was attached to a pole, the base of which was covered in more than 50 drips of tube feeding liquid nutrition. The floor under the base of the pole had an area approximately 12 inches by 6 inches covered in tube feeding liquid. R65's representative stated the tube feeding "mess" bothered them and they were frustrated by the lack of cleanliness. During observation on 5/21/24 at 9:30 a.m., and 2:29 p.m., the tube feeding pump pole and floor were soiled as previously described. During interview on 5/21/24 at 2:32 p.m., licensed practical nurse (LPN)-B stated housekeeping staff cleaned the floor daily, but if nurses spilled something they cleaned it up at that time. They	F 584	F584 ☐ Safe/Clean/Comfortable/Homelike Environment R65's tube feeding equipment was inspected and cleaned. R65's care plan was updated to reflect appropriate tube feeding equipment being cleaned and who is to perform what at what time. All like-residents have had their tube feeding equipment inspected and cleaned. All like-all residents care plans with tube feedings on cleaning practices and, who is to perform what at what time Housekeeping Manager or designee to reeducate appropriate staff on tube feeding equipment cleanliness. Housekeepers were re-educated that they need to check and clean feeding tube equipment daily. Housekeeping Manager or designee to conduct audits weekly times 4 weeks, then monthly times 2 months. Audit findings to be brought to QAPI for further review and recommendations.		

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F 584	Continued From page 10 stated if they noticed the tube feeding equipment was not clean, they would clean it themselves. During interview on 5/21/24 at 2:50 p.m., housekeeper (HSK)-A stated housekeeping cleaned floors in the residents' rooms five days per week, and they had just finished R65's room, however housekeepers was not responsible for cleaning the poles. During interview on 5/21/24 at 3:01 p.m., registered nurse (RN)-C stated housekeeping cleaned the floors and the poles because they used a special spray to help remove any stuck-on substances. RN-C viewed the floor and tube feeing pump pole in R65's room, verified they needed to be cleaned, and indicated they would not leave it in that state in their own home. During interview on 5/22/24 at 12:56 p.m., director of nursing stated staff should ensure the pole and floor are clean each time they change the feeding equipment, and if they could not remove any soiled areas, notify housekeeping. They expected spills to be cleaned, and indicated the drips and spills were not conducive to a homelike environment. In an email dated 5/22/24, the administrator indicted the facility did not have a policy regarding homelike environment or cleaning of resident equipment.	F 584			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656			6/30/24

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F 656	Continued From page 11 care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged	F 656			

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F 656	Continued From page 12 by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive resident-centered care plan with resident-specific target symptom monitoring and resident-specific interventions for 1 of 5 residents (R72) reviewed for unnecessary medications. Findings include: R72's quarterly Minimum Data Set (MDS) dated 4/25/24, indicated R72 had an absence of spoken words, was rarely or never understood, and sometimes understood others. MDS indicated R72 was dependent on staff for all activities of daily living (ADLs). MDS indicated R72 had non-traumatic brain dysfunction, respiratory failure with a tracheostomy (a surgical airway created in the windpipe as an alternative method for breathing), and depression. R72's MDS indicated she had no hallucinations, no delusions and had exhibited no verbal or physical behaviors. R72's MDS indicated she received an antidepressant medication. R72's Care Area Assessment (CAA) for cognitive loss and dementia dated 10/24/23, indicated she had moderate cognitive impairment. R72's Care Area Assessment (CAA) for psychosocial well-being dated 10/24/23, indicated she had moderate depression as evidenced by her score on an assessment scale for depression. The CAA indicated R72 reported difficulty with sleep and feeling tired. The CAA	F 656	F656 – Develop/Implement Comprehensive Care Plan (psychotropics, target behavior monitoring) R72's comprehensive care plan reviewed and updated to reflect resident-specific target symptom monitoring and resident-specific interventions for unnecessary medications. All like-residents to have care plan reviewed and updated to reflect resident-specific target symptom monitoring and resident-specific interventions for unnecessary medications. All like-residents have the potential to be affected by this deficient practice. Social Services or designee to reeducate appropriate staff on resident-specific target symptom monitoring and interventions for unnecessary medications. Social Services or designee to complete audits weekly times 4 weeks, then monthly times 2 months. Audit findings to be brought to QAPI for further review and recommendations.		

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F 656	Continued From page 13 indicated R72 declined additional services offered by the facility, including psychological services. R72's CAA for mood dated 10/24/23, was triggered but lacked additional data. The CAA lacked documentation of R72's specific target symptoms staff would monitor and failed to identify what, if any, non-pharmacological interventions were effective. No CAA for psychotropic medication use was triggered. R72's orders included the following: - Sertraline hydrochloride (HCl) oral tablet (Zoloft); Give 100 mg via gastrostomy (G)-Tube in the morning for depression, dated 2/16/24. - Target Behavior Monitoring (Specify Target Behaviors): Non-Pharmacological, Document # of those Interventions used: 0: N/A, 1: Redirection, 2: Ambulate, 3: Offer Activity, 4: Essential Oils, 5: Reposition, 6: Toileting, 7: Provide 1:1, 8: Offer food/fluids, 9: Offer pain relief every shift for Offer prior to PRN Psychotropic medications If Target Behavior was observed. Select chart other and enter findings in the Nursing Progress Notes. Dated 5/22/24. - Target behavior monitoring (specify target behaviors): Non-pharmacological, Document # of those Interventions used: 0: N/A, 1: Redirection, 2. Provide re-assurance, 3: Offer Activity, 4: Essential Oils, 5: Reposition, 6: Provide 1:1, 7: Offer pain relief. Dated 5/23/24. R72's treatment administration record (TAR) for May 2024 revealed no behavior monitoring was documented for 5/1/24 through 5/22/24.	F 656			

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F 656	Continued From page 14 R72's care plan dated 10/19/23, indicated she had an alteration in her mood and behavior related to her respiratory failure and depression. The care plan indicated she was prescribed the medication sertraline and identified a goal of responded to interventions by staff to calm and redirect. Interventions included medications per provider order, inform the provider of changes in R72's mood state, approach R72 in a calm manner and provide her with choices as able, and remove from crowded area if she becomes anxious. The care plan also identified R72's alteration in psychosocial well-being related to her depression and respiratory failure. The care plan identified interventions of explaining new routines and tasks to avoid confusion and monitoring for changes in her mood to meet R72's psychosocial needs. The care plan also identified R72's potential for adverse drug reactions related to her daily use of psychotropic medication dated 2/8/24. The care plan lacked resident-specific target symptom monitoring and resident-specific interventions, including non-pharmacologic interventions. A behavior monitoring log dated 4/29/24 - 5/28/24, revealed documentation of either "none noted" or "not applicable" for the entirety of the 30-day lookback period. The behaviors identified on the monitoring log lacked resident-specific target symptoms. A review of progress notes dated 1/22/24 - 5/22/24 lacked documentation of behaviors or interventions. A review of the nursing assistant care sheet lacked documentation of R72's target symptoms	F 656			

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F 656	Continued From page 15 or behaviors and resident-specific interventions or non-pharmacologic interventions, unless contraindicated. During interview on 5/23/24 at 11:08 a.m., registered nurse (RN)-D stated for residents receiving psychotropic medications, there is a spot to document behaviors on the TAR. RN-D was unable to locate any target behaviors for R72 in her TAR. RN-D stated nurses could also document behaviors in a progress note. RN-D stated behaviors R72 exhibited included grimacing, flushing of the face, and rapid breathing. During interview on 5/23/24 at 11:23 a.m., RN-C stated for residents taking psychotropic medications, the documentation requirements would be listed in the resident's TAR. RN-C stated if a staff person was documenting an intervention in the TAR, there would be a prompt to re-evaluate and document the effectiveness. RN-C stated the expectation for nurses was to document on the TAR and for nursing assistants (NA) to report back to their charge nurse. RN-C stated non-pharmacologic interventions should be documented in the TAR and stated they should be listed on the NA care sheets. During interview on 5/23/24 at 1:26 p.m., the director of nursing (DON) stated residents on psychotropic medications were expected to have resident-specific interventions and symptom monitoring in place if they were receiving psychotropic medications. Furthermore, the DON stated staff were expected to documented behaviors and whether interventions were effective.	F 656			

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F 656	Continued From page 16 A facility policy titled Psychotropic Medication Use dated 7/28/21, indicated psychotropic medications included antidepressants, anti-anxiety mediations, stimulants, antipsychotics, mood stabilizers and other medications. The policy indicated the interdisciplinary team and the primary provider would gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. The policy guided the interdisciplinary team and the provider to identify, evaluate and document symptoms that may warrant the use of psychotropic medications as well as pertinent non-pharmacological interventions that must be attempted, unless contraindicated, and documented.	F 656			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review the facility failed to ensure diagnostic standards of practice were followed for 1 of 1 resident (R24) who was newly diagnosed with schizophrenia. Findings include: The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) guidelines dated 2013, identified to be diagnosed with schizophrenia, a	F 658	F658 ☐ Services Provided Meet Professional Standards (DX: Schizophrenia) R24 has supporting documentation related to newly diagnosed Schizophrenia. Care plan has been reviewed and updated. R24 was seen in-person by a licensed medical provider (Psychiatrist), evaluated,		6/30/24

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F 658	Continued From page 17 person must have two or more of the following symptoms occurring persistently in the context of reduced functioning: delusions, hallucinations, disorganized speech, disorganized or catatonic behavior, and negative symptoms. Additionally, continuous symptoms should have persisted for at least six months including one month of active phase symptoms listed above. The National Alliance on Mental Illness (NAMI) schizophrenia information page dated 2024, identified although schizophrenia could occur at any age, the average age of onset tended to be in the late teens to the early 20s for men, and the late 20s to early 30s for women. It was uncommon for schizophrenia to be diagnosed in a person younger than 12 or older than 40. R24's face sheet dated 5/23/24, identified age of 77 years and a diagnosis of schizophrenia added on 5/2/24. R24's annual Minimum Data Set (MDS) dated 3/5/24, identified severely impaired cognition, no behaviors, psychosis, or rejection of care. Diagnoses included bipolar disorder in full remission and non-Alzheimer's dementia. R24 required total dependence with transfers, extensive assistance with bed mobility, and was independent with eating after set-up. No diagnosis of schizophrenia was identified on the MDS. R24 took an antipsychotic medication daily. R24's previous quarterly MDS's dated 12/6/23, 9/6/23 and 6/6/23, identified no behaviors, psychosis, or rejection of care and no diagnosis of schizophrenia. R24's mood state Care Area Assessment (CAA)	F 658	assessed, and a plan was developed meeting criteria and a Dx of schizophrenia. On 05/23/2024, Dr. Floyd Anderson, Psychiatrist with ACP, provided a letter to the facility supporting R24's diagnosis of Schizophrenia through clinical assessment and and chart review. All like-residents who have a diagnosis of Schizophrenia care plan and documentation to ensure there is diagnostic standards of practice. All like-residents have the potential to be affected by this deficient practice. MDS Nurse or designee to reeducate appropriate staff regarding supporting documentation related to newly diagnosed Schizophrenia. MDS Nurse or designee to conduct weekly audits times 4 weeks, then monthly times 2 months. Audit findings to be brought to QAPI for further review and recommendations.		

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F 658	Continued From page 18 dated 3/5/24, identified the Patient Health Questionnaire (PHQ-9) was completed with a score of 10/27 which indicated moderate depression. R24's mood was affected by acute illness and room change. R24 had diagnoses of dementia, mood disorder, and bipolar disorder. R24 had scheduled Seroquel (antipsychotic medication) daily and participated in group activities. R24's psychotropic medication CAA dated 3/5/24, identified a potential for adverse effects from Seroquel 50 milligrams (mg) three times daily (TID), and escitalopram (antidepressant medication) 30 mg daily related to bipolar disorder. R24 had not shown any adverse effects of the medications. R24's care plan dated 1/19/24, identified a risk for alteration in mood and behavior related to diagnoses of dementia, behavioral disturbance, bipolar disorder, adjustment disorder with mixed and depressed mood. Target behaviors included anxiety as evidenced by distracted thoughts and fast speech. R24 needed constant reassurance from staff. R24 would occasionally not use her call light and instead would scream for help. R24 had a history of suicidal ideations thoughts of self-harm such as statements of "God take me now". Interventions included: provide emotional support, validation, and comfort measures as needed, keep call light within reach and answer promptly as this promoted reassurance. R24's order dated 6/13/23, identified Seroquel oral tablet, give 50 mg by mouth TID for dementia related to bipolar disorder in full remission, most recent episode manic.	F 658			

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F 658	Continued From page 19 R24's Consultant Pharmacy (CP) Recommendation to Physician form dated 2/26/24, identified clarification was needed due to diagnosis of dementia related to bipolar disorder, which was not considered an appropriate diagnosis for antipsychotic medication. Acceptable diagnoses may include schizophrenia/schizoaffective disorder/schizophreniform disorder, Tourette's disorder, or Huntington's disease, or attempt a gradual dosage reduction (GDR) if clinically appropriate. Medical doctor (MD)-A from Associated Clinic of Psychiatry (ACP) signed the form and schizophrenia/schizoaffective disorder/schizophreniform diagnosis was circled. Interview with MD-A was attempted on 5/22/24 at 10:36 a.m., and 5/23/24 at 8:38 a.m., with no return call received. R24's ACP Diagnostic Assessment dated 2/15/21, identified psychological testing was completed and bipolar disorder, current episode mixed, moderate, and adjustment disorder, with mixed anxiety and depressed mood were the diagnostic impressions. R24's ACP visit notes dated 12/14/23 through 5/2/24, lacked documentation of two or more of the symptoms of schizophrenia occurring persistently in the context of reduced functioning in accordance with DSM-5. R24's Follow Up Question Report (behavior documentation task) dated 1/23/24 through 5/22/24, lacked documentation of two or more of the symptoms of schizophrenia occurring persistently in the context of reduced functioning in accordance with DSM-5.	F 658			

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F 658	Continued From page 20 During an observation and interview on 5/20/24 at 4:42 p.m., R24 was seated in her wheelchair by the main entrance desk and well groomed. Various staff conversed with her as they walked by. R24 was smiling and in good spirits and displayed no behaviors. During an observation and interview on 5/21/24 9:09 a.m., R24 was in bed, well groomed, stated she was looking forward to bingo today. R24 was smiling and in good spirits and displayed no behaviors. During an observation on 5/22/24 at 10:30 a.m., R24 was up in her wheelchair, well groomed, and conversing politely with other residents and staff. R24 was smiling and displayed no behaviors. During an interview on 5/21/24 at 9:11 a.m., nursing assistant (NA)-C stated she worked with R24 routinely and the only behavior noted was not using the call light appropriately. Otherwise, R24 was easy to get along with and easily redirected. If behaviors occurred, they would be charted in the Follow Up Questions task. During an interview on 5/21/24 at 3:52 p.m., NA-B stated she worked with R24 routinely and her mood was stable, the behaviors she observed were not using call light appropriately and occasional crying, however she was easily redirected and had not interfered with preferred activities. If behaviors occurred, they would be charted in the Follow Up Questions task. During an interview on 5/22/24 at 10:17 a.m., registered nurse (RN)-A stated she worked with R24 routinely and knew her well. Behaviors	F 658			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page 21 included crying if her family had not called, however she was easily redirected with activities and R24 liked to be around people. RN-A stated R24's mood was stable. During an interview on 5/22/24 at 10:00 a.m., the social services designee (SSD) stated she worked with R24 routinely and knew her well. R24 had no persistent behaviors but was known to cry and might make a statement such as "God take me now", however was easily redirected with activities and 1:1. R24 especially liked bingo and could keep track with the game despite her dementia. During an interview on 5/23/24 at 10:10 a.m., the director of nursing (DON) stated resident behaviors were charted in ACP visit notes and Follow Up Questions. For appropriate diagnoses the facility would refer to providers, the CP would also make recommendations to ensure compliance with the Center for Medicare and Medicaid Services (CMS) regulations. The DON stated MD-A recently diagnosed R24 with schizophrenia, however, could not locate an assessment or rationale, only the CP form signed 5/2/24, with the diagnosis circled. The DON stated antipsychotics were considered a high-risk medication and required a thorough review. During an interview on 5/23/24 at 10:28 a.m., the facility medical director (MD)-B stated a person was not usually diagnosed with schizophrenia later in life such as age 77 and the diagnosis would usually go along with persistent delusions and hallucinations. MD-B would refer to a psychiatrist for appropriate assessment and diagnostic criteria.	F 658			

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F 658	Continued From page 22 During an interview on 5/23/24 at 11:31 a.m., the CP stated diagnostics were not her specialty, therefore she would refer that to the providers based off CMS standards. It was important to ensure antipsychotics were used for the essential indications. During an interview on 5/23/24 at 2:30 p.m., ACP therapist social services (SS)-A stated she worked with R24 for about one year and was familiar with symptoms of schizophrenia but had not observed any in R24. SS-A reviewed the medical record and stated R24 had some psychosis symptoms on 3/7/24, however it was ruled out by a urinary tract infection. R24's main symptoms were depressed mood related to bipolar disorder. On 5/28/24, a letter from MD-A dated 5/23/24, was provided which indicated a diagnosis of schizophrenia was made after an episode of paranoid psychosis which occurred "last month." Additionally, R24's diagnosis was bipolar 1 disorder, however, it appeared as if the paranoid psychosis was not due to an exacerbation of manic or depressive symptoms. The letter indicated schizoaffective disorder described R24's symptoms more accurately than bipolar 1 disorder. However, a review of R24's medical record lacked description of the described symptoms and in accordance with the DSM-5. The facility's undated policy titled Psychotropic Medication Use, identified the Interdisciplinary team and the primary provider would gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. Diagnosis of a specific condition for which	F 658			

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F 658	Continued From page 23 psychotropic medications were necessary to treat would be based on a comprehensive assessment of the resident. Antipsychotic medications should generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders (current or subsequent editions): a. Schizophrenia; b. Schizo-affective disorder; c. Schizophreniform disorder; d. Delusional disorder; e. Mood disorders (e.g. bipolar disorder, severe depression refractory to other therapies and/or with psychotic features); f. Psychosis in the absence of dementia; g. Medical illnesses with psychotic symptoms (e.g., neoplastic disease or delirium) and/or treatment-related psychosis or mania (e.g., high-dose steroids); h. Tourette's Disorder; i. Huntington Disease; j. Hiccups (not induced by other medications); or k. Nausea and vomiting associated with cancer or chemotherapy. l. Behavioral or psychological symptoms of dementia (BPSD) that present a danger to the resident or others. The facility policy had not matched the recommedations from the CP based on CMS regulations.	F 658			
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing	F 679			6/30/24

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F 679	Continued From page 24 program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident's preferred activities for individual entertainment were available for 1 of 2 residents (R64) reviewed for activities. Findings include: R64's annual Minimum Data Set (MDS) dated 10/30/23, identified he was rarely/never understood. No behaviors or rejection of care occurred. Diagnoses included traumatic brain injury and respiratory failure. The family interview identified it was very important to listen to preferred music and do preferred activities. R64's communication Care Area Assessment (CAA) dated 10/30/23, identified R64 rarely understood and had not spoken or used gestures due to a brain injury. R64 may have been able to hear staff voices but was not able to respond. R64's quarterly MDS dated 5/1/24, identified no behaviors or rejection of care. R64 was totally dependent on staff for all activities of daily living. R64's care plan dated 9/15/23, identified there was an alteration in socialization and potential for activity deficit. R64 was fully dependent on staff to anticipate his needs. Per family member (FM)-A,	F 679	F679 – Activities Meet Interest/Needs of Each Resident R64's therapeutic recreation care plan reviewed and updated to show current activity preferences. All residents preferred activities will be reviewed and care plan updated to reflect preferences. All residents have the potential to be affected by this deficient practice. Therapeutic Recreation Director or designee to reeducate appropriate staff on honoring residents activity preferences. Therapeutic Recreation Director or designee to conduct audits weekly times 4 weeks, then monthly times 2 months. Audit findings to be brought to QAPI for further review and recommendations.		

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F 679	Continued From page 25 R64 enjoyed listening to healing traditional Native American music and staff were directed to turn on the television (TV) in his room to listen to this and for programs of interest. R64's therapeutic recreation (TR) visit log dated 2/5/24 through 5/14/24, identified facetime calls were completed with R64 and FM-A, and identified when he was awake, emotional, happy, and sometimes cried. The logs lacked listening to healing traditional Native American music as an intervention. The TR log also indicated there was a sign in R64's room with music he liked. During an observation on 5/20/24 at 11:53 a.m., R64 was awake in bed with the television on playing the news. R64 turned his head when spoken to but was unable to respond to questions. A sign on the wall indicated to intermittently put on Native American YouTube or flute music to clear negative energy. Registered nurse (RN)-A was in the room, provided cares, exited the room, and had not asked R64 if he wanted anything different on the TV. During an interview on 5/20/24 at 2:43 p.m., R64's family member (FM)-A stated she placed the sign on the wall for native American YouTube or flute music for him. FM-A stated she was not sure how often R64 was involved in preferred activities. During an observation on 5/20/24 at 4:31 p.m., R64 was up in his wheelchair with the same news channel on. R64 was asked by surveyor if he wanted to watch the news and he had no reaction. R64 was asked by surveyor if he liked Native American shows and flute music and he smiled.	F 679			

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F 679	Continued From page 26 During an observation on 5/21/24 at 9:13 a.m., R64 was awake in bed with the television on the same news channel. During an interview on 5/21/24 at 3:48 p.m., nursing assistant (NA)-A stated he was unsure how to tell what a resident's preferred activities were if they were unable to talk. During an interview on 5/21/24 at 3:52 p.m., NA-B stated R64 had a sign on his wall to put on native American music or shows but she was unsure how to do that on the TV. NA-B stated she did not think R64 could voice any preferences. During an observation on 5/21/24 at 3:54 p.m., R64 was awake in bed and turned his head when spoken to. R64's television was off. Surveyor asked R64 if he wanted the TV on, and he smiled. During an observation and interview on 5/22/24 at 2:42 p.m., R64 was awake in bed. The TV was on the menu screen and no shows were on. Registered nurse (RN)-A stated she knew R64 since his admission almost two years ago, and he sometimes made a face like crying and knew he was in pain, otherwise, was unsure how much he comprehended. RN-B also entered the room and cares were provided. After cares were provided RN-A and RN-B were asked by surveyor how to turn on Native American YouTube shows or flute music, and RN-A stated his TV lacked that capability, and she would put in a work order to get him a TV that would accommodate the preference. During an interview on 5/23/24 at 9:30 a.m., the	F 679			

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F 679	Continued From page 27	F 679			
	director of therapeutic recreation (DTR) stated R64 had a sign in his room placed by FM-A with preferences for music and shows. The DTR stated care planned activities should be implemented by staff to promote enrichment and preferred activities. The DTR verified R64's TV lacked the option to play Native American music.				
	A policy for TR was requested, however, not provided.				
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684			6/30/24
	§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure blood thinner medications were held per provider order for 1 of 1 resident (R65), and failed to implement a physician order for 1 of 1 resident (R57) related to a rash.				
	Findings include:				
	R65's significant change Minimum Data Set dated 3/13/24, included R65 was severely cognitively impaired, dependent on staff for all activities of daily living, and had diagnoses of traumatic brain injury due to a gunshot to the				
			F684 ☐ Quality of Care		
			R65 blood thinner medication have been reviewed and are current per physician orders. R57 had TSH, ALT, and and BMP labs completed on 05/23/2024. R65 and R57's care plans and orders were reviewed and updated as necessary.		
			All like-residents who receive blood thinners and requiring labs for medications have been reviewed and are current per physicians' order. All like-residents have the potential to be		

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F 684	Continued From page 28 chest and subsequent cardiac arrest, seizure disorder, muscle spasms, myoclonus (quick, jerky uncontrollable movements), convulsions, tracheostomy, anxiety, and depression. The MDS indicated R65 took an anticoagulant (blood thinner) medication. R65's care plan dated 3/21/24, included they took a blood thinner to prevent blood clots and indicated they were at increased risk of bruising and bleeding complications due to medication use. The care plan instructed staff to administer medication as ordered. R65's pain focus included R65 displayed signs of pain from muscle spasms and provide pain medications as ordered. A neurology provider order dated 11/10/23, included an order for cervical spine baclofen pump for spasticity. R65's MHM IDT Care Conference Form V-4 dated 1/24/24, indicated R65's guardian wanted R65 to remain in the facility until they received a baclofen pump and then take them home. Appointment Referral dated 3/27/24, included "Patient evaluated for baclofen pump. Excellent candidate. Will need intrathecal baclofen trial 1st (first)". R65's Order Summary Report dated 5/22/24, included: * Baclofen Oral Tablet 20 milligrams (mg - a muscle relaxant) four times daily for muscle spasms starting 3/21/24. *Apixaban Oral Tablet 5 mg (a blood thinner), give 5 mg twice daily to prevent blood clots starting 3/21/24, hold from 5/15/24 at 10:59 a.m., until 5/16/24 at 12:00 a.m.	F 684	affected by this deficient practice . DON or designee to reeducate appropriate staff on who receives blood thinner medications, their current with physician orders, assuring orders are followed, theraputic interventions are followed, and any policy and procedure updates. DON or designee to conduct audits weekly times 4 weeks, then monthly times 2 months. Audit findings to be brought to QAPI for further review and recommendations.		

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F 684	Continued From page 29 * Appointment on 5/16/24 at 8:00 a.m. for baclofen test starting 5/15/24. R65's North Memorial Health pre-procedure directions dated 4/11/24, included R65 was scheduled for a trial of intrathecal baclofen on 5/16/24 at 9:30 a.m., to determine if they were a candidate for a baclofen pump and instructed that R65's Eliquis should be held 2 days prior to the procedure, starting 5/14/24. R65's provider progress note dated 5/14/24, included R65 had a baclofen trial "this coming Thursday" and indicated nursing staff reporting R65 had continuous jerking/muscle spasms. There was improvement with baclofen but continued with frequent muscle spasticity and jerking movements. Baclofen 20 mg was increased from three to four times per day. The note indicated "Referral to Neurology for baclofen pump consideration, apt [appointment] scheduled." R65 was noted to have muscle spasms in arms and legs, increased muscle tone in a spasticity in lower legs, and a severe right upper arm contracture. R65's medication administration record (MAR) for Mat 2024, indicated R65 received their blood thinner medication on 5/14/24 at 8:00 a.m., and 8:00 p.m., and 5/15/24 at 8:00 a.m. During interview on 5/20/24 at 1:31 a.m., R65 was lying in bed in the company of their significant other serving as resident representative (RR). RR stated R65 had a baclofen trial procedure scheduled to see if it would help release the tightness in their arm muscles. They stated they waited several months for the appointment, and on the day of the	F 684			

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F 684	Continued From page 30 procedure the facility gave R65 and RR paper records to provide to the proceduralist. When they arrived for the procedure, the staff was unable to read the documents and contacted the facility who faxed the information over so they could be read clearly. Upon review of the records, the proceduralist determined the facility did not follow instructions and gave R65 an anticoagulant against orders. The procedure was cancelled due to the risk of bleeding. R65 and RR were very upset about the delay because they wanted to make plans for discharging from the facility after the baclofen pump procedure. R65's provider progress note dated 5/21/24, indicated the baclofen pump trial was moved to "June". During observation on 5/22/24 at 7:03 a.m., R65 was lying in bed asleep and appeared relaxed and calm. Licensed practical nurse (LPN)-D entered R65's room at 7:30 a.m., to administer medications. While the head of the bed was elevated, R65's body had slid down toward the foot leaving their body nearly flat. LPN-D stated aides recently repositioned R65, however R65 moved around a lot due to muscle spasms and uncontrolled movements. At 7:46 a.m., R65 appeared to be agitated and started to twitch, their right arm held tightly contracted to their upper right chest. Nursing assistant (NA)-F and NA-G began providing cares at 7:52 a.m., and R65 continued to have muscle spasms and twitching movements throughout cares until they fell asleep at 7:58 a.m., when NA-F left the room to get supplies. Upon the NA's returning, R65 was awakened and once again started to appear agitated and had uncontrolled twitching movements until cares were completed at 8:20	F 684			

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F 684	Continued From page 31 a.m. During interview on 5/22/24 at 11:16 a.m., registered nurse (RN)-C stated R65 had an order to hold their blood thinner for two days prior to their baclofen trial procedure, however R65 received at least one dose during those two days which resulted in the cancellation of the procedure. They indicated they thought the order was added on the evening shift instead of the day, and if the procedure had gone forward there was a potential risk of bleeding complications. During interview on 5/22/24 at 1:58 p.m., director of nursing (DON) stated R65 was supposed to have a baclofen pump trial and had orders to hold their anticoagulant for two days before the procedure, however they received a dose they were not supposed to receive. R65's procedure was being rescheduled. DON expected orders to have been entered accurately on the day they were received to ensure residents are given medications according to provider orders to prevent complications. The Medication Administration - General Guidelines policy dated 5/22, included medications are administered in accordance with written orders of the prescriber. R57's quarterly Minimum Data Set (MDS) dated 4/23/24, indicated R57 was severely cognitively impaired. Diagnoses included heart failure and hypertension, R57's provider orders dated 1/5/24 indicated R57 was started on Amiodarone (medication for heart rhythm concerns) 400 milligrams (mg) twice a day for two weeks and then start 400 mg daily	F 684			

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F 684	Continued From page 32 after that. The orders also indicated amiodarone monitoring checklist of labs: thyroid function (TSH) at baseline, 3 months and 6 months and liver function (AST) test at baseline and every 6 months thereafter. Documentation for Drugs.com undated, indicated Amiodarone could cause dangerous side effects on the heart, liver, lungs, and thyroid. Recommended to follow labs per provider orders to decrease risk of serious side effects. Review of R57's medical record from 1/5/24 to 4/23/24, was reviewed and lacked documentation any thyroid function or liver function blood tested were performed. During an interview on 5/23/24 at 11:58 a.m., registered nurse (RN)-A stated when orders were given from providers they were entered into the computer and lab orders were generated that way. Lab would then come in and draw the labs. Results were place on the chart to be reviewed by the nurse and the provider. RN-A reviewed R57's medical record and stated orders for the labs were in place but there were no results on the chart. RN-A also reviewed the labs draw record and acknowledge no labs had been drawn on R57 for the Thyroid function or liver function test. RN-A acknowledge the labs are important to monitor the effects of the medication Amiodarone. During an interview on 5/23/24 at 2"00 p.m., the director of nursing (DON) stated all orders were to be signed off by the nursing staff and the nursing staff would monitor to make sure all labs were completed as orders for the safety of the residents.	F 684			

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F 684	Continued From page 33	F 684			
F 693	Policy for following provider orders was requested but not received.				
SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident was positioned appropriately with the head of the bed (HOB) at 30-45° (degrees) or higher during and after medication administration via gastric tube, failed to label tube feeding nutrition when started, and failed to replace a tube feeding administration set daily for 1 of 1 residents (R65) reviewed for tube feeding.	F 693			6/30/24
			F693 – Tube Feeding Mgmt/Retore Eating Skills R65 is positioned appropriately head of bed at 30-45 degrees or higher during and after feedings. R65 tube feeding bag has been dated and labeled. R65's care plan and orders reviewed and updated.		

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NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT ST PAUL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE SAINT PAUL, MN 55102		
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F 693	Continued From page 34 Findings include: R65's significant change Minimum Data Set dated 3/13/24, included R65 was severely cognitively impaired, dependent on staff for all activities of daily living, and had diagnoses of traumatic brain injury, seizure disorder, muscle spasms, myoclonus (quick, jerky uncontrollable movements), convulsions, tracheostomy, anxiety, and depression. The MDS indicated they had a feeding tube through which they received more than 50% (percent) of their nutrition. R65's Hospitalist Discharge Summary dated 1/17/24, indicated R65 was hospitalized with vomiting, fever, and gastroparesis (a condition where food stays in the stomach for a longer period of time than it should), was diagnosed with aspiration pneumonia, and instructed staff to keep R65's HOB at 30-45° at all times including sleep. R65's After Visit Summary dated 3/7/24, included R65 was sent to the emergency department for abdominal pain at feeding tube site and evaluation for possible pneumonia. R65's Feeding Tube Care Area Assessment (CAA) dated 3/20/24, included R65 could eat pureed foods but was fed primarily via gastric tube. R65 had respiratory distress after eating on 3/16/24, and was sent to the hospital with probable pneumonia. R65's care plan nutrition focus dated 3/21/24, included R65 was at risk for aspiration related to the presence of a feeding tube and directed staff to keep the HOB elevated to 45° at all times, and	F 693	All like-residents who received tube feedings have the potential to be affected by this deficient practice. All like-residents care plan have been reviewed and update to ensure head of bed at 30-45 degrees or higher during and after feedings. Tube feeding bags have been dated and labeled. DOn or designee to reeducate appropriate staff on repositioning residents who receive tube feedings to head of bed at 30-45 degrees or higher during and after feedings to prevent aspiration, and labeling nutrition when started. DON or designee to complete audits weekly times 4 weeks, then monthly times 2 months. Audit findings to be brought to QAPI for further review and recommendations.		

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F 693	Continued From page 35 change syringe, feeding bag, and graduate every 24 hours. R65's Order Summary Report dated 5/22/24, included: * Enteral Feed Order Vital 1.5 rate of 80 milliliters per hour for 24 hours per day via g-tube. May stop during cares. Elevate HOB above 30° while feeding is running starting 5/16/24. * Ensure HOB is 30° or higher with tube feeding, hold if repositioning, every shift starting 3/22/24. R65's care plan aspiration focus dated 4/4/24, included R65 was at risk for aspiration related to the presence of a feeding tube, with instructions to administer tube feedings as ordered, change tube feeding bag and syringe every 24 hours, and keep the HOB elevated at least 45° during and for one hour after feeding. During observation on 5/21/24 at 9:30 a.m., R65 was lying in their bed with tube feeding running at 80 cubic centimeters (cc) per hour. The bottle was not labeled with a date, rate, initials, or a start time, and the tubing had not been changed since the prior day. During interview on 5/21/24 at 2:32 p.m., licensed practical nurse (LPN)-B stated when staff hung a new bottle of nutrition, they changed the tubing at the same time. They stated they always labeled the bottle and the tubing with the date and time it was started, the rate of flow, and the nurse's initials. LPN-B verified R65's tube feeding bottle was unlabeled, and the tubing set was the same one used the prior day, despite noting a new bottle of nutrition was started early that morning on the previous shift.	F 693			

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F 693	Continued From page 36 During interview on 5/21/24 at 3:01 p.m., registered nurse (RN)-C stated it was important to label both the bottle and the tubing, so staff knew when it was hung and by whom, and to discard any leftover nutrition in addition to the administration tubing for infection control purposes to prevent illness. During interview on 5/21/24 at 3:28 p.m., director of nursing (DON) stated staff should throw out any leftover tube feeding supplement and changing the whole tubing every 24 hours to prevent illness. During observation on 5/22/24 at 7:30 a.m., licensed practical nurse (LPN)-D entered R65's room to administer their medications. R65's HOB was at approximately 30°, however R65 had slid toward the foot of the bed, leaving their body flat and their head slightly elevated. R65's feet hung off the end of the bed, the left one off to the left side over the edge of the corner. LPN-D paused R65's running tube feeding pump, disconnected the tubing from R65's gastrostomy tube, gave R65 their medications, flushed the tube, reconnected R65's feeding, and started the pump again. LPN-D confirmed R65 should always be sitting at 30-45° so they don't regurgitate their medications or tube feeding, however their body "scoots down" often because of their movements. LPN-D called for another staff to assist in repositioning R65. At 7:52 a.m., nursing assistant (NA)-F arrived to R65's room, lowered the head of the bed further to a nearly supine (flat) position, and removed R65's pillow from under their head. LPN-D paused R65's tube feeding and at 7:58 a.m., NA-F left the room to get supplies. LPN-D raised the head of R65's bed up to approximately 45° and turned T65's tube feeding back on at	F 693			

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F 693	Continued From page 37 8:00 a.m. while they were still low on the bed, body nearly flat. NA-F returned to the room and stated they were waiting for another aide to assist, and LPN-D left the room. NA-G arrived at the room at 8:11 a.m., paused R65's tube feeding, put the head of the bed fully flat, and both aides provided personal cares until 8:18 a.m., when NA-F and NA-G repositioned R65 up toward the HOB. The head of R65's bed was elevated to approximately 35° at 8:21 a.m. and R65's tube feeding was started again. During interview on 5/22/24 at 8:25 a.m., NA-F stated they always turned off R65's tube feeding pump when providing cares, put their head down, and brought the head back up and restarted the pump afterward. NA-F indicated they would have no way of knowing what time R65 received medications and could not plan to wait until one hour after administration as outlined in the care plan. During interview on 5/22/24 at 11:31 a.m., RN-C stated R65 had a history of aspiration and the HOB should be up above 30 degrees while medications and tube feedings are given. R65's HOB should be left elevated for 30 minutes after administration, however there was no way for the NAs to know when the nurse gave medications via g-tube. During interview on 5/22/24 at 12:56 p.m., DON stated resident with tube feedings should have their HOB elevated at least 30° for any medication administration, water flushes, and tube feedings. They stated R65 had a lot of jerky, involuntary movements which made it difficult to keep them upright in bed, however, it was expected that the nurse reposition R65 prior to	F 693			

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F 693	Continued From page 38 giving medications, and to limit the time lower than 30° to prevent aspiration. The Enteral Tube Feeding by Continuous Pump policy dated 3/23/23, included position the head of the bed at 30° - 45° (semi-Fowler's position) for feeding, unless medically contraindicated. Ensure that feeding tube bag/bottle/tubing have been marked with date and time. If over 24 hours or not marked, dispose of bag/tubing, and obtain new supplies. If opening a new container, mark with date and time it was opened.	F 693			
F 696 SS=D	Prostheses CFR(s): 483.25(j) §483.25(j) Prostheses The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance and coordination of services to ensure timely referral and treatment for prosthetic fit for 1 of 1 resident (R37) reviewed who needed a prosthesis. Findings include: R37's quarterly Minimum Data Set (MDS) dated 2/19/24, included R37 was cognitively intact, had a limb prosthesis, required maximal assistance for lower body dressing, putting on footwear, standing, and transfers, and had diagnoses of	F 696	F696 ☐ Prostheses R37's care plan and therapy orders have been reviewed and updated. R37 was evaluated by therapy on 05/23/2024. All like-residents who have prosthetics care plans have been reviewed and updated for prosthetics and assured referrals, fits, assessments, and orders are being followed. Procedure to be completed with each new admission who has a prosthetic and with		6/30/24

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F 696	Continued From page 39 diabetes, depression, heart failure, tracheostomy, and severe morbid obesity. R37 received 2 days of occupational therapy (OT) and 15 minutes of physical therapy (PT) in the previous 7 days. R37's care plan dated 10/20/23, included R37 had an alteration with transfers related to right BKA (below the knee amputation). The care plan indicated R37 would like to improve her transfer abilities as much as possible and instructed staff to ensure resident has prosthetic on prior to any transfer. R37's provider progress notes dated 1/9/24, 2/9/24, 2/16/24, 3/1/24, 3/5/24, 3/13/24, 3/15/24, 3/22/24, 5/7/24, and 5/21/24 all identified R37 had a history of nontraumatic above-the-knee amputation of the right lower extremity related to diabetes and was motivated to ambulate to increase independence. Patient previously ambulatory prior to amputation. Expected to achieve stand pivot transfer to decrease risk for falls from wheelchair if able to reposition with both lower extremities. A podiatry note dated 3/25/24, indicated the provider encouraged mobilization of LLE (left lower extremity) to maintain circulatory status to the leg, particularly while [they] await adjustment to prosthesis. R37's PT note dated 3/28/24, included R37 had a right BKA and had a prosthesis. The note indicated R37 was discharged from therapy and would resume once their new prosthetic was available. R37's medical records lacked evidence of follow up to ensure R37's had a well-fitting, usable	F 696	any change in conditon/status of prostheses. Facility to review like-resident care plans, orders, referrals, and appointments to assure they are being completed timely and appropriate to the residents condition. DOR or designee to reeducate appropriate staff to provide assistance and coordination of services to ensure timely referral and treatment for prostheses. DOR or designee to conduct audits weekly times 4 weeks, then monthly times 2. Audit findings to be brought to QAPI for further review and recommendations.		

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F 696	Continued From page 40 prosthetic leg. During interview on 5/20/24 at 12:44 p.m., R37 was seated in their wheelchair in their room. A prosthetic leg was standing upright on the far edge of the wall next to their nightstand wearing one pink athletic shoe. R37 stated they could not put the leg on themselves, and it took 2-3 people to secure it. They indicated it was extremely uncomfortable and needed to be re-evaluated by the vendor for fit or a new prosthetic, however the facility had not made any arrangements. During observation on 5/21/24 at 8:03 a.m., R37 was in their wheelchair in the hallway and was not wearing their prosthesis. During interview on 5/21/24 at 2:32 p.m., licensed practical nurse (LPN)-B stated R37 had a leg amputation and staff used a mechanical lift to transfer R37. LPN-B had never seen them wear a prosthetic leg. During interview on 5/21/24 at 2:46 p.m., nursing assistant (NA)-G stated R37 was transferred with a mechanical lift and did not use a prosthetic leg, however they used to wear it when they worked with therapy and could pivot transfer when they first arrived at the facility. NA-G was unsure why they weren't using it anymore. During interview on 5/21/24 at 3:01 p.m., registered nurse (RN)-C stated the last time R37 wore their prosthetic leg was in therapy the previous year. R37 stood once with therapy assistance, however RN-C was not sure why R37 no longer wore it. RN-C was unsure if R37 was supposed to wear it, reviewed their medical records, and confirmed there was an order for the	F 696			

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F 696	Continued From page 41 shrink sock and the application of the prosthesis was outlined in the care plan. During interview on 5/21/24 at 3:19 p.m., physical therapist (PT) indicated R37 was not receiving physical therapy services but did get occupational therapy. During interview on 5/21/24 at 3:25 p.m., certified occupational therapy assistant (OT) reviewed R37's records and indicated R37 was discharged from PT on 3/28/24, prior to receiving their new prosthetic leg. OT stated they were not aware R37 received their new prosthetic but could now step in and evaluate them to identify R37's goals and abilities. OT stated usually nursing staff completed a communication form to update therapy on resident needs, however OT had not received any communication re R37. During observation 5/21/24 at 3:42 p.m., R37 was in their wheelchair exiting the elevator and not wearing their prosthetic leg. During interview on 5/22/24 at 12:56 p.m., director of nursing (DON) stated R37 had "a condition", was unable, and preferred not to wear their prosthesis. They indicated they were unsure when R37 received their current prosthesis, but staff would help them don and doff the leg, and if it did not fit, they would communicate with therapy and contact the prosthetic company to make adjustments to the prosthetic and ensure R37 could have as much independence as possible. A policy pertaining to coordination of prosthetic care was requested but not provided. In an email dated 5/23/24 at 2:12 p.m., the administrator indicated staff worked with therapy on prosthetic	F 696			

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F 696	Continued From page 42	F 696			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758			6/30/24

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F 758	Continued From page 43 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure gradual dose reductions (GDR) were attempted, or an adequate medical justification for the use of psychotropic medications for 1 of 5 residents (R42) reviewed for unnecessary medications. Findings include: R42's annual Minimum Data Set (MDS) dated 4/2/24, indicated no cognitive impairment and no reports of feeling down, depressed, or hopeless. R42's MDS indicated he did not experience any hallucinations or delusions, did not reject care, and did not exhibit any verbal or physical behaviors. The MDS indicated R42's diagnoses included depression, and respiratory failure with a tracheostomy (a surgical airway created in the windpipe as an alternative method for breathing). Furthermore, R42's MDS indicated he was taking an antipsychotic on a routine basis and no GDR had been attempted. A GDR is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be	F 758	F758 ☐ Free from Unnecessary Psychotropic Meds/PRN Use R42's care plan, psychotropic medication list reviewed, and updated as necessary. Consulting pharmacist to complete medication review of R42's anti-psychotic medications and provide recommendations for possible gradual dose reductions (GDRs). GDRs will be attempted on R42. All residents orders will be reviewed to see if they are on psychotropic medications. Facility will review when/if a GDR was last attempted and notify the provider/consulting pharmacist as necessary to ensure GDR attempts are conducted. GDR revview will be completed weekly at target behavior/GDR meetings. All residents receiving psychotropic		

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F 758	Continued From page 44 discontinued. The MDS indicated a provider had documented it was clinically contraindicated on 4/9/24. R42's Care Area Assessment (CAA) dated 4/12/24, for psychotropic drug use indicated he had a potential for adverse effects from his medication use. The CAA indicated R42 had a degenerative disease and suffered from depression because of it. The CAA indicated his symptoms were well-controlled and R42 reported minimal symptoms of depression. The CAA indicated staff would continue to provide medications that helped R42 cope with his disease and would assess for adverse effects. The CAA lacked documentation of resident-specific target symptoms to monitor. The CAA lacked documentation of resident-specific interventions to address symptom management. R42's order summary dated 5/23/24, included the following physician orders: - Olanzapine oral tablet 5 milligrams (mg) (Zyprexa), Give 5 mg via gastrostomy (G)-Tube two times a day for depression, dated 3/21/24. - Sertraline hydrochloride (HCl) oral tablet 100 MG (Zoloft HCl), Give 200 mg via G-Tube one time a day for depression, dated 3/21/24. - Mirtazapine oral tablet 15mg (Remeron), Give 15 mg via G-Tube at bedtime for depression, dated 3/21/24. - Lorazepam oral tablet 0.5mg (Ativan), Give 2.5 mg via G-Tube at bedtime for anxiety, dated 3/21/24.	F 758	medications have the potential to be affected by this deficient practice. Social Services or designee to educate appropriate staff on gradual dose reductions (GDRs). Social Services or designee to audit and review opportunities for GDRs during weekly target behavior meetings times 4 weeks and bring any concerns forth to provider and/or consulting pharmacist. Audit findings to be brought to QAPI for further review and recommendations.		

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F 758	Continued From page 45 R42's treatment administration record (TAR) dated 5/2024, revealed an order dated 12/6/23, for psychotropic monitoring for antianxiety medication. The TAR guided staff to monitor for side effects of drowsiness, dizziness, hypotension (low blood pressure)/hypertension (high blood pressure), weight gain, dry mouth, nausea, constipation, blurred vision, and extrapyramidal reaction (a cluster of symptoms caused by medications that include muscle spasms and contractions, restlessness, tremors, and irregular, jerky movements known as tardive dyskinesia). Similarly, the TAR also revealed an order dated 12/6/23, for antidepressant medication and antipsychotic medication side effect monitoring. R42's undated care plan indicated he used psychotropic medications related to his depression. The care plan identified R42's medications of Zyprexa, sertraline, and Remeron daily and lorazepam as needed for anxiety. The goal was to remain free of drug related complications, including cognitive and behavioral impairment. R42's care plan identified interventions of attempting a GDR of medications as evaluated by the interdisciplinary team (IDT) that included the pharmacist, primary provider, and resident and family. The undated care plan also indicated R42 had an alteration in mood and behavior as it related to his depression and anxiety diagnoses. The undated care plan identified R42 had an alteration in psychosocial well-being related to his complex medical conditions and his depression and anxiety disorders. The care plan lacked resident-specific target symptom monitoring. A review of R42's behavior monitoring lookback log dated 4/30/24 - 5/28/24, revealed one	F 758			

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F 758	Continued From page 46 instance of documented behaviors. On 5/15/24, staff documented R42 exhibited a behavior of "repetitive questions". The remaining documentation reflected either "not applicable" or "none noted". A consultant pharmacist recommendation to physician report dated 2/27/24, indicated R42 was receiving olanzapine for a diagnosis of major depressive disorder which was not considered an appropriate indication for antipsychotic use. The consultant pharmacist's recommendation was if R42 was receiving an antipsychotic without an appropriate diagnosis in accordance with the Centers for Medicare and Medicaid Services (CMS) guidance, to consider a GDR if clinically appropriate. The monthly medication regimen review (MRR) lacked a provider's signature or associated orders. During interview on 5/23/24 at 11:23 a.m., registered nurse (RN)-C stated for residents taking psychotropic medications, the documentation requirements would be listed in the resident's TAR. RN-C stated if a staff person was documenting an intervention in the TAR, there would be a prompt to re-evaluate the effectiveness and document that as well. RN-C stated the expectation for nurses would be to document on the TAR and for nursing assistants (NA) to report back to their charge nurse. RN-C stated non-pharmacologic interventions should be documented in the TAR and stated they should be listed on the NA care sheets. RN-C identified R42's resident-specific interventions in the care plan but was unable to identify any resident-specific target symptoms or documentation of behavior monitoring. RN-C stated the clinically contraindicated GDR	F 758			

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F 758	Continued From page 47 documented on the MDS dated 4/9/24 "could be an error." RN-C reviewed R42's MRRs and was unable to locate documentation of clinical contraindication of a GDR. During interview on 5/23/24 at 1:26 p.m., the director of nursing (DON) stated staff were expected to documented behaviors and whether interventions were effective for residents receiving psychotropic medications. Additionally, the DON stated the facility collaborated with the consultant pharmacist (CP) for MRRs and the expectation for MRR turnaround was approximately 30 days. The DON indicated GDRs were important to avoid overuse of medication and avoid unnecessary medications. During interview on 5/23/24 at 2:23 p.m., the consultant pharmacist (CP) stated during a resident's first year of admission to a facility, two GDRs should be recommended to be attempted. On a resident's second year of living in a facility, one GDR should be recommended to the provider. The CP verified being aware of R42's medication regimen and stated in February of 2024, a clarification was sent out regarding his antipsychotic and diagnosis. The CP stated that there had not been any follow up received from the provider or facility related to the MRR dated 2/27/24. The CP stated it is generally preferred to hear back within the first month or two, but the expectation was to have heard back by the time of the interview. The CP stated R42 was on the list to review for the month of May. During subsequent interview on 5/23/24 at 3:00 p.m., the DON stated R42's GDR was contraindicated because when the MDS was collected, R42 had just returned from the	F 758			

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F 758	Continued From page 48 hospital. A request for the provider's documentation of clinical contraindication was requested but not receive. A facility policy titled Psychotropic Medication Use dated 7/28/21, indicated psychotropic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review as outline with the Gradual Dose Reduction Policy. The policy also indicated the interdisciplinary team and the primary provider would gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. The policy guided the interdisciplinary team and the provider to identify, evaluate and document symptoms that may warrant the use of psychotropic medications as well as pertinent non-pharmacological interventions that must be attempted, unless contraindicated, and documented.	F 758			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880			6/30/24

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F 880	Continued From page 49 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880			

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F 880	Continued From page 50 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to adhere to infection control evidence based practices for a resident urinary catheter bag being placed on the floor for 1 of 1 resident (R72) reviewed for infection prevention and control practices. Findings include: R72's quarterly MDS dated 4/25/24, indicated R72 had an absence of spoken words, was rarely or never understood, and sometimes understood others. MDS indicated R72 was dependent on staff for all activities of daily living (ADLs) and had an indwelling catheter. MDS indicated R72 had non-traumatic brain dysfunction, chronic respiratory failure with a tracheostomy, and had Extended-Spectrum Beta Lactamase (ESBL) resistance (ESBL are found in some bacteria that cannot be killed by many types of antibiotics used to treat infections). R72's CAA for communication dated 10/24/23, indicated she had impaired ability to express herself due to her tracheostomy and mechanical	F 880	F880 – Infection Control & Prevention R72's care plan reviewed and updated. R72's catheter bag was immediately removed from floor once noted and placed in appropriate position. All catheter bags reviewed to ensure they have a place to be hung to prevent breach in ICP practices. All like-residents with catheters have the potential to be affected by this deficient practice. All like residents reviewed to ensure catheter placement is in appropriate position and not touching the floor. DON or designee to provide reeducation to all appropriate staff on infection control & prevention and placement of catheter bags with not touching the floor. DON or designee to conduct audits weekly times 4 weeks, then monthly times 2.		

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F 880	Continued From page 51 ventilation, caused by myasthenia gravis (a chronic weakening autoimmune disorder involving the communication between nerves and muscles). R72's CAA for self-care and mobility dated 10/24/23, indicated R72 was unable to participate in ADLs and indicated needed assistance would be provided to maintain hygiene. R72's CAA for dehydration and fluid maintenance dated 10/23/24, indicated shew as at risk for infection and had a history of UTI. Physician orders for R72 included the following: - Follow EBP while providing tracheostomy and/or ventilation care, Foley, wounds, enteral feeding and other high-contact care activities every shift, dated 4/23/24. R72's care plan undated indicated she was on EBP related to her urinary catheter, tracheostomy, and enteral feeding. The care plan stated staff would follow EBP and explain the reason for EBP. R72's quarterly Minimum Data Set (MDS) dated 4/25/24, indicated R72 had an absence of spoken words, was rarely or never understood, and sometimes understood others. MDS indicated R72 was dependent on staff for all activities of daily living (ADLs) and had an indwelling catheter. MDS indicated R72 had non-traumatic brain dysfunction, chronic respiratory failure with a tracheostomy (a surgical airway created in the windpipe as an alternative method for breathing) and had Extended-Spectrum Beta Lactamase (ESBL) resistance (ESBL are found in some	F 880	Audit findings to be brought to QAPI for further review and recommendations.		

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F 880	Continued From page 52 bacteria that cannot be killed by many types of antibiotics used to treat infections). R72's Care Area Assessment (CAA) for cognitive loss and dementia dated 10/24/23, indicated she did not have a speaking valve (a removable device that can be use with a tracheostomy for speaking) but was able to mouth yes or no. The CAA indicated R72 had moderate cognitive impairment. R72's CAA for communication dated 10/24/23, indicated she had impaired ability to express herself due to her tracheostomy and mechanical ventilation, caused by myasthenia gravis (a chronic weakening autoimmune disorder involving the communication between nerves and muscles). R72's CAA for self-care and mobility dated 10/24/23, indicated R72 was unable to participate in ADLs and indicated needed assistance would be provided to maintain hygiene. R72's CAA for urinary incontinence and indwelling catheter dated 10/24/23, indicated she had both bowel and bladder incontinence. The CAA also indicated R72 had a Foley catheter in place due to an unstageable pressure ulcer on her sacrum, which put her at risk for a urinary tract infection (UTI) and urinary retention. Additionally, the CAA indicated R72 required total assistance with toileting hygiene and to maintain patency of her Foley catheter. R72's CAA for dehydration and fluid maintenance dated 10/23/24, indicated shew as at risk for infection and had a history of UTI.	F 880			

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F 880	Continued From page 53 Physician orders for R72 included the following: - Foley catheter: change Foley catheter and drainage bag once per month dated 10/17/23, - Follow Enhanced Barrier Precautions (EBP) while providing tracheostomy and/or ventilation care, Foley, wounds, enteral feeding and other high-contact care activities every shift, dated 4/23/24. R72's care plan undated indicated she was on EBP related to her urinary catheter, tracheostomy, and enteral feeding. The care plan stated staff would follow EBP and explain the reason for EBP. The care plan also identified R72's alteration in elimination and her use of a Foley catheter. The goal was to remain free from signs and symptoms of UTI by having staff assistance with her toileting needs, including Foley catheter care every shift and as needed. A provider progress note dated 5/7/24, indicated R72 had a recent hospitalization for sepsis due to UTI. The progress note indicated R72 had been treated twice for positive urine cultures (laboratory test used to confirm bacteria growth in urine) between 3/8/24 and date of progress note (5/7/24). A progress note dated 5/22/24 indicated R72 was started on Levaquin (and antibiotic) related to UTI with a urine culture pending. On 5/21/24 at 2:27 p.m., R72's catheter drainage bag was observed to be on the floor next to her bed. During interview on 5/21/24 at 3:32 p.m., registered nurse (RN)-C verified there was a spot	F 880			

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F 880	Continued From page 54 the drainage should be hanging from. RN-C demonstrated the drainage bag had a clamped drainage port and hung bag from R72's bed. RN-C stated the facility utilized a closed-system drainage bag and did not believe it was a problem that R72's catheter drainage bag was on the floor because it was clamped. During interview on 5/22/24 at 9:11 a.m., nursing assistant (NA)-D stated catheter bags should not be on the floor because of germs. During interview on 5/23/24 at 8:45 a.m., R72's nurse practitioner (NP) stated the catheter drainage bag should not be left on the floor as this could introduce new bacteria. During re-interview on 5/23/24 at 12:03 p.m., RN-C stated the catheter bag should be hanging up off the floor for infection prevention, especially for residents that have indwelling catheters because they are already at a high risk for UTIs. RN-C stated the expectation moving forward for catheter cares is to ensure the catheter drainage bag is not set on the floor. RN-C stated there will be increased monitoring and audits to verify this. During interview on 5/23/24 at 1:40 p.m., the director of nursing (DON), stated the catheter bag should "absolutely not" be on the floor for infection control reasons. A facility policy titled Infection Prevention and Control Program dated 3/13/23, indicated important facets of infection included instituting measures to avoid complications or dissemination, educating staff and ensuring that they adhere to proper techniques and procedures, and following established general	F 880			

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F 880	Continued From page 55 and disease-specific guidelines such as those of the Centers for Disease Control (CDC). According to a CDC article titled Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009 last updated 6/6/19, the collection bag should not rest on the floor.	F 880			
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility	F 883			6/30/24

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F 883	Continued From page 56 must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R24, R52) reviewed for immunizations were offered or received the pneumococcal vaccine in accordance with the Center for Disease Control (CDC) recommendations. Findings include: The CDC Pneumococcal Vaccine Timing for Adults dated 3/15/23, indicated adults aged 65 years and older who have had no prior pneumococcal vaccinations could either have	F 883	F883 ☐ Influenza and Pneumococcal Immunizations R24 and R52's were offered pneumococcal immunization. R24 and R52 both received the Pevnar 20 vaccination on 05/28/2024. All residents immunizations have been reviewed for pneumococcal vaccine and will be offered if previously not given. Facility will review all residents upon		

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F 883	Continued From page 57 option A which indicated PCV20, or option B, give PCV15 and follow with PPSV23 after at least one year of giving PCV15. If only the PPSV23 vaccination was administered prior at any age, option A indicated PCV20 could be administered after 1 year or option B indicated PCV15 could be administered after 1 year. If only the PCV13 vaccination was administered at any age, option A indicated PCV20 could be administered after 1 year, or PPSV23. If PCV13 was administered at any age, and PPSV23 was administered prior to 65 years of age, option A indicated PCV20 could be administered after five years, or option B indicated PPSV23 could be administered after 5 years. Additionally, for those who already completed PCV13 at any age, and PPSV23 at age 65 or greater, together, with the patient, vaccine providers may choose to administer PCV20 to adults greater than 65 years old who have already received PCV13 (but not PCV15 or PCV20) at any age and PPSV23 at or after the age of 65 years old. R24 R24's annual Minimum Data Set (MDS) dated 3/5/24, indicated R24 was cognitively intact, did not reject cares, pneumococcal vaccine was offered and declined. R24's face sheet printed on 5/22/24, indicated R24 was 77 years old, and diagnosis included chronic kidney disease. R24's Resident Vaccine Administration (RAC) form signed 9/15/22, indicated vaccines to be given included influenza, pneumococcal and Covid-19 vaccine/booster.	F 883	admission to ensure they have received the appropriate immunizations. If they have not received the appropriate immunizations, facility will offer and administer as necessary. DON or designee will reeducate appropriate staff on immunizations and timing for adults aged 65 years and older who've had no prior pneumococcal vaccinations. DON or designee will conduct pneumococcal vaccine audits weekly times 4 weeks, then monthly times 2. Audit findings to be brought to QAPI for further review and recommendations.		

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F 883	Continued From page 58 R24's 10/17/23, RAC form indicated, with a check mark, R24 was administered the influenza and COVID-19 vaccine/booster. However, next to the pneumococcal vaccine indication, the box was unchecked, indicating the resident did not receive the vaccination. Additionally, the form had a box to indicate "I do not wish to have the following vaccinations at this time", which was unchecked. During survey on 5/21/24, the facility provided a signed RAC form by the resident dated 5/21/24, for pneumococcal vaccine administration. This form indicated the resident consented to the pneumococcal vaccination, however one was not administered. R52 R52's quarterly MDS dated 5/9/24, indicated R52 was cognitively intact, did not reject cares, or medications and was up to date with his pneumococcal vaccine. R52's face sheet printed 5/22/24, indicated R52 was 67 years old, and diagnosis included chronic respiratory failure with hypercapnia (presence of higher than normal level of carbon dioxide in the blood.) and hypoxia (low levels of oxygen in your body tissues) and had type 2 diabetes mellitus. R52's immunization record in the electronic health record (EHR) indicated R52 received Pneumococcal Conjugate Vaccine (PCV13) in 3/3/2015, and received the Pneumococcal Polysaccharide Vaccine (PPSV23) in 8/9/2007.	F 883			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2024
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F 883	Continued From page 59 R52's recommendation per CDC guidelines included: give one dose of Prevnar 20 (PCV20) at least five years after the last pneumococcal vaccine dose or give one more dose of PPSV23 at least one year after PCV13 and at least 5 years after previous PPSV23 dose. R52's consent for pneumococcal vaccine was requested but not received. During interview on 5/22/24 at 1:55 p.m., director of nursing (DON), who is also the infection preventionist, stated the facility tracked immunizations and completed audits to ensure vaccines were offered and consents were being reviewed with residents. DON further clarified the facility was implementing a new system to better track immunization consents and administration documentation and would be training staff to pull resident's vaccination records from Minnesota Immunization Information Connection (MIIC) system into the resident's EHR. The facility Pneumococcal policy updated 2/2024, indicated prior to or upon admission to the facility (within 5 days), all residents will be assessed for current immunization status and eligibility to receive the pneumococcal vaccine. Within 30 days of admission, resident will be offered the vaccine, when indicated, unless the resident has already been vaccinated or the vaccine is medically contraindicated. Consent will be obtained and the pneumococcal vaccination will be administered to residents, per physician order and CDC recommendations, and will be documented in the resident ' s medical record.	F 883			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on May 21, 2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Emeralds at St. Paul, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

06/13/2024

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: 245295	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2024
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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Emeralds at St. Paul is a 4-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1968 and was determined to be of Type II(222) construction. In 1982, an addition was constructed to the East side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing	K 000			

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K 000	Continued From page 2 buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 100 beds and had a census of 89 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not properly maintain enclose stairways used for exits and smoke proof enclosures in accordance with NFPA 101 (2012), Life Safety Code, section 7.1.3.2.1. These deficient findings could an widespread impact on the residents within the facility. Findings include:	K 225	K225 – Stairways and Smokeproof Enclosures All hand sanitizer dispensers were removed from the stairwells on 5/21/2024. Staff were educated that hand sanitizer dispensers are prohibited in stairwells. Maintenance Director or designee to	6/30/24	

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K 225	Continued From page 3 On 05/21/2024, between 8:45 AM and 11:30 AM, it was revealed by observation that Alcohol Based Hand Sanitizer containers had been installed in each stairwell on each level. Storage or placement of combustible or flammable materials in stairwells is prohibited. An interview with the Maintenance Director and the Administrator verified these deficient findings at the time of discovery.	K 225	complete weekly audits times 4 weeks. Audit findings to be brought to QAPI for further review and recommendations.		
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain and/or install proper exit signage under NFPA 101 (2012 edition), Life Safety Code sections 19.2.10.1, 7.10.1.2.2, 7.10.83, 7.10.8.31 and 7.10.8.3.2. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 05/21/2024, between 8:45 AM and 11:30 AM, it was revealed by observation that the door leading to the Courtyard from the Lobby was missing a "NO EXIT" sign. The NO EXIT sign shall have the word NO in letters 2 in. (51 mm) high, with a	K 293	K293 – Exit Signage “NO EXIT” sign was ordered. Maintenance Director will place “NO EXIT” sign on the door leading to the courtyard from the lobby once received. Maintenance Director designee to reeducate staff on “NO EXIT” sign being posted on the door leading to the courtyard from the lobby. Findings to be brought to QAPI for further	6/30/24	

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K 293	Continued From page 4 stroke width of 3.8 in. (9.5 mm), and the word EXIT in letters 1 in. (25 mm) high, with the word EXIT below the NO. An interview with the Maintenance Director and the Administrator verified this deficient finding at the time of discovery.	K 293	review and recommendations.		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, section 8.5.5.3.1. This deficient finding could have an widespread impact	K 351	K351 – Sprinkler System – Installation Maintenance Director getting quotes to have fire department connection (FDC) more easily accessible to the fire department.	6/30/24	

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K 351	Continued From page 5 on the residents within the facility. Findings include: On 05/21/2024, between 8:45 AM and 11:30 AM, it was revealed by observation that the fire department connection (FDC) was located within an area that is secured by a fence and not easily accessible to the fire department. An interview with the Maintenance Director and the Administrator verified this deficient finding at the time of discovery.	K 351	Maintenance Director or designee to reeducate staff where to locate the FDC in case of a fire needing to be put out by the fire department. Maintenance Director or designee to complete audits weekly times 4 weeks. Audit findings to be brought to QAPI for further review and recommendations.	6/30/24	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K 712	K712 – Fire Drills Maintenance Director to ensure that fire drills are conducted per NFPA 101 (2012 edition), life safety code sections 19.7.1.6. Maintenance Director or designee to reeducate staff on Fire Drills and compliance.		

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K 712	Continued From page 6 On 05/21/2024, between 8:45 AM and 11:30 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that fire drills were conducted on the second shift of the 3rd quarter and the first and third shift of the 4th quarter. An interview with the Maintenance Director and the Administrator verified these deficient findings at the time of discovery.			K 712	Maintenance Director or designee to complete Audits monthly times 3 months. Audit findings to be brought to QAPI for further review and recommendations.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 7, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: NCJ211

Dear Administrator:

The above facility was surveyed on May 20, 2024 through May 23, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nathan Schreier, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: nate.schreier@state.mn.us
Office: (651) 201-4348 Mobile (651) 392-2726

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00913	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/23/2024
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/20/24 - 5/23/24, a licensing 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 correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

06/13/24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00913	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/23/2024
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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H52953776C (MN00101605) H52953774C (MN00101095) H52953775C (MN00101043) H52953778C (MN00100614) and NO licensing orders were issued. 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 surveyors 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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be	2 000		

Minnesota Department of Health

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2 000	Continued From page 2 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening	2 265			6/30/24

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2 265	Continued From page 3 conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a physician was notified of elevated blood glucose results for 1 of 1 resident (R20) reviewed who had specific physician's orders with parameters for physician notification of high blood glucose results. Findings Include: R20's admission Minimum Data Set (MDS) dated 2/28/24, indicated R20 was cognitively intact, did not exhibit rejection of care during the assessment period, and diagnosis included diabetes mellitus and peripheral vascular disease. R20 also received insulin seven days during the assessment period. R20's care plan printed 5/22/24, indicated a focus for potential for alteration in blood sugar related to diagnosis of diabetes with history of refusing blood sugar checks, and medications. Goals included R20's blood sugar would be maintained between 60 and 120. Interventions included resident and family education provided and to monitor resident for signs/symptoms of	2 265	Corrected.		

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2 265	Continued From page 4 hyperglycemia and hypoglycemia. R20's face sheet printed 5/22/24, indicated R20's diagnosis included type 2 diabetes mellitus with ketoacidosis without coma and epilepsy without status epilepticus (a seizure with 5 minutes or more of continuous clinical and/or electrographic seizure activity or recurrent seizure activity without recovery between seizures). R20's physician order dated 5/3/2024, indicated blood sugars: notify nurse practitioner or physician if two blood glucose results are <75 or >350 in a 24 hour period and/or condition change, before meals and at bedtime related to related to type 2 diabetes mellitus with ketoacidosis without coma. R20's medication administration record (MAR) for 5/2024, indicated the following blood glucose readings: 5/9/24, evening blood glucose result was 594. 5/10/24, evening blood glucose was 450; bedtime blood glucose was 418. 5/11/24 evening blood glucose was 420; bedtime blood glucose was 460. 5/12/24, evening blood glucose was 368. 5/13/24 morning blood glucose was 440; evening blood glucose was 385. 5/14/24, morning blood glucose was 387; evening blood glucose was 591; and bedtime blood glucose was 369. 5/15/24, night blood glucose was 375. 5/16/24, evening blood glucose was 400 and bedtime blood glucose was 400. 5/17/24, morning blood glucose was 393; evening blood glucose was 434. 5/18/24, morning blood glucose was 357; evening blood glucose was 450; and bedtime blood	2 265			

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2 265	Continued From page 5 glucose was 436. 5/20/24, evening blood glucose was 482. 5/21/24, evening blood glucose was 400. R20's progress notes dated 5/9/24, indicated BG >500, 5 units one time given per nurse practitioner (NP). R20's progress notes lacked documentation the physician was updated on the other dates indicated above, when R20's blood glucose results were elevated. R20's physician regulatory visit progress notes dated 5/17/2024, indicated type 2 diabetes mellitus with other circulatory complications. Multiple diabetic ketoacidosis (DKA, a life-threatening problem that affects people with diabetes. It occurs when the body starts breaking down fat at a rate that is much too fast. The liver processes the fat into a fuel called ketones, which causes the blood to become acidic) episodes: 12/26/23, 1/15/24, and 2/18/24. Also, with hypoglycemic episode on 4/7/24. Endocrinology was consulted. R20's physician progress notes printed 5/24/24, indicated R20 was hospitalized 2/18/2024 - 2/22/2024, for evaluation of elevated blood sugar. During interview on 5/22/24 at 8:23 a.m., nurse manager, registered nurse (RN)-A stated R20 refused cares and medications often, however staff should have notified the provider with blood glucose results that were elevated per the physician orders. RN-A explained the facility utilized the nursing agency on the evening shift often and as a result the physician notification was not being completed for R20. RN-A also clarified as the nurse manager they were	2 265			

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2 265	Continued From page 6 responsible to monitor R20's elevated glucose level and to ensure physician was updated per R20's physician order. R20's nurse practitioner was called on 5/22/24 at 8:48 a.m., with message left with answering service staff, however a return call was not received. During interview on 5/22/24 at 1:55 p.m., the director of nursing (DON) stated nursing staff should have notified the provider per the physician order with R20's elevated blood glucose results. DON further clarified that the agency staff also viewed the providers' orders when they on duty and were expected to follow the physician orders as prescribed. The facility policy on physician notification was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to significant change in Minimum Data Set (MDS)assessments, including identification of when a significant change in condition has occurred and collection of required information. The director of nursing or designee should educate staff to policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265			

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2 930	Continued From page 7	2 930		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident was positioned appropriately with the head of the bed (HOB) at 30-45° (degrees) or higher during and after medication administration via gastric tube, failed to label tube feeding nutrition when started, and failed to replace a tube feeding administration set daily for 1 of 1 residents (R65) reviewed for tube feeding. Findings include: R65's significant change Minimum Data Set dated 3/13/24, included R65 was severely cognitively impaired, dependent on staff for all activities of daily living, and had diagnoses of traumatic brain injury, seizure disorder, muscle spasms, myoclonus (quick, jerky uncontrollable movements), convulsions, tracheostomy, anxiety,	2 930	Corrected.	6/30/24

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2 930	Continued From page 8 and depression. The MDS indicated they had a feeding tube through which they received more than 50% (percent) of their nutrition. R65's Hospitalist Discharge Summary dated 1/17/24, indicated R65 was hospitalized with vomiting, fever, and gastroparesis (a condition where food stays in the stomach for a longer period of time than it should), was diagnosed with aspiration pneumonia, and instructed staff to keep R65's HOB at 30-45° at all times including sleep. R65's After Visit Summary dated 3/7/24, included R65 was sent to the emergency department for abdominal pain at feeding tube site and evaluation for possible pneumonia. R65's Feeding Tube Care Area Assessment (CAA) dated 3/20/24, included R65 could eat pureed foods but was fed primarily via gastric tube. R65 had respiratory distress after eating on 3/16/24, and was sent to the hospital with probable pneumonia. R65's care plan nutrition focus dated 3/21/24, included R65 was at risk for aspiration related to the presence of a feeding tube and directed staff to keep the HOB elevated to 45° at all times, and change syringe, feeding bag, and graduate every 24 hours. R65's Order Summary Report dated 5/22/24, included: * Enteral Feed Order Vital 1.5 rate of 80 milliliters per hour for 24 hours per day via g-tube. May stop during cares. Elevate HOB above 30° while feeding is running starting 5/16/24. * Ensure HOB is 30° or higher with tube feeding, hold if repositioning, every shift starting 3/22/24.	2 930			

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2 930	Continued From page 9 R65's care plan aspiration focus dated 4/4/24, included R65 was at risk for aspiration related to the presence of a feeding tube, with instructions to administer tube feedings as ordered, change tube feeding bag and syringe every 24 hours, and keep the HOB elevated at least 45° during and for one hour after feeding. During observation on 5/21/24 at 9:30 a.m., R65 was lying in their bed with tube feeding running at 80 cubic centimeters (cc) per hour. The bottle was not labeled with a date, rate, initials, or a start time, and the tubing had not been changed since the prior day. During interview on 5/21/24 at 2:32 p.m., licensed practical nurse (LPN)-B stated when staff hung a new bottle of nutrition, they changed the tubing at the same time. They stated they always labeled the bottle and the tubing with the date and time it was started, the rate of flow, and the nurse's initials. LPN-B verified R65's tube feeding bottle was unlabeled, and the tubing set was the same one used the prior day, despite noting a new bottle of nutrition was started early that morning on the previous shift. During interview on 5/21/24 at 3:01 p.m., registered nurse (RN)-C stated it was important to label both the bottle and the tubing, so staff knew when it was hung and by whom, and to discard any leftover nutrition in addition to the administration tubing for infection control purposes to prevent illness. During interview on 5/21/24 at 3:28 p.m., director of nursing (DON) stated staff should throw out any leftover tube feeding supplement and changing the whole tubing every 24 hours to	2 930			

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2 930	Continued From page 10 prevent illness. During observation on 5/22/24 at 7:30 a.m., licensed practical nurse (LPN)-D entered R65's room to administer their medications. R65's HOB was at approximately 30°, however R65 had slid toward the foot of the bed, leaving their body flat and their head slightly elevated. R65's feet hung off the end of the bed, the left one off to the left side over the edge of the corner. LPN-D paused R65's running tube feeding pump, disconnected the tubing from R65's gastrostomy tube, gave R65 their medications, flushed the tube, reconnected R65's feeding, and started the pump again. LPN-D confirmed R65 should always be sitting at 30-45° so they don't regurgitate their medications or tube feeding, however their body "scoots down" often because of their movements. LPN-D called for another staff to assist in repositioning R65. At 7:52 a.m., nursing assistant (NA)-F arrived to R65's room, lowered the head of the bed further to a nearly supine (flat) position, and removed R65's pillow from under their head. LPN-D paused R65's tube feeding and at 7:58 a.m., NA-F left the room to get supplies. LPN-D raised the head of R65's bed up to approximately 45° and turned T65's tube feeding back on at 8:00 a.m. while they were still low on the bed, body nearly flat. NA-F returned to the room and stated they were waiting for another aide to assist, and LPN-D left the room. NA-G arrived at the room at 8:11 a.m., paused R65's tube feeding, put the head of the bed fully flat, and both aides provided personal cares until 8:18 a.m., when NA-F and NA-G repositioned R65 up toward the HOB. The head of R65's bed was elevated to approximately 35° at 8:21 a.m. and R65's tube feeding was started again. During interview on 5/22/24 at 8:25 a.m., NA-F	2 930			

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2 930	Continued From page 11 stated they always turned off R65's tube feeding pump when providing cares, put their head down, and brought the head back up and restarted the pump afterward. NA-F indicated they would have no way of knowing what time R65 received medications and could not plan to wait until one hour after administration as outlined in the care plan. During interview on 5/22/24 at 11:31 a.m., RN-C stated R65 had a history of aspiration and the HOB should be up above 30 degrees while medications and tube feedings are given. R65's HOB should be left elevated for 30 minutes after administration, however there was no way for the NAs to know when the nurse gave medications via g-tube. During interview on 5/22/24 at 12:56 p.m., DON stated resident with tube feedings should have their HOB elevated at least 30° for any medication administration, water flushes, and tube feedings. They stated R65 had a lot of jerky, involuntary movements which made it difficult to keep them upright in bed, however, it was expected that the nurse reposition R65 prior to giving medications, and to limit the time lower than 30° to prevent aspiration. The Enteral Tube Feeding by Continuous Pump policy dated 3/23/23, included position the head of the bed at 30° - 45° (semi-Fowler's position) for feeding, unless medically contraindicated. Ensure that feeding tube bag/bottle/tubing have been marked with date and time. If over 24 hours or not marked, dispose of bag/tubing, and obtain new supplies. If opening a new container, mark with date and time it was opened.	2 930			

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2 930	Continued From page 12 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for resident positioning during and after medication and nutrition delivered via gastric tube feeding according to evidence based practices/procedures. Nursing staff could be educated to the importance of resident positioning and the replacement and labeling of tube feeding supplies and nutrition. The DON or designee, could audit positioning, labeling, and replacement of tubing by all nursing staff assigned to residents effected and take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 930			
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of	21390			6/30/24

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21390	Continued From page 13 employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to adhere to infection control evidence based practices for a resident urinary catheter bag being placed on the floor for 1 of 1 resident (R72) reviewed for infection prevention and control practices. Findings include: R72's quarterly MDS dated 4/25/24, indicated R72 had an absence of spoken words, was rarely or never understood, and sometimes understood others. MDS indicated R72 was dependent on staff for all activities of daily living (ADLs) and had an indwelling catheter. MDS indicated R72 had non-traumatic brain dysfunction, chronic respiratory failure with a tracheostomy, and had Extended-Spectrum Beta Lactamase (ESBL) resistance (ESBL are found in some bacteria that cannot be killed by many types of antibiotics used to treat infections). R72's CAA for communication dated 10/24/23, indicated she had impaired ability to express herself due to her tracheostomy and mechanical ventilation, caused by myasthenia gravis (a	21390	Corrected.	

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21390	Continued From page 14 chronic weakening autoimmune disorder involving the communication between nerves and muscles). R72's CAA for self-care and mobility dated 10/24/23, indicated R72 was unable to participate in ADLs and indicated needed assistance would be provided to maintain hygiene. R72's CAA for dehydration and fluid maintenance dated 10/23/24, indicated shew as at risk for infection and had a history of UTI. Physician orders for R72 included the following: - Follow EBP while providing tracheostomy and/or ventilation care, Foley, wounds, enteral feeding and other high-contact care activities every shift, dated 4/23/24. R72's care plan undated indicated she was on EBP related to her urinary catheter, tracheostomy, and enteral feeding. The care plan stated staff would follow EBP and explain the reason for EBP. R72's quarterly Minimum Data Set (MDS) dated 4/25/24, indicated R72 had an absence of spoken words, was rarely or never understood, and sometimes understood others. MDS indicated R72 was dependent on staff for all activities of daily living (ADLs) and had an indwelling catheter. MDS indicated R72 had non-traumatic brain dysfunction, chronic respiratory failure with a tracheostomy (a surgical airway created in the windpipe as an alternative method for breathing) and had Extended-Spectrum Beta Lactamase (ESBL) resistance (ESBL are found in some bacteria that cannot be killed by many types of antibiotics used to treat infections).	21390			

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21390	Continued From page 15 R72's Care Area Assessment (CAA) for cognitive loss and dementia dated 10/24/23, indicated she did not have a speaking valve (a removable device that can be use with a tracheostomy for speaking) but was able to mouth yes or no. The CAA indicated R72 had moderate cognitive impairment. R72's CAA for communication dated 10/24/23, indicated she had impaired ability to express herself due to her tracheostomy and mechanical ventilation, caused by myasthenia gravis (a chronic weakening autoimmune disorder involving the communication between nerves and muscles). R72's CAA for self-care and mobility dated 10/24/23, indicated R72 was unable to participate in ADLs and indicated needed assistance would be provided to maintain hygiene. R72's CAA for urinary incontinence and indwelling catheter dated 10/24/23, indicated she had both bowel and bladder incontinence. The CAA also indicated R72 had a Foley catheter in place due to an unstageable pressure ulcer on her sacrum, which put her at risk for a urinary tract infection (UTI) and urinary retention. Additionally, the CAA indicated R72 required total assistance with toileting hygiene and to maintain patency of her Foley catheter. R72's CAA for dehydration and fluid maintenance dated 10/23/24, indicated shew as at risk for infection and had a history of UTI. Physician orders for R72 included the following: - Foley catheter: change Foley catheter and	21390		

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21390	Continued From page 16 drainage bag once per month dated 10/17/23, - Follow Enhanced Barrier Precautions (EBP) while providing tracheostomy and/or ventilation care, Foley, wounds, enteral feeding and other high-contact care activities every shift, dated 4/23/24. R72's care plan undated indicated she was on EBP related to her urinary catheter, tracheostomy, and enteral feeding. The care plan stated staff would follow EBP and explain the reason for EBP. The care plan also identified R72's alteration in elimination and her use of a Foley catheter. The goal was to remain free from signs and symptoms of UTI by having staff assistance with her toileting needs, including Foley catheter cares every shift and as needed. A provider progress note dated 5/7/24, indicated R72 had a recent hospitalization for sepsis due to UTI. The progress note indicated R72 had been treated twice for positive urine cultures (laboratory test used to confirm bacteria growth in urine) between 3/8/24 and date of progress note (5/7/24). A progress note dated 5/22/24 indicated R72 was started on Levaquin (and antibiotic) related to UTI with a urine culture pending. On 5/21/24 at 2:27 p.m., R72's catheter drainage bag was observed to be on the floor next to her bed. During interview on 5/21/24 at 3:32 p.m., registered nurse (RN)-C verified there was a spot the drainage should be hanging from. RN-C demonstrated the drainage bag had a clamped drainage port and hung bag from R72's bed. RN-C stated the facility utilized a closed-system	21390			

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21390	Continued From page 17 drainage bag and did not believe it was a problem that R72's catheter drainage bag was on the floor because it was clamped. During interview on 5/22/24 at 9:11 a.m., nursing assistant (NA)-D stated catheter bags should not be on the floor because of germs. During interview on 5/23/24 at 8:45 a.m., R72's nurse practitioner (NP) stated the catheter drainage bag should not be left on the floor as this could introduce new bacteria. During re-interview on 5/23/24 at 12:03 p.m., RN-C stated the catheter bag should be hanging up off the floor for infection prevention, especially for residents that have indwelling catheters because they are already at a high risk for UTIs. RN-C stated the expectation moving forward for catheter cares is to ensure the catheter drainage bag is not set on the floor. RN-C stated there will be increased monitoring and audits to verify this. During interview on 5/23/24 at 1:40 p.m., the director of nursing (DON), stated the catheter bag should "absolutely not" be on the floor for infection control reasons. A facility policy titled Infection Prevention and Control Program dated 3/13/23, indicated important facets of infection included instituting measures to avoid complications or dissemination, educating staff and ensuring that they adhere to proper techniques and procedures, and following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC). According to a CDC article titled Guideline for Prevention of Catheter-Associated Urinary Tract	21390			

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21390	Continued From page 18 Infections 2009 last updated 6/6/19, the collection bag should not rest on the floor. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21390			
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must	21426			6/30/24

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21426	Continued From page 19 be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a tuberculosis skin test (TST) or chest X-rays were conducted timely and the results documented for 3 of 5 employees (licensed practical nurse (LPN)-C, Social service director (SSD-B), culinary aide (CA)-A and for 1 of 5 residents (R79) reviewed for tuberculosis (TB) screening as directed by the Centers for Disease Control and Prevention. Findings Include: LPN-C was hired on 3/11/24, and terminated on 4/2/24, but lacked tuberculosis screening documentation and documentation of a TST, CXR or QuantiFERON TB Gold Plus. Additional TB documentation was requested for LPN-C but it was not received. SSD-B was hired on 4/23/24, and was given a TST step one on 4/23/24, but lacked any follow-up reading of TSTstep one result and also lacked documentation for a step two TST documentation. Facility provided documentation during survey on 5/20/24, that a TST step one was administered with results pending. Additional TB documentation was requested for SSD-B but was not received. CA-A was hired on 1/29/24, and received the step one TST which was negative, but was missing a	21426	Corrected.		

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21426	Continued From page 20 step two TST documentation. Additional TB documentation was requested for CA-A but was not received. R79's electronic health record (EHR) indicated he was admitted on 1/19/24. R79's immunizations were reviewed in the EHR indicated R79 received the TST step one on 1/19/24, which was negative, but did not have documentation for a second step TST until 4/16/24, indicated as first step and a second step on 4/28/24, which were negative. R79's 1/19/24, TST, was the admission TST and lacked a second step documentation. Additional TB documentation was requested for R79 but it was not received. During interview on 5/22/24 at 10:33 a.m., director of nursing (DON) and corporate nurse leader (CNL) stated staff were screened for tuberculosis upon hire and residents upon admission with the required followup expected to be completed. DON further clarified they were now beginning a new process to track staff and resident's immunizations to ensure they were current and up to date on required screenings and vaccines. The facility TB Risk Assessment updated 7/11/23, indicated a baseline TB screening of all patients was performed at time of admission and a baseline TB screening was performed for all healthcare professional at time of hire. The facility Tuberculosis Screening and Prevention policy updated 7/31/23, indicated employees will be screened using an individual risk assessment and symptom evaluation upon hire. TB testing may be completed with an interferon-gamma assay (IGRA) or a Tuberculin	21426			

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21426	Continued From page 21 Skin Test (TST) 2-step method for persons without documented prior TB disease, latent TB infection (LTBI). SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one- (21) days.	21426			
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be	21435			6/30/24

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21435	Continued From page 22 provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident's preferred activities for individual entertainment were available for 1 of 2 residents (R64) reviewed for activities. Findings include: R64's annual Minimum Data Set (MDS) dated 10/30/23, identified he was rarely/never understood. No behaviors or rejection of care occurred. Diagnoses included traumatic brain injury and respiratory failure. The family interview identified it was very important to listen to preferred music and do preferred activities. R64's communication Care Area Assessment (CAA) dated 10/30/23, identified R64 rarely understood and had not spoken or used gestures due to a brain injury. R64 may have been able to hear staff voices but was not able to respond. R64's quarterly MDS dated 5/1/24, identified no behaviors or rejection of care. R64 was totally dependent on staff for all activities of daily living. R64's care plan dated 9/15/23, identified there was an alteration in socialization and potential for activity deficit. R64 was fully dependent on staff to anticipate his needs. Per family member (FM)-A, R64 enjoyed listening to healing traditional Native American music and staff were directed to turn on the television (TV) in his room to listen to this and	21435	Corrected.	

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21435	Continued From page 23 for programs of interest. R64's therapeutic recreation (TR) visit log dated 2/5/24 through 5/14/24, identified facetime calls were completed with R64 and FM-A, and identified when he was awake, emotional, happy, and sometimes cried. The logs lacked listening to healing traditional Native American music as an intervention. The TR log also indicated there was a sign in R64's room with music he liked. During an observation on 5/20/24 at 11:53 a.m., R64 was awake in bed with the television on playing the news. R64 turned his head when spoken to but was unable to respond to questions. A sign on the wall indicated to intermittently put on Native American YouTube or flute music to clear negative energy. Registered nurse (RN)-A was in the room, provided cares, exited the room, and had not asked R64 if he wanted anything different on the TV. During an interview on 5/20/24 at 2:43 p.m., R64's family member (FM)-A stated she placed the sign on the wall for native American YouTube or flute music for him. FM-A stated she was not sure how often R64 was involved in preferred activities. During an observation on 5/20/24 at 4:31 p.m., R64 was up in his wheelchair with the same news channel on. R64 was asked by surveyor if he wanted to watch the news and he had no reaction. R64 was asked by surveyor if he liked Native American shows and flute music and he smiled. During an observation on 5/21/24 at 9:13 a.m., R64 was awake in bed with the television on the same news channel.	21435			

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21435	Continued From page 24 During an interview on 5/21/24 at 3:48 p.m., nursing assistant (NA)-A stated he was unsure how to tell what a resident's preferred activities were if they were unable to talk. During an interview on 5/21/24 at 3:52 p.m., NA-B stated R64 had a sign on his wall to put on native American music or shows but she was unsure how to do that on the TV. NA-B stated she did not think R64 could voice any preferences. During an observation on 5/21/24 at 3:54 p.m., R64 was awake in bed and turned his head when spoken to. R64's television was off. Surveyor asked R64 if he wanted the TV on, and he smiled. During an observation and interview on 5/22/24 at 2:42 p.m., R64 was awake in bed. The TV was on the menu screen and no shows were on. Registered nurse (RN)-A stated she knew R64 since his admission almost two years ago, and he sometimes made a face like crying and knew he was in pain, otherwise, was unsure how much he comprehended. RN-B also entered the room and cares were provided. After cares were provided RN-A and RN-B were asked by surveyor how to turn on Native American YouTube shows or flute music, and RN-A stated his TV lacked that capability, and she would put in a work order to get him a TV that would accommodate the preference. During an interview on 5/23/24 at 9:30 a.m., the director of therapeutic recreation (DTR) stated R64 had a sign in his room placed by FM-A with preferences for music and shows. The DTR stated care planned activities should be implemented by staff to promote enrichment and	21435			

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21435	Continued From page 25 preferred activities. The DTR verified R64's TV lacked the option to play Native American music. A policy for TR was requested, however, not provided. SUGGESTED METHOD OF CORRECTION: The director of therapuetic recreation, or designee, could train all staff to ensure each resident's assessed activity preferences are honored, and then audit to ensure this is occurring. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21435		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a homelike environment for 1 of 1 residents (R65) reviewed who had enteral feeding liquid spilled on the bottom of the tube feeding pump pole and on the floor. Findings include: R65's significant change Minimum Data Set	21695	Corrected.	6/30/24

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21695	Continued From page 26 dated 3/13/24, included R65 was severely cognitively impaired, dependent on staff for all activities of daily living, had a diagnosis of traumatic brain injury, and indicated they had a feeding tube through which they received more than 50% of their nutrition. During observation and interview on 5/20/24 at 2:13 p.m., R65 was lying in bed in their room with tube feeding running and their representative present. The tube feeding pump was attached to a pole, the base of which was covered in more than 50 drips of tube feeding liquid nutrition. The floor under the base of the pole had an area approximately 12 inches by 6 inches covered in tube feeding liquid. R65's representative stated the tube feeding "mess" bothered them and they were frustrated by the lack of cleanliness. During observation on 5/21/24 at 9:30 a.m., and 2:29 p.m., the tube feeding pump pole and floor were soiled as previously described. During interview on 5/21/24 at 2:32 p.m., licensed practical nurse (LPN)-B stated housekeeping staff cleaned the floor daily, but if nurses spilled something they cleaned it up at that time. They stated if they noticed the tube feeding equipment was not clean, they would clean it themselves. During interview on 5/21/24 at 2:50 p.m., housekeeper (HSK)-A stated housekeeping cleaned floors in the residents' rooms five days per week, and they had just finished R65's room, however housekeepers was not responsible for cleaning the poles. During interview on 5/21/24 at 3:01 p.m., registered nurse (RN)-C stated housekeeping cleaned the floors and the poles because they	21695			

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21695	Continued From page 27 used a special spray to help remove any stuck-on substances. RN-C viewed the floor and tube feeding pump pole in R65's room, verified they needed to be cleaned, and indicated they would not leave it in that state in their own home. During interview on 5/22/24 at 12:56 p.m., director of nursing stated staff should ensure the pole and floor are clean each time they change the feeding equipment, and if they could not remove any soiled areas, notify housekeeping. They expected spills to be cleaned, and indicated the drips and spills were not conducive to a homelike environment. In an email dated 5/22/24, the administrator indicted the facility did not have a policy regarding homelike environment or cleaning of resident equipment. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing, or housekeeping supervisor, or designee could ensure cleanliness of tube feeding equipment and resident floor areas. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure cleaning is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695			