STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emeralds at St Paul LLC	420 Marshall Avenue Saint Paul, MN 55102

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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 Based on interview and document review the facility failed to timely respond to ventilator alarms for 1 of 3 residents (R1) reviewed for response to ventilator alarms. This resulted in an immediate jeopardy (IJ) for R1 when R1's ventilator alarmed intermittently on [DATE] from 3:19 a.m. to 5:47 a.m., 237 times, for an alarm that indicated high pressure in the ventilator or an obstruction in the ventilation system. The IJ began on [DATE] at 3:19 a.m., when R1's ventilator alarmed intermittently on [DATE], 237 times between 3:19 a.m., and 5:47 a.m., without staff response. The director of nursing (DON), facility owner, and senior nurse consultant were notified of the IJ on [DATE] at 1:31 p.m. The IJ was removed [DATE] at 2:28 p. m., but noncompliance remained at the lower scope and severity level of a D which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's face sheet, undated indicated R1 admitted to the facility with diagnosis of chronic respiratory failure and dependence upon a ventilator when she is sleeping. R1's quarterly Minimum Data Set, dated dated dated [DATE], indicated R1 was moderately cognitively impaired. R1's care plan dated [DATE] indicated R1 had chronic respiratory failure with ventilator dependence. The interventions included monitor for cyanosis, shortness of breath, increased respirations, and difficulty coughing up sputum. The care plan indicated R1 was ventilator-dependent related to chronic respiratory failure, but lacked mention R1 was ventilator-dependent only when asleep. R1's Physician's Orders dated [DATE], indicated R1 used a ventilator with oxygen to keep oxygen saturations greater than 90%. R1's ventilator report for [DATE] from 3:19 a.m. to 5:47 a.m., indicated R1's ventilator alarmed for high inspiratory pressure. The ventilator alarm self-corrected for most of the alarms without measuring the number of seconds the ventilator alarmed. The ventilator report indicated alarm times were lengthier than a few seconds and identified the following: At 4:07 a.m., the ventilator alarmed for 114 seconds. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emeralds at St Paul LLC	420 Marshall Avenue Saint Paul, MN 55102

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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 4:10 a.m., the ventilator alarmed for 115 seconds. At 4:13 a.m., the ventilator alarmed for 81 seconds. At 4:16 a.m., the ventilator alarmed for 141 seconds. At 4:20 a.m., the ventilator alarmed for 785 seconds (13 minutes). At 4:38 a.m., the ventilator alarmed for 695 seconds (11 minutes). At 4:57 a.m., the ventilator alarmed for 1288 seconds (21 minutes). At 5:19 a.m., the ventilator alarmed for 92 seconds. At 5:33 a.m., the ventilator alarmed for 82 seconds. At 5:40 a.m., the ventilator alarmed for 339 seconds (5 minutes). At 5:47 a.m., the ventilator alarmed for 566 seconds (9 minutes). At 5:59 a.m., the ventilator was disconnected as R1 was up for the day. On [DATE] at 12:05 p.m., R1's family member (FM)-A stated a video indicated R1's ventilator alarmed on [DATE] from approximately 3:00 a.m., to about 6:00 a.m. without staff attention. On [DATE] at 4:47 p.m., respiratory therapist (RT)-A stated R1 required a ventilator at night because of her weight and her chronic respiratory failure. If a ventilator alarmed for high ventilator pressure, staff should check on the resident as it could mean the ventilator was obstructed with a mucus plug, the resident was not able to breathe, or was in respiratory distress. Every alarm should be treated as an emergency. The facility was not doing audits on ventilator alarms nor on how long staff took to respond to each of the alarms. She was not aware R1's alarms were not answered. The RT department checked the ventilator settings every working shift and reviewed the alarm settings. On [DATE] at 10:13 a.m., licensed practical nurse (LPN)-A stated she worked on [DATE], night shift and was assigned to R1. If a typical ventilator patient's alarm went off it was an emergency, but not R1, as she was more stable than the rest of the ventilator residents. If R1's was going off for 10 minutes, it was not an emergency, but staff should still check on her. At 12:48 p.m., LPN-A stated there were times she could not hear alarms if she was working on other hallways. LPN-A acknowledged she didn't check R1's alarms on [DATE] and had worked other times with only two nurses but was unable to identify dates. During a subsequent interview on [DATE] at 11:12 a.m., LPN-A stated on [DATE], during the night there was a new admission, and all four working staff were in that resident's room together. She was sure she heard alarms that night when she was walking down the hall, but there were other alarms going off too, and there were only two nurses working that night. No one told her R1's alarm was going off. I don't know what happened that night. Maybe other residents were more critical. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emeralds at St Paul LLC	420 Marshall Avenue Saint Paul, MN 55102

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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10:33 a.m., the director of nursing (DON) stated a ventilator should not alarm for greater than 10 minutes without staff looking at it, as the resident could die. Other staff didn't hear the alarm going off for so long. On [DATE] at 11:28 a.m., registered nurse (RN)-B stated if a ventilator alarmed more than 5 minutes the resident would be in respiratory distress, and more than 10 minutes, the resident could be deceased . If a ventilator alarmed, it should be assessed. He did not respond to R1's alarms on [DATE], as R1 was assigned to LPN-A. On [DATE] at 11:55 a.m., nurse practitioner (NP)-A stated R1 required nocturnal ventilation related to obesity hypoventilation syndrome (a condition in which severely overweight people fail to breathe rapidly or deeply enough resulting in low oxygen levels and high carbon dioxide levels) and it was not feasible nursing staff didn't hear the alarms for hours. On ,d+[DATE] 24 at 1:57 p.m., R1 stated she did not know how long the ventilator alarms went off on [DATE], as she was asleep at the time. On [DATE] at 2:21 p.m., RN-A stated he worked night shift on [DATE]. He did not respond to R1's alarms as he was working with other residents, and R1 was assigned to LPN-A. At approximately 3:00 a.m. to 3:30 a.m. , all four staff working that night were in one room with one resident who was in respiratory crisis. If R1 was sleeping when the ventilator alarmed, R1 might not know she was in respiratory trouble. There was a night, [DATE], he worked with 17 ventilated residents as was the only nurse on the floor for approximately four hours. On [DATE] at 11:28 a.m., during a subsequent interview the DON stated the facility had 15 ventilator-dependent residents on [DATE], who required two nurses and two nursing assistants for care, but would staff three nurses for 16 ventilator-dependent residents. The DON stated with fewer than 16 ventilator-dependent residents two nurses was enough and safe. The facility had not reviewed ventilator alarm response times prior to this incident, there was no policy for answering ventilator alarms, and he did not know the ventilator-dependent residents were not mentioned in the acuity section of the facility assessment. On [DATE] at 11:51 a.m., RT-B stated if a ventilator alarm persisted to go off, staff should investigate. If a ventilator alarmed for 11 minutes, R1 was not getting the required air volume, and R1 would not be getting enough air to the lungs. A single high-pressure alarm could indicate a cough, but, No one coughs for two and half hours. There was an alarm for 1288 seconds, or 21 minutes, and staff should have checked to see what was going on. There were codes on R1's ventilator report which indicated the alarm escalated to three higher levels, indicating more emergent need because the alarms were not answered timely. He spoke to the DON on [DATE] about R1's alarms, and the DON told him staff might have been in another room. On [DATE] at 12:39 p.m., RT-B stated he did not think the machine malfunctioned on [DATE], The alarms are there for a reason. The Facility assessment dated [DATE], indicated the acuity of the residents was based upon the activities of daily living (ADLs) of each resident, and whether the resident was independent, required the assistance of , d+[DATE] staff for assistance, or was fully dependent upon staff for ADL assistance. Additionally, the FA identified resident mobility as a measure of acuity based upon whether the resident was independent, required an assistive device, or was, In a chair most of the time. The FA lacked ventilator-dependent resident consideration to determine resident acuity. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emeralds at St Paul LLC	420 Marshall Avenue Saint Paul, MN 55102

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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Respiratory Therapy Policy dated [DATE], directed respiratory therapy services were for the assessment, treatment and monitoring of patients with deficiencies or abnormalities of pulmonary function. Respiratory therapy services included coughing, deep breathing, nebulizer treatments, assessing breath sounds, and mechanical ventilation which must be provided by a respiratory therapist or trained respiratory nurse. The policy stated a respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws. The policy stated nurses who performed respiratory therapy services would complete competencies for pre-assessment/evaluation of respirations and lung sounds, set up, administration and clean-up of nebulizer and post-assessment/ evaluation of respirations and lung sounds. The policy did not address how staff should manage ventilator alarms. A ventilator policy was requested, but not provided. The immediate jeopardy that began on [DATE], was removed on [DATE], after it was verified nursing staff and respiratory therapists were educated about the policies and procedures for ventilator care and response to ventilator alarms, with the expectation staff would answer ventilator alarms within two minutes. R1's care plan was reviewed and updated to ensure her ventilator needs were identified. The facility ordered walkie talkies to ensure timely access to assistance from other units' staff as needed. Facility staff was educated to ensure one staff was always available to monitor ventilator alarms. A third nurse was added to third shift to ensure adequate nurse to resident care ratios. Audits for response to ventilator alarms were implemented. The noncompliance remained at the lower scope and severity level of a D-isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm, that is not immediate jeopardy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emeralds at St Paul LLC	420 Marshall Avenue Saint Paul, MN 55102

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 44654 Based on interview and document review, the facility failed to identify in the facility assessment (FA) protocol related to the acuity for day-to-day operations and for emergencies for fifteen ventilator-dependent residents. Additionally, the facility failed to review the FA annually. Findings include: Review of the facility assessment tool dated 11/22/23, indicated the acuity of the residents was based upon the activities of daily living (ADLs) of each resident, whether the resident was independent, required the assistance of 1-2 staff, or was fully dependent upon staff for ADL assistance. Additionally, the FA identified resident mobility as a measure of acuity based upon whether the resident was independent, required an assistive device, or was, In a chair most of the time. The FA lacked ventilator-dependent residents in the consideration to determine resident acuity. On 7/17/24 at 11:28 a.m., during an interview the director of nursing (DON) acknowledged the FA lacked mention of the ventilator-dependent residents in the acuity section. The DON further stated the staffing for the second floor, where the vent-dependent residents lived, required two nurses during the night shift, but staffing would increase to three nurses if there were 16 residents with ventilators. 7/18/24 at 5:02 p.m., during an interview the regional nurse consultant. (RNC) stated she was not aware the facility assessment didn't contain acuity for the vent-dependent residents and was not aware the FA was not reviewed annually.