STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview and record review the facility failed to ensure allegation of a potential drug diversion was recognized and reported to the state agency (SA), reviewed for misappropriation of property. Finding s included: R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 was cognitive and had a diagnosis of narcolepsy (a rare neurological condition that makes people very sleepy during the day and can cause them to fall asleep suddenly). R1's order summary dated 1/6/25, identified an order for methylphenidate long acting (LA) (a stimulant medication to help with narcolepsy) 20 mg capsule to be given every day in the morning for narcolepsy. R1's Medication Administration Record (MAR) dated 1/6/25, identified R1 did not receive methylphenidate extended release (ER) 20 mg capsule as indicated by the number, 5 documented that indicated to see progress note. It was documented from 1/6/25 to 1/20/25, that R1 received his methylphenidate daily as indicated by nurse initials. R1's progress note dated 1/9/25 at 1:45 p.m., identified physical therapy (PT) went in R1's room to find R1 unresponsive to verbal and tactile stimuli. Writer was called and found R1 unresponsive, nystagmus (eyes rolled back in head), and experiencing involuntary jerking of bilateral arms. R1 had change in mental status and was unable to say his name and where he was. Writer notified primary and got the green light to send him to the hospital. 911 called and R1 was taken to the hospital. All parties notified. R1's ED (emergency department) progress note dated 1/9/25, at 1:54 p.m., identified during physical therapy (PT) R1 had a syncopal episode witnessed by staff. R1 was diagnosed with syncope (a brief loss of consciousness, or fainting, that occurs when blood flow to the brain is reduced) and collapse (a sudden loss of consciousness). Discharge instructions identified to follow up with provider and return if symptoms worsen. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2025
NAME OF PROVIDER OR SUPPLIER The Emeralds at Faribault LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Southeast First Street Faribault, MN 55021	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's progress note dated 1/9/25 at 6:00 p.m., R1 was returned via ambulance at 6:00 p.m. and was transferred to bed. R1 came back alert and orientated x 3. No significant findings found. No new orders given. When asked if R1 remembered what caused him to go to the hospital R1 stated he didn't remember a thing. R1's progress note dated 1/10/25 at 1:54 p.m., identified R1 was sent to the ED for decreased level of responsiveness . R1's hospital lab results dated 1/10/25 at 4:59 p.m., identified R1's inhouse rapid urine drug screen collected at 6:46 p.m., did not detect methamphetamine or amphetamines. The threshold concentrations used for amphetamines and methamphetamines was 500 ng/ml respectively. R1's ED course summary dated 1/10/25, identified R1 presented to the ED with intermittent episodes of confusion. EMS (emergency medical services) was called because R1 had one of what sounds to be his typical narcolepsy episode. R1's MAR from his nursing facility was reviewed and it does appear that he had been receiving his methylphenidate. It is possible he needed a dose adjustment on this medication. I did also consider possible drug diversion, given family stated that R1 had been on this dose of medication for quite some time and had been stable. At 5:10 p.m., amphetamine not detected .which was somewhat unexpected for R1 who was supposed to be receiving methylphenidate, including this morning. At 5:29 p.m., discussed with pharmacist and agree, would anticipate positive test for amphetamines on UDS (urine drug screen) if R1 was being given his medications appropriately. This does raise the concern for diversion of medications. At 6:52 p.m., R1's family was notified about the urine drug screen results, as well as my concern that we are not seeing an anticipated false positive for amphetamines in the setting of methylphenidate which was reportedly administered per MAR provided by nursing home, including this morning. Family would like to send confirmatory blood test; aware this is a send out test and this will take several days. At 6:56 p.m., emergency department registered nurse (EMRN)-A called and spoke with nurse for R1 at the Emeralds. Informed her of concern due to negative amphetamine results in urine drug screen although R1 was prescribed methamphetamines. Facility nurse stated she will email this information to their DON. R1's discharge summary dated 1/10/25, identified R1's urine drug screen was negative for amphetamines, which is unexpected if you are taking methylphenidate. A confirmatory test will be sent and takes several days to come back. Please ensure that your medications are being administered as prescribed. This would likely be causing your increased episodes related to narcolepsy and cataplexy (sudden muscle weakness that occurs while a person is awake). R1's progress note dated 1/10/25 at 10:34 p.m., identified R1 came from hospital at around 9:45 p.m., lab showed that R1's urine screen was negative for amphetamines which showed that R1 has not been taking methylphenidate. Further identified R1 was seen for the following diagnoses altered mental status, unspecified altered mental status, narcolepsy and cataplexy. During an interview on 1/16/25 at 2:37 p.m., R1 was lying in bed and stated he was not sure if he was getting his medication for his narcolepsy and indicated he had been on that medication for years. R1 stated he normally took a white capsule. R1 stated if he doesn't take it, he would be sleeping. R1 further stated he never knows when the narcolepsy would hit him, but when he does fall asleep, he had been told its very hard to wake him. R1 further indicated he has had several ED trips since being in the facility and was not sure what he was at the ED for. (continued on next page)

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	245067	A. Building B. Wing	01/22/2025

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/21/25 at 2:45 p.m., via phone EDRN-A stated on 1/10/25 R1 was in the ED and the ED staff were very concerned that R1 had not been receiving his narcolepsy medication while at the nursing home due to R1's symptoms he was exhibiting and the negative urine drug screen that was performed. EDRN-A stated there was no way R1 could have been getting the medication because the urine test would have showed it. EDRN-A indicated she had called the facility and spoke to a nurse on 1/10/25 around 6:30 p. m., to report the ED's suspicions of drug diversion and the facility nurse told me they had no one on call and would notify their DON by email and follow up with this. During an interview on 1/22/25 at 11:23 a.m., via phone licensed practical nurse (LPN)-A stated he was the nurse responsible for R1 on the evening of 1/10/25. LPN-A indicated when R1 came back from the hospital he read R1's hospital discharge summary that indicated R1 was potentially not receiving his narcolepsy medication and confirmed he put a progress note in R1's record indicating this. LPN-A stated he did not report this to anyone because the supervisor at the facility was aware of this already. During a return phone call interview on 1/26/25, at 9:31 a.m., LPN-A indicated she was the nurse manager for R1 and was made aware that R1 potentially was not receiving his narcolepsy medication on 1/11/25, when she read R1's 1/10/25 progress note that indicated a hospital urine drug screen test did not show that R1 was receiving his narcolepsy medication. LPN-A immediately called the administrator to report it and was told to call the DON and report it. LPN-A called the DON on 1/11/25 at 2:24 p.m. and informed him R1's hospital urine drug screen was negative for amphetamines which showed R1 was not getting his medications. DON had directed LPN-A ensure the narcolepsy medication was in the lock box of the medication cart and to check PCC to ensure it was signed out after verifying it was given all days except for 1/6/25 due to not having a prescription. LPN-A stated she was not given any further instruction to investigate a drug diversion. LPN-A further indicated R1's family members had concerns R1 was not getting his narcolepsy medication due to his syncope episodes requiring ED visits, the family indicated he had been stable on this medication for quite some time with no syncope episodes. LPN-A stated with any allegations of drug diversion she would immediately report to the DON and administrator which she stated she did. During an interview on 1/21/25 at 3:30 p.m., interim director of nursing (IDON) verified through R1's medical record that R1's urine drug screen test results from the hospital dated 1/10/25, were negative for methylphenidate and the ED notes identified potential drug diversion for R1. DON indicated he had not reported this potential drug diversion to the state. During an interview on 1/22/25 at 9:08 a.m., the administrator stated the nurse that took the call from the hospital on 1/10/25 about R1's narcolepsy medication not being in his system on 1/10/25 would be an allegation of potential drug diversion and should have been reported immediately to the DON or myself and was not. Administrator further stated this should have been reported to the state agency immediately and the investigation would have immediately followed and had not been done. The facility policy, Abuse Prohibition/Vulnerable Adult Policy reviewed 3/24, identified Policy interpretation and implementation, 1. All staff are responsible for reporting any situation that is considered abuse or neglect along (continued on next page)

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	245067	A. Building B. Wing	01/22/2025

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with injuries of unknown origin (including suspicious bruises, skin tears, or other injuries), misappropriation of resident property, or involuntary seclusion. A completed incident report will be routed per facility procedure. 2. A Supervisor will be notified immediately and will assess the situation to determine if any emergency treatment or action is required. Immediately, upon learning of the incident, staff will take necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated .Incidents that must be reported to MDH include .g. Misappropriation of resident property .How and when to report to the Minnesota Department of Health (MDH)/ Office of Health Facility Complaints (OHFC) .3. If the suspected Neglect, Exploitation, or Misappropriation of resident property did not result in serious bodily injury, the reports must be made within 24 hours.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview and document review the facility failed to put a protection plan in place and thoroughly investigate an allegation of drug diversion for 1 of 1 resident (R1), reviewed for misappropriation of property. Finding s included: R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 was cognitive and had a diagnosis of narcolepsy (a rare neurological condition that makes people very sleepy during the day and can cause them to fall asleep suddenly). R1's order summary dated 1/6/25, identified an order for methylphenidate long acting (LA) (a stimulant medication to help with narcolepsy) 20 mg capsule to be given every day in the morning for narcolepsy. R1's Medication Administration Record (MAR) dated 1/6/25, identified R1 did not receive methylphenidate extended release (ER) 20 mg capsule as indicated by the number, 5 documented that indicated to see progress note. It was documented from 1/6/25 to 1/20/25, that R1 received his methylphenidate daily as indicated by nurse initials. R1's progress note dated 1/9/25 at 1:45 p.m., identified physical therapy (PT) went in R1's room to find R1 unresponsive to verbal and tactile stimuli. 911 called and R1 was taken to the hospital. All parties notified. R1's ED (emergency department) progress note dated 1/9/25, at 1:54 p.m., identified during physical therapy (PT) R1 had a syncopal episode witnessed by staff. R1 was diagnosed with syncope (a brief loss of consciousness, or fainting, that occurs when blood flow to the brain is reduced) and collapse (a sudden loss of consciousness). Discharge instructions identified to follow up with provider and return if symptoms worsen. R1's progress note dated 1/9/25 at 6:00 p.m., R1 was returned via ambulance at 6:00 p.m. and was transferred to bed. R1 came back alert and orientated x 3. No significant findings found. No new orders given. When asked if R1 remembered what caused him to go to the hospital R1 stated he didn't remember a thing. R1's progress note dated 1/10/25 at 1:54 p.m., identified R1 was sent to the ED for decreased level of responsiveness. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's ED course summary dated 1/10/25, identified R1 presented to the ED with intermittent episodes of confusion. EMS (emergency medical services) was called because R1 had one of what sounds to be his typical narcolepsy episode. R1's MAR from his nursing facility was reviewed and it does appear that he had been receiving his methylphenidate. It is possible he needed a dose adjustment on this medication. I did also consider possible drug diversion, given family stated that R1 had been on this dose of medication for quite some time and had been stable. At 5:10 p.m., amphetamine not detected .which was somewhat unexpected for R1 who was supposed to be receiving methylphenidate, including this morning. At 5:29 p.m., discussed with pharmacist and agree, would anticipate positive test for amphetamines on UDS (urine drug screen) if R1 was being given his medications appropriately. This does raise the concern for diversion of medications. At 6:52 p.m., R1's family was notified about the urine drug screen results, as well as my concern that we are not seeing an anticipated false positive for amphetamines in the setting of methylphenidate which was reportedly administered per MAR provided by nursing home, including this morning. Family would like to send confirmatory blood test; aware this is a send out test and this will take several days. At 6:56 p.m., emergency department registered nurse (EMRN)-A called and spoke with nurse for R1 at the Emeralds. Informed her of concern due to negative amphetamine results in urine drug screen although R1 was prescribed methamphetamines. Facility nurse stated she will email this information to their DON. The facility documentation did not identify a protection plan for R1 and like residents from potential drug diversion and did not include investigation activities as to why R1's drug screen would not be positive for amphetamine as per the hospital notations. During an interview on 1/21/25 at 2:45 p.m., via phone EDRN-A stated on 1/10/25 R1 was in the ED and the ED staff were very concerned that R1 had not been receiving his narcolepsy medication while at the nursing home due to R1's symptoms he was exhibiting and the negative urine drug screen that was performed. EDRN-A stated there was no way R1 could have been getting the medication because the urine test would have showed it. EDRN-A indicated she had called the facility and spoke to a nurse on 1/10/25 around 6:30 p. m., to report the ED's suspicions of drug diversion and the facility nurse told me they had no one on call and would notify their DON by email and follow up with this. During an interview on 1/16/25 at 2:37 p.m., R1 was lying in bed and stated he was not sure if he was getting his medication for his narcolepsy and indicated he had been on that medication for years. R1 stated he normally took a white capsule. R1 stated if he doesn't take it, he would be sleeping. R1 further indicated he has had several ED trips since being in the facility and was not sure what he was at the ED for. During an interview on 1/22/25 at 11:23 a.m., via phone licensed practical nurse (LPN)-A stated he was the nurse responsible for R1 on the evening of 1/10/25. LPN-A stated he did not report the potential drug diversion as indicated by the hospital discharge summary to anyone because the supervisor at the facility was aware. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a return phone call interview on 1/26/25, at 9:31 a.m., LPN-A indicated she was the nurse manager for R1 and was made aware that R1 potentially was not receiving his narcolepsy medication on 1/11/25, when she read R1's 1/10/25, progress note that indicated a hospital urine drug screen test did not show that R1 was receiving his narcolepsy medication. LPN-A stated she immediately called the administrator to report it and was told to call the DON and report it. LPN-A stated she called the DON on 1/11/25 at 2:24 p.m., and informed him R1's hospital urine drug screen was negative for amphetamines which showed R1 was not getting his medications. DON directed LPN-A to ensure the narcolepsy medication was in the lock box of the medication cart and to check PCC to ensure it was signed out after verifying it was given all days except for 1/6/25 due to not having a prescription. LPN-A stated she was not given any further instruction to investigate a drug diversion. During an interview on 1/21/25 at 3:30 p.m., interim director of nursing (IDON) verified through R1's medical record that R1's urine drug screen test results from the hospital dated 1/10/25, were negative for methylphenidate and the ED notes identified potential drug diversion for R1. DON indicated he had not put a protection plan in place or thoroughly investigate the potential drug diversion. During an interview on 1/22/25 at 9:08 a.m., the administrator stated the nurse that took the call from the hospital on 1/10/25 about R1's narcolepsy medication not being in his system on 1/10/25 would be an allegation of potential drug diversion and should have been reported immediately to the DON or myself and was not. Administrator further stated this should have been reported to the state agency immediately and the investigation would have immediately followed and had not been done. The facility policy, Abuse Prohibition/Vulnerable Adult Policy reviewed 3/24, identified Policy interpretation and implementation, 1. All staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin (including suspicious bruises, skin tears, or other injuries), misappropriation of resident property, or involuntary seclusion. A completed incident report will be routed per facility procedure. 2. A Supervisor will be notified immediately and will assess the situation to determine if any emergency treatment or action is required. Immediately, upon learning of the incident, staff will take necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated .Incidents that must be reported to MDH include .g. Misappropriation of resident property .How and when to report to the Minnesota Department of Health (MDH)/ Office of Health Facility Complaints (OHFC) .3. If the suspected Neglect, Exploitation, or Misappropriation of resident property did not result in serious bodily injury, the reports must be made within 24 hours.