



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 14, 2022

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

RE: CCN: 245295
Cycle Start Date: July 26, 2022

Dear Administrator:

On September 12, 2022, the Minnesota Department of Health 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

Electronically delivered

September 14, 2022

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

Re: Reinspection Results
Event ID: PK4V12

Dear Administrator:

On September 12, 2022 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 July 26, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Electronically delivered
August 16, 2022

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

RE: CCN: 245295
Cycle Start Date: July 26, 2022

Dear Administrator:

On July 26, 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:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 October 26, 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).

The Emeralds At St Paul LLC

August 16, 2022

Page 3

In addition, if substantial compliance with the regulations is not verified by January 26, 2023 (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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/14/2022
FORM APPROVED
OMB NO. 0938-0391

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 07/26/2022
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
F 000	INITIAL COMMENTS On 7/25/22-7/26/22, 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: H52953261C (MN85170), with deficiencies cited at F609, F610, F689. 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			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 609			8/1/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/24/2022

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 609	Continued From page 1 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure timely reporting of an incident due to potential neglect to the State Agency (SA) immediately (within two hours) for 1 of 3 residents (R1) reviewed for accidents. Findings include: R1's quarterly Minimum Data Set (MDS) assessment dated 6/1/22, identified R1 was moderately cognitively impaired, non-verbal, understood others and was sometimes understood by others. R1's diagnoses included traumatic brain injury, dementia, anxiety, and depression, had not exhibited wandering behavior, and used a wheelchair for mobility. R1's care plan dated 6/13/22, indicated R1 was a vulnerable adult and R1 would remain free from abuse and/or neglect. The care plan instructed staff to continue to respond to all concerns in a	F 609	F609-Reporting of Alleged Violations Immediate Corrective Action: Resident #1 refused skin assessment upon return to facility. Resident #1 elopement assessment and care plan were updated to reflect incident. All wander guard door alarms were checked and are functioning properly. Corrective Action as it applies to others: The Abuse Prevention Policy and Procedure was reviewed and remains current. DON & Administrator were educated on Abuse Prevention Policy and Procedure and Elopement Policy and Procedure.		

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F 609	Continued From page 2 timely manner per facility policy and procedure, and to follow the facility vulnerable adult abuse and reporting policy. The care plan also included the local Ombudsman, adult protection, police, and/or state/financial agencies would be notified of any suspected abuse or financial exploitation. R1's Order Summary Report dated 7/26/22, indicated R1 required supervision for leaves of absence from the facility. A progress note dated 7/14/22, at 11:02 p.m. indicated registered nurse (RN)-D discovered R1 was not in the building around 3:45 p.m. on 7/14/22. The note indicated review of security camera footage revealed R1 left the facility at 12:21 p.m. R1 returned to the facility at approximately 6:30 p.m. after being located by family who indicated R1 was "running away". During interview on 7/25/22, at 11:46 a.m. family member (FM)-A stated R1 suffered a traumatic brain injury due to a gunshot wound many years ago, and his father had recently died unexpectedly. She stated the administrator called her at 4:17 p.m. on 7/14/22, to ask if R1 was with her as he had not been seen since 12:32 on 7/14/22. FM-A stated she went out and drove around the area to look for him and she returned to the facility at 5:00 p.m. to see if he had come back. She received a call from a family friend who stated R1 was seen approximately one mile from the facility. FM-A stated R1's wheelchair had somehow gotten stuck, and a community member called an ambulance. FM-A reached R1 as he was about to be placed from his wheelchair onto a gurney to be placed in the ambulance. She stated R1 was unable to communicate his needs since he was non-verbal and left his "talk box" at	F 609	Date of Compliance: 8/1/22 Recurrence will be prevented by: Audit to ensure allegations of abuse and reportable events are reported to MN Department of Health immediately is being completed weekly x 4 weeks then monthly x 2 months. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/Designee		

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F 609	Continued From page 3 the facility. FM-A declined the ambulance and followed R1 in her car as he drove his wheelchair the mile back to the facility. She stated she didn't know how he could have crossed all of those busy streets to get to where he was, and he was "discombobulated" and could not find his way back. FM-A stated the facility did not "hit the panic button" fast enough. She stated, her son was "in danger" and the next day she asked the facility for information regarding the incident in writing and they acted like nothing really happened. She stated the facility told her they called the police and the police stated R1 was an adult and had to be missing longer. She stated she asked to see the police report, and questioned staff about why they didn't make this a "red alert" since he had a traumatic brain injury. During interview on 7/26/22, at 3:09 p.m. director of nursing (DON) stated she and the administrator questioned whether the elopement was reportable to the SA, however they were told by corporate staff it was not since R1 was his own person and he was just not following his leave of absence (LOA) orders. During interview on 7/26/22, at 3:20 p.m. administrator stated he reviewed the incident with corporate consultants, and it was decided the LOA policy applied and the facility would report the missing resident to the SA if he did not return within 24 hours. He stated anyone in the facility was considered vulnerable and confirmed R1 required supervision to leave the facility. He stated looking back at it, it should have been reported to the SA. The facility policy Abuse Prevention/Vulnerable Adult Plan dated 4/11/22, indicated suspected	F 609			

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F 609	Continued From page 4	F 609			
F 610 SS=D	abuse shall be reported to OHFC online reporting process not later than two hours after forming the suspicion of abuse. The policy identified incidents to be reported included mistreatment, neglect, abuse, avoidable accidents, and elopement. Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate following an incident of elopement for 1 of 3 residents (R1) reviewed for accidents. Findings include: R1's quarterly Minimum Data Set (MDS) dated 6/1/22, identified R1 was moderately cognitively	F 610	F610-Investigate/Prevent/Correct Alleged Violation Immediate Corrective Action: Facility conducted a thorough investigation of R#1 elopement on 7/26/22 Corrective Action as it applies to others:	8/1/22	

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F 610	Continued From page 5 impaired, non-verbal, understood others and was sometimes understood by others. R1's diagnoses included traumatic brain injury, dementia, anxiety, and depression, had not exhibited wandering behavior, and used a wheelchair for mobility. R1's care plan dated 6/13/22, indicated R1 was a vulnerable adult and R1 would remain free from abuse and/or neglect. The care plan instructed staff to continue to respond to all concerns in a timely manner per facility policy and procedure, and to follow the facility vulnerable adult abuse and reporting policy. The care plan also included the local Ombudsman, adult protection, police, and/or state/financial agencies would be notified of any suspected abuse or financial exploitation. R1's Order Summary Report dated 7/26/22, indicated R1 required supervision for leaves of absence from the facility. A progress note dated 7/14/22, at 11:02 p.m. indicated registered nurse (RN)-D discovered R1 was not in the building around 3:45 p.m. on 7/14/22. The note indicated review of security camera footage revealed R1 left the facility at 12:21 p.m. R1 returned to the facility at approximately 6:30 p.m. after being located by family who indicated R1 was "running away". R1's medical record reviewed on 7/25/22, lacked evidence of incident review and analysis. During interview on 7/25/22, at 11:46 a.m. family member (FM)-A stated R1 suffered a traumatic brain injury due to a gunshot wound many years ago, his father had recently died unexpectedly, and he was struggling with his mental health. She stated the administrator called her at 4:17 p.m. on	F 610	The Abuse Prevention Policy and Procedure was reviewed and remains current. DON & Administrator were educated on Abuse Prevention Policy and Procedure including completing a thorough investigation. All staff educated on LOA Policy and Procedure and LOA orders to ensure that residents that need to have supervised LOAs are accompanied on their LOA and reviewing the LOA list at the receptionist desk. Date of Compliance: 8/1/22 Recurrence will be prevented by: Audits to ensure any abuse/neglect is thoroughly investigated weekly x 4 weeks then monthly x 2 months. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/Designee		

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F 610	Continued From page 6 7/14/22, to ask if R1 was with her as he had not been seen since 12:32 on 7/14/22. FM-A stated she went out and drove around the area to look for him and she returned to the facility at 5:00 p.m. to see if he had come back. She received a call from a family friend who stated R1 was seen approximately one mile from the facility. FM-A stated R1's wheelchair had somehow gotten stuck, and a community member called an ambulance. FM-A reached R1 as he was about to be placed from his wheelchair onto a gurney to be placed in the ambulance. She stated R1 was unable to communicate his needs since he was non-verbal and left his "talk box" at the facility. FM-A declined the ambulance and followed R1 in her car as he drove his wheelchair the mile back to the facility. She stated she didn't know how he could have crossed all those busy streets to get to where he was, and he was "discombobulated" and could not find his way back. FM-A stated the facility did not "hit the panic button" fast enough. She stated, her son was "in danger" and the next day she asked the facility for information regarding the incident in writing and they acted like nothing really happened. She stated the facility told her they called the police and the police stated R1 was an adult and had to be missing longer. She stated she asked to see the police report, and questioned staff about what they didn't make this a "red alert" since he had a traumatic brain injury. During interview on 7/26/22, at 8:37 a.m. front desk staff (FD)-A stated he recalled R1 sitting outside the front door in the sun in the afternoon on 7/14/22, but was not sure of the time. He stated a nurse came down at the end of his shift around 3:30 and asked him where R1 was. He stated neither the director of nursing (DON) nor	F 610			

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F 610	Continued From page 7 the administrator had asked him any questions after the incident, and he was unaware of any investigation. During interview on 7/26/22, at 3:09 p.m. DON stated. She was unaware of any formal investigation and stated this was an isolated event. During interview on 7/26/22, at 12:59 p.m. administrator stated he was just informed moments earlier that two front desk staff had witnessed R1 go outside on 7/14/22, at 12:32 p.m. During interview on 7/26, 22, at 3:20 p.m. administrator stated his investigation included an interview with FM-A to find the root cause and a couple of staff, however no formal investigation was conducted. He stated if a thorough investigation would have been completed additional information could have been gathered to help identify witnesses and potential process concerns. The facility policy Abuse Prevention/Vulnerable Adult Plan dated 4/11/22, indicated the Investigative Team (including, but not limited to the administrator, DON, nurse manager, and social worker) will review all incident reports regarding residents including those that indicate abuse, and investigation will begin immediately. The investigation may include interviewing staff, residents, or other witnesses to the incident, and corrective action based on the investigation will be completed. All documentation will be kept in a confidential file in the facility in accordance with State Law.	F 610			

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OMB NO. 0938-0391

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 07/26/2022
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
F 689 F 689 SS=D	Continued From page 8 Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive re-assessment was completed and individualized interventions were implemented for 1 of 3 residents (R2) reviewed for accidents. Findings include: R2's quarterly Minimum Data Set (MDS) assessment dated 5/4/22, indicated R2 had a brief interview for mental status (BIMS) score of 10 which indicated R2 had moderate cognitive impairment with diagnoses of adult failure to thrive and alcohol abuse. R2's MDS further indicated R2 had no wandering behaviors. R2's elopement risk assessment dated 12/27/22, indicated R2 was a low risk for elopement. R2's risk assessment further directed staff to evaluate residents elopement potential upon admission and with significant change. R2's progress note dated 6/2/22, at 2:09 p.m. indicated R2 approached social worker (SW)-A several times wanting to go out to buy cigarettes. SW-A told R2 he was not safe out in the	F 689 F 689	F689-Free of Accident Hazards/Supervision/Devices Immediate Corrective Action: R#2 was discharged from facility on 7/22/22 Corrective Action as it applies to others: Elopement Guideline policy was reviewed and remains current. Nurse Managers educated by DON on Elopement Policy guidelines including completing elopement assessments with residents. All resident LOA orders reviewed, elopement risk assessments completed, and care plans were updated to reflect assessment. All staff educated on LOA Policy and Procedure and LOA orders to ensure that residents that need to have supervised		8/1/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 9 community on his own and R2 was upset. R2's progress note dated 6/20/22, at 1:34 p.m. indicated SW-A met with R2 to discuss R2 wanting to leave the facility. R2 had his bags packed and was ready to go. SW-A informed R2 it was not safe for him in the community without supervision. SW-A called R2's guardian and was able to redirect R2 from leaving. R2's progress note dated 7/5/22, at 9:48 a.m. indicated SW-A was informed R2 was attempting to leave the facility and was downstairs by the receptionist with his bags packed. R2 indicated he was tired of the facility and was going to go to his brother's house. R2's progress note further indicated R2 no longer wanted to be at the facility and could walk out the doors. SW-A was able to redirect R2 after family involvement. R2's progress note dated 7/14/22, at 11:32 a.m. indicated R2 attempted to leave the facility around 7:15 a.m. R2 became combative, impulsive, and difficult to stop. R2 left the facility and was followed by staff. The note further indicated R2 had eventually returned to the facility with staff and had remained on 1:1 supervision until sent to the hospital for evaluation. R2's electronic medical record (EMR) lacked evidence an elopement re-assessment was completed, or interventions were implemented to ensure R2's safety after the above elopement attempts. R2's EMR lacked evidence a wander guard was ordered, applied, or monitored. R2's care plan lacked evidence interventions had	F 689	LOAs are accompanied on their LOA and reviewing the LOA list at the receptionist desk. Date of Compliance: 8/1/22 Recurrence will be prevented by: Audits to ensure any abuse/neglect is thoroughly investigated weekly x 4 weeks then monthly x 2 months. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/Designee		

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F 689	Continued From page 10 been implemented to ensure safety and prevent R2 from eloping. In an interview on 7/26/22, at 9:18 a.m. registered nurse (RN)-A stated after a resident had an attempt to elope or eloped, RN-B would complete the elopement risk assessment and update the care plan. RN-A verified only RN-B completed resident assessments and updated care plans. Staff then followed the care plan. A resident's leave of absence (LOA) status was an order and populated on the EMR banner. This banner communicated to staff if the resident required supervision or was independent with LOA. RN-A verified R2 was independent. RN-A further stated "we were all aware "of R2 wanting to leave the facility and go stay with his brother; R2 was always saying that. RN-B acknowledged R2 was downstairs with his belongings at times. RN-A stated SW-A was informed to help when R2 wanted to leave. RN-A thought R2 had a wander guard but was not certain. RN-A was not sure about any other interventions in place to prevent R2 from attempting to leave the facility. In an interview on 7/26/22, at 9:32 a.m. RN-C stated staff had to look at a resident's care plan to determine their elopement risk. An elopement assessment was completed by the RN-B or the providers after a resident attempted to leave. This also helped to determine if a resident could leave the facility without supervision. RN-B was aware R2 did not like being at the facility and was downstairs smoking most of the time. RN-C verified R2's EMR banner lacked direction to staff if supervision was needed if R2 were to leave the facility and no information in R2's care plan. Furthermore, RN-C was not sure if R2 had a wander guard.	F 689			

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F 689	Continued From page 11 In an interview on 7/26/22, at 9:50 a.m. SW-A stated staff were usually aware of elopement attempts before she was. If there was an attempt, staff would notify her to meet with the resident and redirect. SW-A verified R2 had attempted to leave because of cigarettes or trying to go to his brother's house. SW-A further stated usually R2 would redirect but acknowledged R2 did not like being at the facility and R2 felt like he was grown and could make his own decisions. SW-A confirmed R2 was not able to leave the facility independently due to R2's cognition status. SW-A thought R2 had a wander guard on his walker, but also had refused to use the walker at some point. In an interview on 7/26/22, at 10:34 a.m. R2's guardian stated R2 was not accepting of having to reside in a facility. R2 wants to live on his own and smoke when wanted. The guardian stated R2's attempts to leave the facility were around wanting to move out or about wanting to obtain more cigarettes. R2's guardian acknowledged SW-A did talk about the possibility of moving R2 to a sister facility which had a locked unit the day R2 had been admitted to the hospital, but there were no other discussions or any interventions or a wander gaud placement to prevent R2 from leaving the facility. R2 was now discharged from the hospital but was residing at a different facility with a locked unit. In an interview on 7/26/22, at 12:19 p.m. the Director of Nursing (DON) stated an elopement risk was expected to be completed on admission, annually, and as needed. The DON further clarified "as needed" included circumstances where there was a change in behavior, wandering	F 689			

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F 689	Continued From page 12 more, making statements of wanting to leave, an attempt for elopement or an actual elopement. Any of these circumstances would warrant resident re-assessment for elopement be completed. The DON was aware of R2's increased behaviors of wanting to leave the facility and had put in place interventions such as calling R2's brother or guardian, SW-A involvement, and increased activities. The DON acknowledged these interventions were not on R2's care plan. The DON stated R2 had been redirected and felt the interventions were working, so a re-assessment was not completed. In a follow up interview at 12:58 p.m. the DON verified R2 having bags packed to leave the facility was an attempted elopement and R2 should have been re-assessed for risk of elopement and interventions developed at those times. A facility policy titled Elopement Guideline dated 11/2017, directed staff to assure each resident was assessed on an ongoing basis and had appropriate safety precautions in place. Documentation should include a care plan that addressed the potential to wander or exit the facility and the measures taken to prevent wandering/elopement.	F 689			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 16, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: PK4V11

Dear Administrator:

The above facility was surveyed on July 25, 2022 through July 26, 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

The Emeralds At St Paul LLC

August 16, 2022

Page 2

"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:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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

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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 7/25/22-7/26/22, 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			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

08/24/22

Minnesota Department of Health

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H52953261C (MN85170), with a licensing ordered 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 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.	2 000			

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2 000	Continued From page 2 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			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive re-assessment was completed and individualized interventions were implemented for 1 of 3 residents (R2) reviewed for accidents. Findings include: R2's quarterly Minimum Data Set (MDS) assessment dated 5/4/22, indicated R2 had a brief interview for mental status (BIMS) score of 10 which indicated R2 had moderate cognitive impairment with diagnoses of adult failure to	2 830	Corrected		8/1/22

Minnesota Department of Health

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2 830	Continued From page 3 thrive and alcohol abuse. R2's MDS further indicated R2 had no wandering behaviors. R2's elopement risk assessment dated 12/27/22, indicated R2 was a low risk for elopement. R2's risk assessment further directed staff to evaluate residents elopement potential upon admission and with significant change. R2's progress note dated 6/2/22, at 2:09 p.m. indicated R2 approached social worker (SW)-A several times wanting to go out to buy cigarettes. SW-A told R2 he was not safe out in the community on his own and R2 was upset. R2's progress note dated 6/20/22, at 1:34 p.m. indicated SW-A met with R2 to discuss R2 wanting to leave the facility. R2 had his bags packed and was ready to go. SW-A informed R2 it was not safe for him in the community without supervision. SW-A called R2's guardian and was able to redirect R2 from leaving. R2's progress note dated 7/5/22, at 9:48 a.m. indicated SW-A was informed R2 was attempting to leave the facility and was downstairs by the receptionist with his bags packed. R2 indicated he was tired of the facility and was going to go to his brother's house. R2's progress note further indicated R2 no longer wanted to be at the facility and could walk out the doors. SW-A was able to redirect R2 after family involvement. R2's progress note dated 7/14/22, at 11:32 a.m. indicated R2 attempted to leave the facility around 7:15 a.m. R2 became combative, impulsive, and difficult to stop. R2 left the facility and was followed by staff. The note further indicated R2 had eventually returned to the facility with staff and had remained on 1:1 supervision	2 830			

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2 830	Continued From page 4 until sent to the hospital for evaluation. R2's electronic medical record (EMR) lacked evidence an elopement re-assessment was completed, or interventions were implemented to ensure R2's safety after the above elopement attempts. R2's EMR lacked evidence a wander guard was ordered, applied, or monitored. R2's care plan lacked evidence interventions had been implemented to ensure safety and prevent R2 from eloping. In an interview on 7/26/22, at 9:18 a.m. registered nurse (RN)-A stated after a resident had an attempt to elope or eloped, RN-B would complete the elopement risk assessment and update the care plan. RN-A verified only RN-B completed resident assessments and updated care plans. Staff then followed the care plan. A resident's leave of absence (LOA) status was an order and populated on the EMR banner. This banner communicated to staff if the resident required supervision or was independent with LOA. RN-A verified R2 was independent. RN-A further stated "we were all aware "of R2 wanting to leave the facility and go stay with his brother; R2 was always saying that. RN-B acknowledged R2 was downstairs with his belongings at times. RN-A stated SW-A was informed to help when R2 wanted to leave. RN-A thought R2 had a wander guard but was not certain. RN-A was not sure about any other interventions in place to prevent R2 from attempting to leave the facility. In an interview on 7/26/22, at 9:32 a.m. RN-C stated staff had to look at a resident's care plan to determine their elopement risk. An elopement	2 830			

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2 830	Continued From page 5 assessment was completed by the RN-B or the providers after a resident attempted to leave. This also helped to determine if a resident could leave the facility without supervision. RN-B was aware R2 did not like being at the facility and was downstairs smoking most of the time. RN-C verified R2's EMR banner lacked direction to staff if supervision was needed if R2 were to leave the facility and no information in R2's care plan. Furthermore, RN-C was not sure if R2 had a wander guard. In an interview on 7/26/22, at 9:50 a.m. SW-A stated staff were usually aware of elopement attempts before she was. If there was an attempt, staff would notify her to meet with the resident and redirect. SW-A verified R2 had attempted to leave because of cigarettes or trying to go to his brother's house. SW-A further stated usually R2 would redirect but acknowledged R2 did not like being at the facility and R2 felt like he was grown and could make his own decisions. SW-A confirmed R2 was not able to leave the facility independently due to R2's cognition status. SW-A thought R2 had a wander guard on his walker, but also had refused to use the walker at some point. In an interview on 7/26/22, at 10:34 a.m. R2's guardian stated R2 was not accepting of having to reside in a facility. R2 wants to live on his own and smoke when wanted. The guardian stated R2's attempts to leave the facility were around wanting to move out or about wanting to obtain more cigarettes. R2's guardian acknowledged SW-A did talk about the possibility of moving R2 to a sister facility which had a locked unit the day R2 had been admitted to the hospital, but there were no other discussions or any interventions or a wander guard placement to prevent R2 from	2 830			

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 07/26/2022
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2 830	Continued From page 6 leaving the facility. R2 was now discharged from the hospital but was residing at a different facility with a locked unit. In an interview on 7/26/22, at 12:19 p.m. the Director of Nursing (DON) stated an elopement risk was expected to be completed on admission, annually, and as needed. The DON further clarified "as needed" included circumstances where there was a change in behavior, wandering more, making statements of wanting to leave, an attempt for elopement or an actual elopement. Any of these circumstances would warrant resident re-assessment for elopement be completed. The DON was aware of R2's increased behaviors of wanting to leave the facility and had put in place interventions such as calling R2's brother or guardian, SW-A involvement, and increased activities. The DON acknowledged these interventions were not on R2's care plan. The DON stated R2 had been redirected and felt the interventions were working, so a re-assessment was not completed. In a follow up interview at 12:58 p.m. the DON verified R2 having bags packed to leave the facility was an attempted elopement and R2 should have been re-assessed for risk of elopement and interventions developed at those times. A facility policy titled Elopement Guideline dated 11/2017, directed staff to assure each resident was assessed on an ongoing basis and had appropriate safety precautions in place. Documentation should include a care plan that addressed the potential to wander or exit the facility and the measures taken to prevent wandering/elopement. SUGESTED METHOD OF CORRECTION: The administrator and/or designee could	2 830			

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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 07/26/2022
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2 830	Continued From page 7 develop/revise policies or procedures to ensure staff are following the elopement policy and reassessing a resident's risk for elopement with changes in behaviors or an attempt was made. The administrator and/or designee could provide education to staff and conduct audits to ensure assessments and care plans are updated. Thee administrator and/or designee could conduct audits to ensure assessments are completed and care plans are updated. 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.	2 830			