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	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emeralds at Faribault LLC	500 Southeast First Street Faribault, MN 55021

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45843 Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R5) who was observed to have medications in his room, had been appropriately assessed and deemed safe to self-administer medications. Findings include: R5's admission record, indicated history of a heart disease, morbid obesity and type 2 diabetes. R5's annual Minimum Data Set (MDS) assessment dated [DATE], indicated R5 was cognitively intact, had clear speech, could understand and be understood. R5 was dependent upon staff for most activities of daily living other than set up for eating and oral hygiene. R5's June medication administration record (MAR) and treatment administration record (TAR) indicated 9:00 a.m. oral medication orders: 1. Cardizem CD capsule extended release 24-hour 120 milligram (mg) Give 1 capsule by mouth one time a day, dated 9/25/23. 2. Digox oral tablet 125 microgram (mcg) give 0.125 mg by mouth one time a day. Dated 9/25/23. 3. Losartan Potassium oral tablet 50 mg. Give 1 tablet by mouth one time a day. Dated 7/4/23. 4. Montelukast sodium oral tablet 10 mg. Give 1 tablet by mouth one time a day. Dated 7/4/23. 5. Potassium chloride oral packet 20 milliequivalent (MEQ). Give 20 MEQ by mouth in the morning for hypokalemia. Dated 2/28/24. 6. Torsemide oral tablet 40 MG. Give 80 mg by mouth one time a day. Dated 9/25/23. 7. Apixaban oral tablet. Give 5 mg by mouth two times a day. Dated 7/3/23. 8. Doxycycline hyclate tablet 100 mg. Give 1 tablet by mouth two times a day. Dated 6/10/24. 9. Sertraline HCL oral tablet. Give 100 mg by mouth two times a day. (continued on next page)

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.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10. Pramipexole dihydrochloride oral tablet 1 mg. Give 1 mg by mouth three times a day. R5's care plan dated 7/27/23, indicated administer medications as ordered. R5's provider visit date of service 5/9/24, indicated resident was ok to keep inhalers at bedside. Documentation did not address any other self-administration orders. R5's medical record lacked documentation of assessments for safe self-administration of oral medications. During an observation on 6/17/24 at 11:50 a.m., in R5's room, observed one paper souffle cup with multiple oral medications inside it and a plastic medication inhaler on R5's bedside table over her bed. During an interview on 6/17/24 at 11:50 a.m., R5 stated the medications and inhaler on her bedside table she had been given around 8:30 a.m. or 9:00 a.m R5 stated the nurse had come in earlier and told me to take the medications. The nurse had come back later and peaked her head in the door and said quick take those pills and again had come back before she left and asked did you take those pills. I don't want to get anyone in trouble, I just forgot to take them. During an interview on 6/17/24 at 12:08 p.m., trained medication aide (TMA)-A stated after looking into the computer for R5's MAR it identified R5 did have a self-administration order for her inhalers but did not have a self-administration order for oral medications. TMA-A stated R5 would not be capable to self-administer medications without a proper order from her provider. TMA-A was informed of finding medications in R5's room. TMA-A stated medications can only be left in a resident's room if the resident had a self-administration of medication order. During an interview on 6/18/24 at 11:43 a.m., director of nursing (DON) stated she would expect the person on the floor passing medications to follow the facility policy and what they had learned in school. DON stated visual observation of the resident taking the medications is expected if they do not have a self-administration order. DON stated for a resident to have a self-administration order they would need to be assessed and deemed safe to administer by them self and a provider would need to put in the self-administration order. Facility Policy dated 5/2022, indicated: 14) residents can self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications. 18) the resident is always observed after the administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is to be noted on the MAR, and action is taken as appropriate.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45843 Based on observation, interview, and record review the facility failed to follow the standards of practice for the: (1) administration of nebulizer treatment solution and do the necessary assessment during and after the administration of the nebulizer treatment solution; and (2) failure to follow physician order to apply compression stockings daily for one of one resident (R8) observed for medication administration. Findings Include: R8's admission record indicated R8 had a history of acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, and history of pulmonary embolism. R8's admission Minimum Data Set (MDS) dated [DATE], indicated R8 was cognitively intact, had clear speech and was able to understand and be understood. MDS also indicated R8 had not exhibited rejection of cares. Resident's care plan for activities of daily living (ADL's) dated 6/18/24, indicated intervention of resident is able to put compression stockings on with help of a sock aide. R8's medication administration record (MAR) and treatment administration record (TAR) dated 6/2024 included orders for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 milligrams per 3 milliliters (mg/3ml). Inhale orally three times a day. R8's record also included Teds (Thrombo Embolic Deterrent) Stockings (anti-embolism stockings for the legs that help prevent blood clots) on in the a.m. and off in the p.m. for edema order start date of 4/13/24. During an observation on 6/17/24 at 1:07 p.m., R8 was being administered Ipratropium-Albuterol Inhalation solution 0.5-2.5 mg.3ml with nebulizer (drug delivery device used to administer medication in the form of a mist inhaled into the lungs) treatment (Ipratropium-Albuterol Sulfate Inhalation Solution - the Albuterol is a beta-adrenergic bronchodilator which have cardiac effects that should be monitored during treatment) in R8's room. The assigned trained medication assistant (TMA)-B was observed by the medication cart near the nurses' station and was looking at the computer monitor to set up the next residents' medications. Observation revealed TMA-B left R8 unsupervised during the administration of the nebulizer treatment. TMA did not listen to R8's lung sounds, heart rate, check oxygen saturation and or pulse after the nebulization treatment. R8 was also observed to have swollen lower extremities with areas of redness and shininess noted on both lower extremities. Resident did not have any kind of stocking, wrap or compression dressing on. During an interview on 6/17/24 at 2:21 p.m., R8 stated she was supposed to have compression stockings on daily as her legs get swollen and will break open with sores. R8 reported she had been told by staff she needed to put them on herself and she stated she had told the staff multiple times she was unable to get the stockings on. R8 stated she had told the nurse but nothing had been done related to her concerns. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R8's MAR/TAR on 6/17/24 at 2:27 p.m., indicated R8 to have compression stockings on. R8's medical record reviewed and lacked documentation to indicate assessment of lung sound assessments, pulse, restlessness, and or nervousness related to nebulizer treatments. During an observation on 6/17/24, at 2:27 p.m. R8 did not have any [NAME] stockings or compression wraps of any kind on her legs and they were noted to be open to air. During an interview on 6/18/24, at 9:21 a.m. R8 reported her legs had not gotten [NAME] stockings on yesterday and no one had removed them the night before as she has not had them on for days. R8 again reported concern of her skin splitting open and noted a small open area on the back of her right ankle. During an interview with the Director of Nursing (DON) on 4/14/23 at 9:51am, the above observations were relayed to the DON and the surveyor asked the DON about her expectations when nursing staff administer nebulizer treatment to any resident. The DON stated, [I expect the nursing staff] to stay with them [residents during the administration of the nebulizer treatment]. The DON further stated, I do not know the current policy for nebulizer treatments without looking it up but I would expect staff to follow the facility policy on administering nebulizer treatments. DON also stated if the TAR indicated for resident to have [NAME] stockings on daily staff should be documenting them to be on only if they are on and if they are not on should be documenting why they are not on and informing the provider if resident is refusing and or not wearing them. If staff were to document the resident has [NAME] stockings on and they didn't this is an error and depending on the severity we would provide corrective action and or re-education. Review of the facility's Oral Inhalation Administration policy and procedure revised 1/2018, included the following instructions for administering medication through a small volume (handheld) nebulizer, with additional instructions not listed below. K. Instruct the resident to take a deep breath, and then exhale normally. Repeat pattern throughout treatment. L. Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer. M. Approximately five minutes after the treatment begins (or sooner if clinical judgment indicates) obtain the resident's pulse. N. Monitor for medication side effects, including rapid pulse, restlessness, and nervousness throughout the treatment. O. Stop treatment and notify the physician if the pulse increases 20 percent above baseline or if the resident complains of nausea or vomits. P. Tap the nebulizer cup occasionally to ensure release of droplets from the sides of the cup. Q. Encourage resident to cough and expectorate as needed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R. Administer therapy until medication is gone (mist has stopped) or until the designated time of the treatment has been reached. S. When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece, and medication cup. T. Obtain post-treatment pulse, respiratory rate and lung sounds and document findings (on the MAR or in the resident's medical record.)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45843 Based on interview, record review and observation, the facility failed to provide pharmacy services for 1 of 1 resident (R6), who did not receive her scheduled medication for pain resulting in uncontrolled pain and the use of narcotic pain medication. Furthermore, the facility failed to follow safeguards to ensure residents received the correct medications for 1 of 1 resident (R6). R6's admission record indicated R6 had a history of perforation of the intestine, encounter for surgery on the digestive system, gastrostomy status and colostomy status. R6's admission Minimum Data Set (MDS) dated [DATE], indicated she was unable to complete the cognitive assessment and was sometimes understood and sometimes able to understand. MDS also indicated R6 to have pain and used as needed pain medication (PRN) in the last 5 days. R6's medication administration record (MAR) dated June 2024, indicated she was supposed to receive acetaminophen 1000 milligrams (mg) every 6 hours via percutaneous endoscopic gastrostomy (PEG) tube, for pain. During an observation of medication pass on 6/17/24 at 12:58 p.m., trained medication assistant (TMA)-B was observed setting up medications for a resident who needed medications via tube. TMA-B dispensed the medications into a blue cup wrote the room number on the cup and placed them in the top of the medication cart and locked the cart and walked away. During an interview on 6/17/24 at 12:58 p.m. TMA-B stated she was setting up medications for the nurse to administer when they returned from their break. TMA-B stated she was able to set medications up to assist the nurse and had not been told that she was not supposed to set medications up that she was not giving. During an interview on 6/17/24 at 1:07 p.m., clinical manager (CM)-A stated nobody should set up medications for someone else to give. If a person was to give medications, they had not dispensed they would not be able to identify they were giving the correct medications. During an observation on 6/17/24 at 2:43 p.m., R6 heard yelling and crying for help stating her pain was unbearable. During an interview on 6/17/24 at 2:43 p.m., R6 stated she was needing something for pain. R6 reported she had been asking for medication for pain since around noon and had been told that someone would be back in a couple minutes but they had never returned. During an interview on 6/17/24 at 2:51 p.m. registered nurse (RN)-A stated he had just started his shift and had been told R6 had not gotten her noon medications because the physician assistant had been in her room meeting with her and R6 had reported to her she was not having pain. RN-A reported he had given R6 her PRN oxycodone for a pain level of 10 per R6's request and physician orders. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/18/24 at 11:43 a.m., director of nursing (DON) stated the expectation is for the person passing medications on the floor to follow facility policy and what they had learned in school. DON indicated TMAs in the facility are not able to give medications through PEG tubes but should not be pre-setting or setting medications for others to pass ever as it is against facility policy. The person who would set up the medications is the person who should give the medications. Facility policy titled, Pharmacy Services for Nursing Facilities revised 12/2019, Medication administration general guidelines. 4.) Five Rights-Right resident, right drug, right dose, right route, and right time are applied for each medication being administered. A triple check of these 5 rights is recommended at three steps in the process of preparation of a medication for administration. 7.) The person who prepares the dose for administration is the person who administers the dose. Facility policy titled, General Guidelines for Administering Medication Via Enteral Tube revised 1/2018, indicated, The facility assures safe and effective administration of enteral formulas and medications via enteral tubes. Selection of enteral formulas, routes and methods of administration, and the decision to administer medications via enteral tubes are based on nursing assessment of the resident's condition, in consultation with the physician, dietitian, and consultant pharmacist.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45843 Based on interview and document review, the facility failed to ensure a provider order for a urine analysis with urine culture (UA/UC) and sensitivity had been obtained in a timely manner for 1 of 1 resident (R7) reviewed for change of condition. Findings include: R7's admission record indicated a history of hemiplegia and hemiparesis following cerebral infarction, and chronic kidney disease. R7's quarterly Minimum Data Set (MDS) dated [DATE], indicated R7 was cognitively intact, had clear speech and was understood and able to understand others. R7's provider order dated 6/13/24, indicated R7 required a UA/UC with sensitivity related to diagnosis of dysuria. R7's medication administration record (MAR) and treatment administration record dated 6/2024 indicated an order for UA/UC had been put in on 6/14/24 and had check marks with initials noted for the evening and night shift for 6/14, 6/15, 6/16, and 6/17. No documentation noted for the day shift. Leaving open holes on the day shifts. R7 progress note date 6/13/24 at 8:40 p.m., indicated having acute visit with provider for dysuria and facial tingling. Resident reported dysuria multiple times per day with urination, and incontinence with coughing and whenever she stands in EZ stand (mechanical lift used to assist resident to stand from seated position) to transfer to and from wheelchair. R7 progress note dated 6/18/24 at 10:27 a.m. indicated resident urine sample collected and sent to lab via staff. During an interview on 6/18/24 R 8:25 a.m., R7 stated she was informed by her nurse practitioner (NP) that she could have an urinary tract infection (UTI) even if she was on preventative medication. Provider had ordered UA/UC awhile ago and staff had still not collected the sample and she still did not have results. R7 reported she still had burning at times when she urinated. During an interview on 6/18/24 at 9:12 a.m., licensed practical nurse (LPN)-A stated if a resident has an order for a UA/UC it would be on the treatment administration record (TAR)and it should be collected as soon as possible. LPN-A stated she could see R7 had an order for an UA/UC but could not identify if the order had been completed as the documentation in the TAR indicated it had been completed every shift for the last three days. LPN-A stated sometimes the nurse on the floor will collect a specimen and send it in and forget to discontinue the order. She stated they should write a progress note or document somewhere in the medical record when the order had been completed but was unable to locate documentation. LPN-A indicated she would need to check with the nurse manager to find out if the UA/UC had been completed. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/18/24 at 12:50 p.m., NP stated she had seen R7 on 6/13/24 and had educated her to the fact that even when a person is taking prophylactic medications for UTI's they could still get the infection. NP indicated she had ordered an UA/UC on that date and still had not received the results of that lab test. NP stated she would expect that the facility would be able to collect the specimen within 48 hours or they should contact her. NP indicated that getting UTI results late could cause infection to travel to the kidneys, increase the infection and or cause more distress. During an interview on 6/18/2 at 11:43 a.m., the director of nursing (DON) stated she would expect that if a resident has an order for an UA/UC the urine specimen should be collected as soon as possible. Documentation in the MAR or TAR every shift related to if the specimen was collected, if it was not completed during their shift, staff should document in the medical record why it wasn't completed. A facility procedure/process for lab collection was requested however was not received.