Electronically delivered
January 21, 2022

Administrator
The Emeralds At Faribault LLC
500 Southeast First Street
Faribault, MN 55021

RE: CCN: 245067
Cycle Start Date: January 21, 2022

Dear Administrator:

On January 11, 2022, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 April 11, 2022 (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 July 11, 2022 (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/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING _____ B. WING _____	C 01/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT FARIBAULT LLC	**500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/10/22 through 1/11/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5067081C (MN74222), with a deficiency cited at F688. The following complaints were found to be SUBSTANTIATED: H5067092C (MN60814), H5067091C (MN60828), H5067089C (MN61814), H5067080C (MN76415), H5067093C (MN60474), H5067086C (MN67375), H5067087C (MN67337), however NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be UNSUBSTANTIATED: H5067090C (MN60979), H5067082C (MN73683), H5067083C (MN73255), H5067088C (MN63555), H5067085C (MN69087), H5067084C (MN70466), H5067079C (MN79793/MN79823). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/31/2022

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 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure bilateral upper extremity (BUE) passive range of motion (PROM) home exercise program (HEP) exercises were consistently implemented and palmar hand splint was received, to restore,maintain and prevent loss of range of motion for 1 of 1 resident (R1) reviewed for contractures. Findings include: R1's quarterly Minimum Data Set (MDS) assessment, dated 4/26/21, identified R1 had intact cognition and demonstrated no delusions or other behaviors. R1 had functional limitations in activities of daily living (ADL), bilateral hand contractures, and required extensive assistance	F 688	Based on observation, interview, and document review, the facility failed to ensure bilateral upper extremity (BUE) passive range of motion (PROM) home exercise program (HEP) exercises were consistently implemented and Palmar Hand Splint was received, to restore, maintain and prevent loss of range of motion for 1 of 1 resident (RI) reviewed for contractures. R1 is currently being seen by occupational therapy (OT) for range of motion and contracture management. PROM and active range of motion (AROM) are currently being performed by therapists with the goal to develop a range of motion	2/9/22

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F 688	Continued From page 2 with bed mobility, toileting, eating; total assistance with transfers and personal hygiene. R1 did not ambulate. The MDS further identified diagnosis including history of multiple sclerosis (MS) (An immune system disease causing nerve damage affecting communication between brain and rest of body); osteoporosis and chronic pain syndrome. R1's Occupational Therapy Toolkit Passive Range of Motion dated 4/23/21; identified types of exercises, repetitions, and times per day nursing staff were to complete to BUE. Therapy recommendations specified PROM exercises be completed three times to each BUE site on a daily basis by nursing staff. PROM exercises included; shoulder blade, front arm raise, side arm raise, arm turns, making a fist, finger spread, thumb across, elbow bend, forearm turns, and wrist turns. Review of Occupational Therapy Treatment Encounter Note (s) dated 4/29/21, indicated plans for R1 to trial palmar hand splint at next session on 5/3/21. R1 had follow-up sessions scheduled with occupational therapy (OT) on 5/5/21, 5/10/21, 5/12/21, 5/14/21, 5/18/21, 5/21/21; trialing of palmar hand splints did not occur at any of these visits. Review of Occupational Therapy OT Evaluation and Plan of Treatment Note (s) dated 6/9/21, indicated R1 had been receiving HEP of ROM of BUE by nursing daily, therefore would not need to address contracture impairment at visit, as functional maintenance program (FMP) already was in place. On 1/10/22, at 11:00 a.m. R1 was observed	F 688	program when appropriate. Also, OT is currently working on splinting tolerance with the goal for R1 to wear splints 6-8 hours per day. Once R1 has achieved the goals with PT and OT, a Functional Maintenance Program form will be completed and presented to the director of nursing and/or the nurse manager. The staff will then be trained on the functional maintenance program by OT. All residents will be screened at the time of admission to evaluate for range motion deficits and will be treated accordingly. Those patients that flag for range of motion deficits and/or contractures will be screened quarterly to ensure range of motion has been maintained. If not, new interventions will be implemented. An evaluation of resident ROM can be requested by the nursing department at any time if a concern arises. When therapy develops a functional maintenance program (FMP) or adds additional interventions, education will be provided to the nursing staff. The nurse manager will implement to FMP by placing an order in PCC after updating the physician. A copy of the FMP will be placed in the resident's room, and in the Therapy Binder on the nursing unit. The DON and/or designee will monitor the functional maintenance program weekly for four weeks and then review with the	

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F 688	Continued From page 3 sitting in her wheelchair in room. R1's third, fourth, and fifth finger of both hands; was observed to appear tight, rigid, and curled inwards toward palm of hands. R1 was observed to not have a palmar splint in place to either hand. When R1 tried to extend her fingers, she could extend the first and second fingers,but third-fifth fingers remained flexed on both hands. Palms of both hands observed to be pink in color with fingernail indentation, skin remained intact. R1 indicated being aware of having therapy exercises to BLE's, but not to her BUE's. During an interview on 1/10/22 at 12:16 p.m. occupational therapist (OT)-A indicated R1 had been fitted for and received bilateral palmar hand splint. OT-A indicated when reviewing Occupational Therapy Treatment Encounter notes from 4/28/21 and 4/29/21, she believed R1 had been fitted for and received bilateral palmar hand splint around that time, but could not confirm the exact date. OT-A indicated nursing staff were provided Occupational Therapy Toolkit Passive Range of Motion sheets, a written exercise program for nursing staff to follow for R1's BUE, which had been given to nursing staff prior to fitting of hand splints. OT-A indicated when recommendations were provided, nursing staff were informed, and recommendations were placed in nursing therapy book. OT-A indicated exercises for BUE PROM HEP should be located in R1's room, either taped to the wall or pinned to bulletin board, and nursing staff were informed to review. OT-A indicated R1 had an evaluation on 6/9/21 for wheelchair positioning and BUE contractures. OT-A indicated R1 had no changes with contractures, so visit was primarily focused on wheelchair.	F 688	OT to ensure progress related to the FMP has been maintained. The results of the audits will be presented at the Quality Assurance and Process Improvement Committee (QAPI) for review and further recommendations. Audits will be completed weekly x 4, monthly x 2 and results will be reported to the Quality Assurance and Process Improvement Committee for further review and recommendations.	

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F 688	Continued From page 4	F 688		

When interviewed on 1/10/22, at 2:05 p.m. nursing assistant (NA)-A indicated she was aware of R1's care needs. NA-A indicated that all NAs were provided daily a facility NA task list consisting of each resident's care needs to be completed for each shift working. NA-A was observed during interview to retrieve a copy of NA task list titled "East," updated 1/6/22, which indicated R1's care needs for NA staff to complete during 1/10/22 shift. Review of task list noted to have PROM exercises for BLE's, did not indicate any exercises for BUE. NA-A indicated all NAs document completion of resident's cares in EMR (Electronic Medical Record) system. Review of R1's care needs provided by NAs in EMAR system did not indicate for NAs to perform PROM to BUE, only to BLE. NA-A indicated remembering R1 had hand splints at one time long ago, unable to recall how long ago when asked. NA-A indicated that she had not had to complete any cares for R1 that included applying or removing splints to BUE's, nor any exercises for bilateral hand contractures. NA-A indicated from what she could remember R1 was compliant with wearing BUE splints, and therapy recommendations for exercises and wearing brace to BLE. NA-A indicated being aware of type of exercises, and brace application and removal needed for R1's BLE. NA-A showed writer NA unit communication book, paper sheet task lists included in book. Paper sheet task list provided by NA-A, verified R 1 was not listed to receive any therapy exercises for BUE's or splint application and removal. NA-A confirmed that R1 did not have any therapy exercises for BUE's or splint application and removal by aides listed in the EMR system. NA-A indicated all exercises needing to be completed were posted on wall in each resident's room. NA-A showed writer

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F 688	Continued From page 5	F 688		

exercises in R1's room to be completed, verified exercises to be for BLE's only. NA-A proceeded to look around R1's room for palmar hand splints, finding BLE braces and back brace but unable to located palmar hand splints.

During an interview on 1/10/22 at 2:30 p.m. licensed practical nurse (LPN)-A indicated not being aware of any therapy exercises or splint application and removal for R1's BUE's. LPN-A indicated if nursing was to complete anything for residents receiving therapy services; orders, recommendations, and exercise hand-outs would be placed in nursing therapy binder. LPN-A proceeded to look through nursing therapy binder for R1's exercise regimen, splint application and removal recommendations. LPN-A indicated noting PROM therapy exercises, brace application and removal for BLE only.

When interviewed on 1/10/22 at 2:40 p.m. the director of nursing (DON) indicated the process for receiving therapy orders; consisted of, therapists discussing recommendations with nurse on unit and to provide nursing staff with any new written orders or recommendations. Nursing to update all staff on unit of any new changes in therapy orders and recommendations for continued care. Nursing to update unit therapy book with new written orders or recommendations provided by therapy staff, then place copy of therapy recommendations or orders on the DON's desk. The DON would then update care plan based on therapy recommendations, which triggered nursing and NA task list to complete in EMAR system. The DON indicated not being aware of any therapy recommendation for R1's BUE contractures. The DON confirmed through review of R1's care plan and orders, R1

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did not have any therapy treatments listed for BUE's.

On 1/10/22, at 2:57 a.m. OT-A indicated she reviewed occupational therapy treatment encounter notes from 4/28/21-5/21/21, and verified an error had occurred with trialing palmar hand splints. OT-A indicated per 4/29/21 note; R1 would trial palmar hand splint at next session, which did not occur as splints were placed on back order. OT-A confirmed R1 had not been trialed or fitted for palmar hand splint once supply was available. OT-A validated forgetting to place R1 on follow-up list. Furthermore, OT-A verified BUE exercises were not in nursing therapy book or in R1's room, confirmed BLE exercises only in nursing therapy book and in R1's room.

During an interview on 1/11/22 at 11:02 a.m. physical therapist (PT)-A indicated Occupational Therapy OT Evaluation and Plan of Treatment was completed for bilateral hand contractures on 1/11/22. PT-A indicated based on evaluation, R1 had had no changes or worsening of bilateral hand contractures. Occupational Therapy OT Evaluation and Plan of Treatment, dated 1/11/22, verified no new or worsening changes to bilateral hand contractures. PT-A provided therapy recommendations form, dated 1/11/22; which indicated for nursing and NA staff to complete BUE range of motion (ROM) program once daily with all exercises indicated on form. A copy of exercise hand-out was placed by PT-A and OT-A on bulletin board behind R1's bed, as well as in therapy recommendation book.

Facility policy titled "Remedy Therapy Services Long Term Care Programming: UE Contracture Management," undated, directed goal of program

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F 688	Continued From page 7 to maintain or improve impairments and prevent further decline through splinting device or range of motion program, indicated type of program would involve significant training to ensure proper carryover was completed. Policy included resident identification of need, screening process and tools, evaluation process, common interventions used; assessment of splint fit and staff training regarding ROM program, as well as splint wear schedule and application removal; general treatment principles included assessment of the splint wear and tolerance was part of the treatment sessions, goal and documentation examples, terminology/caregiver education, splint guide for types used.	F 688		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 21, 2022

Administrator
The Emeralds At Faribault LLC
500 Southeast First Street
Faribault, MN 55021

Re: State Nursing Home Licensing Orders
Event ID: F60E11

Dear Administrator:

The above facility was surveyed on January 10, 2022 through January 11, 2022 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.



Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00571	A. BUILDING: _____ B. WING _____	C 01/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT FARIBAULT LLC	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/10/22 through 1/11/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5067081C (MN74222), with a licensing order issued at 0895. The following complaints were found to be SUBSTANTIATED: H5067092C (MN60814), H5067091C (MN60828), H5067089C (MN61814), H5067080C (MN76415), H5067093C (MN60474), H5067086C (MN67375), H5067087C (MN67337); however, NO licensing orders were issued. The following complaints were found to be UNSUBSTANTIATED: H5067090C (MN60979), H5067082C (MN73683), H5067083C (MN73255), H5067088C (MN63555), H5067085C (MN69087), H5067084C (MN70466), H5067079C (MN79793/MN79823). 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to	2 000		

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2 000	Continued From page 2 you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	2 895	Based on observation, interview, and	1/31/22

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2 895	Continued From page 3 review, the facility failed to ensure bilateral upper extremity (BUE) passive range of motion (PROM) home exercise program (HEP) exercises were consistently implemented and palmar hand splint was received, to restore,maintain and prevent loss of range of motion for 1 of 1 resident (R1) reviewed for contractures. Findings include: R1's quarterly Minimum Data Set (MDS) assessment, dated 4/26/21, identified R1 had intact cognition and demonstrated no delusions or other behaviors. R1 had functional limitations in activities of daily living (ADL), bilateral hand contractures, and required extensive assistance with bed mobility, toileting, eating; total assistance with transfers and personal hygiene. R1 did not ambulate. The MDS further identified diagnosis including history of multiple sclerosis (MS) (An immune system disease causing nerve damage affecting communication between brain and rest of body); osteoporosis and chronic pain syndrome. R1's Occupational Therapy Toolkit Passive Range of Motion dated 4/23/21; identified types of exercises, repetitions, and times per day nursing staff were to complete to BUE. Therapy recommendations specified PROM exercises be completed three times to each BUE site on a daily basis by nursing staff. PROM exercises included; shoulder blade, front arm raise, side arm raise, arm turns, making a fist, finger spread, thumb across, elbow bend, forearm turns, and wrist turns. Review of Occupational Therapy Treatment Encounter Note (s) dated 4/29/21, indicated plans for R1 to trial palmar hand splint at next session	2 895	document review, the facility did not ensure bilateral upper extremity (BUE) passive range of motion (PROM) home exercise program (HEP) exercises were consistently implemented and palmar hand splint was received, to restore, maintain and prevent loss of range of motion for 1 of 1 resident (RI) reviewed for contractures. All residents are screened at the time of admission and quarterly to evaluate for range of motion deficits. When a therapy plan for the range of motion deficit has been formulated, it will be brought to the nurse manager (NM) and/or director of nursing (DON) to review. Together, therapy, NM and/or DON will plan staff education, update care plans and place recommendations on the treatment administration record. All staff will be educated in the process related to therapy recommendations, the importance of increasing or keeping resident function. The director of nursing or designee will conduct random audits to ensure screening and implementation of restorative maintenance plans. Audits will be completed weekly x 4,	

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2 895	Continued From page 4 on 5/3/21. R1 had follow-up sessions scheduled with occupational therapy (OT) on 5/5/21, 5/10/21, 5/12/21, 5/14/21, 5/18/21, 5/21/21; trialing of palmar hand splints did not occur at any of these visits. Review of Occupational Therapy OT Evaluation and Plan of Treatment Note (s) dated 6/9/21, indicated R1 had been receiving HEP of ROM of BUE by nursing daily, therefore would not need to address contracture impairment at visit, as functional maintenance program (FMP) already was in place. On 1/10/22, at 11:00 a.m. R1 was observed sitting in her wheelchair in room. R1's third, fourth, and fifth finger of both hands; was observed to appear tight, rigid, and curled inwards toward palm of hands. R1 was observed to not have a palmar splint in place to either hand. When R1 tried to extend her fingers, she could extend the first and second fingers,but third-fifth fingers remained flexed on both hands. Palms of both hands observed to be pink in color with fingernail indentation, skin remained intact. R1 indicated being aware of having therapy exercises to BLE's, but not to her BUE's. During an interview on 1/10/22 at 12:16 p.m. occupational therapist (OT)-A indicated R1 had been fitted for and received bilateral palmar hand splint. OT-A indicated when reviewing Occupational Therapy Treatment Encounter notes from 4/28/21 and 4/29/21, she believed R1 had been fitted for and received bilateral palmar hand splint around that time, but could not confirm the exact date. OT-A indicated nursing staff were provided Occupational Therapy Toolkit Passive Range of Motion sheets, a written exercise program for nursing staff to follow for	2 895	monthly x 2 and results will be reported to the Quality Assurance and Process Improvement Committee for further review and recommendations.	

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2 895	Continued From page 5 R1's BUE, which had been given to nursing staff prior to fitting of hand splints. OT-A indicated when recommendations were provided, nursing staff were informed, and recommendations were placed in nursing therapy book. OT-A indicated exercises for BUE PROM HEP should be located in R1's room, either taped to the wall or pinned to bulletin board, and nursing staff were informed to review. OT-A indicated R1 had an evaluation on 6/9/21 for wheelchair positioning and BUE contractures. OT-A indicated R1 had no changes with contractures, so visit was primarily focused on wheelchair. When interviewed on 1/10/22, at 2:05 p.m. nursing assistant (NA)-A indicated she was aware of R1's care needs. NA-A indicated that all NAs were provided daily a facility NA task list consisting of each resident's care needs to be completed for each shift working. NA-A was observed during interview to retrieve a copy of NA task list titled "East," updated 1/6/22, which indicated R1's care needs for NA staff to complete during 1/10/22 shift. Review of task list noted to have PROM exercises for BLE's, did not indicate any exercises for BUE. NA-A indicated all NAs document completion of resident's cares in EMR (Electronic Medical Record) system. Review of R1's care needs provided by NAs in EMAR system did not indicate for NAs to perform PROM to BUE, only to BLE. NA-A indicated remembering R1 had hand splints at one time long ago, unable to recall how long ago when asked. NA-A indicated that she had not had to complete any cares for R1 that included applying or removing splints to BUE's, nor any exercises for bilateral hand contractures. NA-A indicated from what she could remember R1 was compliant with wearing BUE splints, and therapy recommendations for exercises and wearing	2 895		

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2 895	Continued From page 6	2 895		

brace to BLE. NA-A indicated being aware of type of exercises, and brace application and removal needed for R1's BLE. NA-A showed writer NA unit communication book, paper sheet task lists included in book. Paper sheet task list provided by NA-A, verified R 1 was not listed to receive any therapy exercises for BUE's or splint application and removal. NA-A confirmed that R1 did not have any therapy exercises for BUE's or splint application and removal by aides listed in the EMR system. NA-A indicated all exercises needing to be completed were posted on wall in each resident's room. NA-A showed writer exercises in R1's room to be completed, verified exercises to be for BLE's only. NA-A proceeded to look around R1's room for palmar hand splints, finding BLE braces and back brace but unable to located palmar hand splints.

During an interview on 1/10/22 at 2:30 p.m. licensed practical nurse (LPN)-A indicated not being aware of any therapy exercises or splint application and removal for R1's BUE's. LPN-A indicated if nursing was to complete anything for residents receiving therapy services; orders, recommendations, and exercise hand-outs would be placed in nursing therapy binder. LPN-A proceeded to look through nursing therapy binder for R1's exercise regimen, splint application and removal recommendations. LPN-A indicated noting PROM therapy exercises, brace application and removal for BLE only.

When interviewed on 1/10/22 at 2:40 p.m. the director of nursing (DON) indicated the process for receiving therapy orders; consisted of, therapists discussing recommendations with nurse on unit and to provide nursing staff with any new written orders or recommendations. Nursing to update all staff on unit of any new changes in

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2 895	Continued From page 7	2 895		

therapy orders and recommendations for continued care. Nursing to update unit therapy book with new written orders or recommendations provided by therapy staff, then place copy of therapy recommendations or orders on the DON's desk. The DON would then update care plan based on therapy recommendations, which triggered nursing and NA task list to complete in EMAR system. The DON indicated not being aware of any therapy recommendation for R1's BUE contractures. The DON confirmed through review of R1's care plan and orders, R1 did not have any therapy treatments listed for BUE's.

On 1/10/22, at 2:57 a.m. OT-A indicated she reviewed occupational therapy treatment encounter notes from 4/28/21-5/21/21, and verified an error had occurred with trialing palmar hand splints. OT-A indicated per 4/29/21 note; R1 would trial palmar hand splint at next session, which did not occur as splints were placed on back order. OT-A confirmed R1 had not been trialed or fitted for palmar hand splint once supply was available. OT-A validated forgetting to place R1 on follow-up list. Furthermore, OT-A verified BUE exercises were not in nursing therapy book or in R1's room, confirmed BLE exercises only in nursing therapy book and in R1's room.

During an interview on 1/11/22 at 11:02 a.m. physical therapist (PT)-A indicated Occupational Therapy OT Evaluation and Plan of Treatment was completed for bilateral hand contractures on 1/11/22. PT-A indicated based on evaluation, R1 had had no changes or worsening of bilateral hand contractures. Occupational Therapy OT Evaluation and Plan of Treatment, dated 1/11/22, verified no new or worsening changes to bilateral hand contractures. PT-A provided therapy

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2 895	Continued From page 8 recommendations form, dated 1/11/22; which indicated for nursing and NA staff to complete BUE range of motion (ROM) program once daily with all exercises indicated on form. A copy of exercise hand-out was placed by PT-A and OT-A on bulletin board behind R1's bed, as well as in therapy recommendation book. Facility policy titled "Remedy Therapy Services Long Term Care Programming: UE Contracture Management," undated, directed goal of program to maintain or improve impairments and prevent further decline through splinting device or range of motion program, indicated type of program would involve significant training to ensure proper carryover was completed. Policy included resident identification of need, screening process and tools, evaluation process, common interventions used; assessment of splint fit and staff training regarding ROM program, as well as splint wear schedule and application removal; general treatment principles included assessment of the splint wear and tolerance was part of the treatment sessions, goal and documentation examples, terminology/caregiver education, splint guide for types used. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to implementation of range of motion services, could assure proper assessment and interventions are being implemented. The DON could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review.	2 895		

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2 895	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		