Electronically Submitted
July 3, 2019

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

RE: Project Number H5295167C

Dear Administrator:

On June 19, 2019, an extended survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted past non-complaince, immediate jeopardy (Level J). The Statement of Deficiencies (CMS-2567) is being electronically delivered. Past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On June 14, 2019, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department is recommending the following enforcement remedy listed below to the CMS Region V Office for imposition:

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

If the Centers for Medicare and Medicaid Services (CMS) decides to impose this recommended remedy they will send you a notice of imposition of the remedy and appeal rights.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 19, 2019. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division

Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

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

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

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

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

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

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

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

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING _____ B. WING _____	C 06/19/2019

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THE EMERALDS AT ST PAUL LLC	420 MARSHALL AVENUE SAINT PAUL, MN 55102

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F 000	INITIAL COMMENTS On 6/17/19 through 6/19/19, an abbreviated survey to review complaint #H5295167C, was completed by a surveyor from the Minnesota Department of Health (MDH) to determine compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. Complaint #H5295167C was substantiated with a deficiency issued at past non-compliance Immediate Jeopardy (IJ) identified at F689. The IJ began on 6/12/19, when the facility failed to ensure a resident's safety with the use of oxygen was immediately implemented. The immediate jeopardy was removed on 6/14/19, when the facility had implemented appropriate corrective action to prevent the situation from recurring. In addition, an extended survey was completed on 6/17/19, 6/18/19, and 6/19/19 as a result of the past non-compliance IJ identified at F689. While the facility receives a CMS 2567 documenting the findings, past non-compliance does not require a plan of correction.	F 000	Past noncompliance: no plan of correction required.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		7/3/19

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

Electronically Signed | 07/03/2019

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F 689	Continued From page 1 by: Based on interview, observation, and document review, the facility failed to ensure adequate measures and monitoring were implemented to ensure residents whom utilized oxygen did not smoke while using their portable oxygen for 2 of 3 residents (R1 and R2) reviewed whom smoked and used oxygen. The deficiency was identified as past non-compliance and issued at Immediate Jeopardy (IJ) level. The IJ began on 6/12/19, when R1 was in the smoking area outside the building and used a butane lighter to light a cigarette while using his portable O2 (oxygen) at 3 liters per nasal cannula. This resulted in burns to his nares and face requiring hospitalization. However, the facility implemented a corrective action to prevent recurrence by 6/14/19. The facility had immediately reviewed each resident's chart to verify smokers who used oxygen and placed alarms on the portable oxygen tank with a wanderguard alarm system so the door alarmed when resident entered the smoking area with a tank. Monitoring of each tank for alarms was implemented every shift. In addition, facility policies had been reviewed for adequacy and updated with an addendum. Staff education had also been implemented to ensure each shift of staff understood the facility policies and implemented testing skills to verify staff could follow through with implementation of smokers with portable oxygen tanks. Findings include: R1's quarterly Minimum Data Set (MDS) dated 2/21/19, included R1 was cognitively intact, was independent to supervision needed for activities	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

of daily living (ADL's), used a wheel chair, and was on oxygen therapy. The MDS had not been marked if R1 was a current tobacco user or not. R1's Admission Record face sheet identified diagnoses including acute respiratory failure and chronic obstructive pulmonary disease. R1's care plan dated 1/8/19, included resident was independent in most activities of daily living. R1's behavior care plan dated 3/14/19, included, "Resident was found smoking a cigarette in his room by his oxygen tank. Resident was talked to about not smoking a cigarette in his room and the dangers of smoking a cigarette by oxygen tanks. Resident signed the the smoking policy and understands the policy." The goal for R1 was dated 4/26/19, and listed as, "Resident will continue to smoke in designated smoking area for safety and remove his oxygen tank before going outside to smoke a cigarette." R1's physician orders dated 3/14/19, included to use oxygen at 3 liters per minute via nasal cannula and may use portable oxygen tank when up. Staff were to ensure the tank was filled every day when in use.

R1's Smoking Evaluation assessment dated 3/13/19, at 8:56 p.m. included, resident was capable of lighting [R1] own cigarette, did not have cognitive loss, did not have visual deficit and the summary read, "Resident was seen smoking a cigarette in [R1] room. Resident completed the Smoking Policy. Resident agreed to not smoke cigarettes in [R1] room. The facility was not aware that R1 had started smoking since the admission in November 2018. R1 informed SS-A that [R1] started smoking cigarettes again after 10 days of being in the facility and stated, "I was upset and depressed." The assessment failed to address R1's use of oxygen and being a smoker.

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R1's progress notes (PN) dated 3/13/19, at 11:30 a.m. read, "Resident's room smelled like cigarette smoke in AM, writer asked resident if [R1] was smoking, [R1] answered "yes, but only 2 puffs." resident educated on safety hazard to self and others smoking inside building, while O2 is present in room. Resident stated [R1] understood but stated it wasn't that bad because [R1] only took 2 puffs and turned O2 off. Writer reminded resident that it is always unsafe. Updated Social worker, will continue to monitor." The progress note did not identify what type of monitoring would be continued.

R1's Facility Report to the State Agency dated, 6/12/19, at 6:39 p.m. included, "At 4:45 pm LNHA [licensed nursing home administrator] and Nurse Managers were working in the conference room and notified by reception that this residents O2 tank was on fire. All members ran outside to the smoking patio and there was no evidence of an active fire but there was a smell of smoke and residents hair on the side of the face was singed and black and resident was holding the nasal prongs of nasal cannula in [R1] nose. Nurse Managers immediately assessed resident for major injury and respiratory distress, resident was alert and oriented. Resident was worked up stating 'Just let me breathe' staff let resident rest for a minute with O2 on and resident respiratory status improved. Then Nurse Manager [registered nurse (RN)-B] took resident upstairs to the unit for evaluation."

R1 progress notes dated 6/12/19, (no time specified) included, "While upstairs in [R1] room placed on large O2 tank, nebulizer administered and vitals obtained. T 97.6, P 97, R12, O2 95% at

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6 L. [R1] beard was trimmed to assess for possible burns and major injuries. Upon assessment, [R1] was noted to have facial burn of [R1] beard and black nasal passages. It was also observed [R1] had burn and redness on right side of zygomatic [cheek] region and around [R1] upper lip. Medical Director call [sic] and order received to sent [sic] resident to hospital for evaluation." R1 progress notes dated 6/12/19, at 10:26 p.m. included, "Resident was admitted to Regions Hospital Burn Unit. The nurse at Regions Hospital Burn Unit stated that resident has small burns and treating it with Bacitracin. [Nurse] added that resident is stable and they're keeping the resident overnight to monitor [R1]."

R1's investigation document review written by the DON, dated 6/14/19, at 4:30 p.m. read, "Resident stated [R1] asked the nurse at the nursing station to fill [R1] O2 tank. [R1] stated the nurse told [R1] to bring [R1] O2 tank downstairs and someone will fill it for [R1]. Resident stated [R1] brought [R1] tank downstairs and left it on the table by the smoking patio door. [R1] put a note on it for 3rd floor aide to fill. [R1] went back upstairs. Later [R1] grabbed one of [R1] other portable tanks to use to go downstairs and smoke. [R1] forgot to take [R1] tank off before going out to smoke because [R1] was distracted while [R1] was chatting with someone else while [R1] was wheeling [R1] out. Resident stated [R1] is not going to smoke anymore and will continue to wear the patch. Resident stated was given an extra tank a long time ago by staff when [R1] was going to an appointment so [R1] wouldn't run out."

R1 returned to the facility from the hospital on 6/14/19, at 3:30 p.m. and was transported via paramedics on 9 liters of oxygen.

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When interviewed in the outside smoking area on 6/17/19, at 8:10 a.m. R3 stated, "[R1] comes out with the O2 tank on and covers it with [R1] jacket. That day the flames were shooting out the top of the tank. That black spot is still there on the cement where [R9] got up out of [R9's] chair and broke the tubing by stomping on it, and so no more O2 could start on fire. [R1] jumped out of [R1's] wheel chair and ran behind the chairs to get away from the fire. I ran inside and told the desk we had a fire in the smoking area and they acted real fast to get out there." Furthermore, R3 stated, "I told [R1] [R1] should not be out here and [R1] said, 'I have it covered with my jacket,' [R1] knew it was a danger, we are all lucky that tank did not explode." During this interview R8 was present and verified R3's statement and R8 further stated, "Pure stupidity to smoke with oxygen." R3 and R8 verified they had not been interviewed specifically by the facility but validated lots of facility people were there once [R1] started the fire.

R1 was observed on 6/17/19, at 10:00 a.m. partially sitting/lying in bed with head against the wall to the left side propped by pillows, R1 expressed being in pain and waiting for the nurse to bring in pain medication. R1 expressed great discomfort in both nostrils, and the area around the mouth and cheekbone area from the, "burn" incident last week. Both nares appeared black and crusty. R1 verified not smoking since the incident 6/12/19, and expressed no desire to smoke at this time. There was no portable oxygen tank in the room. R1 was receiving oxygen from the large liquid cylinder in the bedroom.

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R2's annual MDS dated 3/22/19, included she was cognitively intact, had no behavior issues, required extensive assistance with most activities of daily living, but ambulated independently. The MDS indicated R2 was a current tobacco user.

R2's progress notes dated 4/23/19, at 5:15 p.m. written by social service (SS)-A read, "This writer met with resident after it being reported that resident was smoking a cigarette with [R2] O2 tank on. This writer and resident talked about the dangers with that. This writer asked resident if [R2] would be willing to store [R2] cigarettes up at the front desk and drop off [R2] O2 tank so there are no situations. Resident agreed. This writer and resident reviewed the smoking policy and resident signed. This writer and resident got [R2] box up at the front desk to store [R2] cigarettes. This writer uploaded the smoking policy in resident chart."

R2's care plan initiated 4/24/19 and revised on 6/21/19, included, R2 had been found smoking with oxygen on in the smoking area and had entered into a contract with the facility to leave oxygen tank at front desk before smoking and a wanderguard (a tracking device that will set off an alarm to alert staff the tank is being brought outside the door going to the smoking area). R2 was required to leave her tank at the front desk in exchange for her smoking materials. R2's physician order dated 6/17/19, included oxygen use at 3 liters per minute via nasal cannula for chronic respiratory failure.

R2 treatment sheet indicated on 6/14/19, night shift staff at 10:30 p.m. initiated the signing out to ensure the wanderguard on portable O2 every

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shift to ensure placement and ensure the resident have on portable tank at all times. A new entry on the Tx started 6/14/19, at 10:30 p.m. read, Portable O2 tank to be kept at NS (nursing station) when not in use." "Remind [R2] to not smoke with oxygen when giving [R2] the tank every shift. Furthermore, the treatment record started 6/14/19, 7-3 shift to complete searches daily with 2 staff on day shift for smoking materials. If found, remove and give to receptionist for usage. Document in the PN (progress notes) if materials found."

When interviewed on 6/17/19, at 11:22 p.m. with the administrator and director of nursing (DON) it was revealed that the facility had concerns with R2 who was observed 4/23/19, smoking outside while being on the portable O2 tank. The administrator verified that on 4/23/19, the facility started the process to assess the use of a wanderguard system on the portable O2 tanks so that the door would alarm if a resident went outside with the portable O2 tank to the smoking area. However, this process could not start until the wanderguard system was placed on the door to the smoking area on 6/6/19. This was over a month after R2 was found smoking with oxygen on while in the smoking area. They were unable to determine when R1 had been given an extra portable oxygen tank without the wanderguard system attached. The resident (R1) stated it had been, "a long time ago." This allowed R1 to go to the smoking area with a portable oxygen tank running and would not alert staff.

After the incident on 6/12/19, all residents who smoke and are on oxygen were assessed and educated on oxygen use and smoking. Orange tape was added to each portable oxygen tank for

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staff to easily identify a portable tank belonging to a resident who smokes. A system for checking wanderguard's on portable oxygen tanks every shift was initiated. In addition, facility smoking policies had been reviewed for adequacy and updated with an addendum. Staff education had also been implemented to ensure each shift of staff, prior to working, understood the facility's policies and implemented testing skills on employees for each shift to verify staff could follow through with implementation of smokers with portable oxygen tanks, so that tanks would not be taken to the smoking area.

Training material and sign in sheets were reviewed. Staff were being trained prior to starting their shift on each of the following areas: Smoking policy, smoking policy addendum, incident with R1, and a list of residents who smoke and are on oxygen. Sign in sheets had started in the evening of 6/12/19. Monitoring was added to resident treatment records to ensure wanderguard's were on smokers portable oxygen tanks on 6/14/19.

When interviewed on 6/18/19, at 9:20 a.m. RN-H stated she as trained on the smoking addendum and procedures for ensuring residents do not bring oxygen out to the smoking area.

When interviewed on 6/18/19, at 9:24 a.m. NA-B stated she had been trained on the smoking addendum and procedures for ensuring residents do not bring oxygen out to the smoking area.

When interviewed on 6/18/19, at 9:25 a.m. RN-B stated she had been trained on the smoking addendum and procedures for ensuring residents do not bring oxygen out to the smoking area.

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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 689	Continued From page 9	F 689		

When interviewed on 6/18/19, at 9:30 a.m. R6 stated she had been educated on not using oxygen while smoking, she does not have a portable oxygen tank, she just goes out twice a day to smoke without bringing any oxygen with her.

When interviewed on 6/18/19, at 9:35 a.m. NA-A sated she had been trained on the smoking addendum and procedures for ensuring residents do not bring oxygen out to the smoking area.

When interviewed on 6/18/19, at 2:55 p.m. LPN-B stated she had been trained on the smoking addendum and procedures for ensuring residents do not bring oxygen out to the smoking area.

When interviewed on 6/18/19, at 2:57 p.m. NA-I stated she had been trained on the smoking addendum and procedures for ensuring residents do not bring oxygen out to the smoking area.

When interviewed on 6/18/19, at 3:00 p.m. LPN-E stated she had been trained on the smoking addendum and procedures for ensuring residents do not bring oxygen out to the smoking area.

When interviewed on 6/18/19, at 3:03 p.m. RN-D stated she had been trained on the smoking addendum and procedures for ensuring residents do not bring oxygen out to the smoking area.

When interviewed on 6/18/19, at 3:04 p.m. the health unit coordinator (HUC) stated she had been trained on the smoking addendum and procedures for ensuring residents do not bring oxygen out to the smoking area.

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	245295	A. BUILDING _____ B. WING _____	C 06/19/2019

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F 689	Continued From page 10	F 689		

When interviewed on 6/18/19, at 3:05 p.m. NA-J stated she had been trained on the smoking addendum and procedures for ensuring residents do not bring oxygen out to the smoking area.

When interviewed on 6/18/19, at 3:07 p.m. RN-J stated she had been trained on the smoking addendum and procedures for ensuring residents do not bring oxygen out to the smoking area.

When interviewed on 6/18/19, at 3:17 p.m. LPN-R stated she had been trained on the smoking addendum and procedures for ensuring residents do not bring oxygen out to the smoking area.

When interviewed on 6/18/19, at 3:20 p.m. HUC-A stated she had been trained on the smoking addendum and procedures for ensuring residents do not bring oxygen out to the smoking area.

The past non-compliance that began on 6/12/19, was verified during the 6/19/19 onsite visit and was corrected on 6/14/19. The facility had immediately reviewed each resident's chart to verify smokers who used oxygen and then placed alarms on the portable oxygen tank with a wander guard alarm system. The door alarmed when resident entered the smoking area with a tank. Monitoring of each tank for alarms was implemented every shift. In addition, facility policies had been reviewed for adequacy and updated with an addendum. Staff education had also been implemented to ensure each shift of staff understood the facility policies which was reinforced by testing skills to verify staff could follow through with implementation of smokers with portable oxygen tanks.

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F 689	Continued From page 11	F 689		

An undated Resident Smoking Policy, which R1 signed on 3/14/19, indicated, The approved designated smoking area in the facility is in the back yard smoking area on the first level. The Smoking Safety Assessment must be completed by the care plan team upon admission, annually thereafter, and must be reviewed at least quarterly or with a change in condition that impacts the resident's ability to safely smoke. Environmental Considerations addressed that were in support of the facility smoking policy included *A method of observation/supervision by facility associates *Maintenance of emergency equipment and supplies-i.e.... sprinklers, fire extinguishers, storage. assignment of safety equipment i.e. smoking aprons, or devices to assist residents in smoking * The furnishings within the smoking area that meet flame retardant requirements *The location of designated smoking area and provisions to assure residents with the need for supplemental O2 do not access the area while smoking is taking place *The storage of any hazardous materials i.e. oxygen, medical gas, combustible or flammable materials are not located near the approved smoking area *The placement of the fan above the door is to remain in compliance with the MN Clean Air Act and Life Safely Codes in order to keep smoke fumes out of the building. This fan is to be turned on at all times.

An Addendum to the Resident Smoking Policy, dated 6/13/19, identified the risks to be,"*Burn, *Fire, *Death, *Smoke inhalation, *Particularly, in the presence of flammable gasses or liquids such as Oxygen, *The fire and burn risk of smoking is much higher when around oxygen and includes risk of facial flash burn and respiratory distress.

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F 689	Continued From page 12 We advise you to keep at least a 10 foot radius around those who are using oxygen while you are smoking. If oxygen tanks explode, you and those around you are at risk for serious injury and/or death."	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

July 3, 2019

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

RE: Project Number H5295167C

Dear Administrator:

On June 19, 2019, an abbreviated standard survey was conducted to investigate complaint Number H5295167C at your facility by the Minnesota Department of Health, Office of Health Facility Complaints 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.

The investigation resulted in no deficiencies being issued. Electronically attached is your copy of the Federal Form CMS-2567. 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. Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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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 6/17/19-6/19/19 surveyors of this Department's staff visited the above provider for a complaint investigation to investigate complaint H5295167C. No correction orders were issued The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is	2 000		

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2 000	Continued From page 1 not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		