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	11/14/2024

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

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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** 48037 49338 Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician orders and failed to identify and report medication errors according to facility policy for 3 of 3 (R1, R2, R3) residents reviewed for medication administration. Findings include: R1 R1's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R1 admitted on [DATE] with diagnoses including unspecified pain and had intact cognition. R1 received scheduled pain medication, received PRN (as needed) pain medication, and took opioid (a drug classification including some medications for pain relief) medication. R1's care plan included an alteration in comfort dated 10/13/24, with intervention of pain medication as ordered by MD (physician). R1's physician orders included an order for oxycodone HCl (oxycodone hydrochloride, an opioid drug used to treat moderate to severe pain) oral tablet 5 mg (milligrams) with start date 10/17/24 and discontinue date 11/6/24. Instructions were give 5 mg by mouth every 6 hours as needed for pain, (max of 3 doses a day). R1's physician orders included an order for oxycodone HCl oral tablet 5 mg with start date 11/8/24. Instructions were give 5 mg by mouth every 4 hours as needed for pain max of 15 mg a day. R1's medication administration record (MAR) for October and November 2024, identified administrations of the oxycodone outside of the ordered daily maximums including: - On 10/23/24 at 12:04 a.m., 8:19 a.m., 4:04 p.m., and 11:49 p.m. Four doses were administered for a total of 20 mg of oxycodone. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 10/27/24 at 2:46 a.m., 8:40 a.m., 3:30 p.m., and 9:56 p.m. Four doses were administered for a total of 20 mg of oxycodone. - On 11/9/24 at 12:13 a.m., 5:10 a.m., 9:08 a.m., 3:37 p.m., and 8:30 p.m. Five doses were administered for a total of 25 mg of oxycodone. - On 11/10/24 at 5:35 a.m., 11:56 a.m., 4:40 p.m., and 9:41 p.m. Four doses were administered for a total of 20 mg of oxycodone. - On 11/11/24 at 5:13 a.m., 9:15 a.m., 1:18 p.m., and 8:40 p.m. Four doses were administered for a total of 20 mg of oxycodone. In an interview on 11/14/24 at 11:56 p.m., licensed practical nurse (LPN)-A stated residents who are cognitively intact ask for their PRN medications. LPN-A noted PRN medications have time frames for how frequently that can be administered. He noted some PRN medications have a maximum daily dose that can be given and he would look at the administration record to calculate how much had been given recently to determine if the maximum had been reached. In an interview on 11/14/24 at 12:13 p.m., registered nurse (RN)-A stated for PRN medications there are time frames of how frequently the medication is allowed to be administered and the MAR would tell you if you tried to administer it too soon after the previous dose. RN-A noted some PRN medications have a maximum amount that could be administered and staff have to check the MAR to see how the amount of the medication that had already been administered. She stated if someone wanted PRN pain medication but the maximum allowable administrations had already been reached she would assess the resident and contact the provider to ask about other options. In an interview on 11/14/24 at 12:24 p.m., clinical manager (CM)-A stated for PRN medications the MAR would say if the dose shouldn't exceed a certain amount and nurses can see on the administration record how many times a medication has been given and how much medication was administered. CM-A noted the information was in the electronic health record's medication administration charting system, but it would not pop up with an alert for administering medication in excess of an ordered total amount or total doses, though it would if nurses administered the medication too early. Nurses would have to look at the administration record to determine the total doses or amount already given. CM-A noted if the total available dose had been exceeded and someone wanted a PRN pain medication staff should contact the provider to see what they want to do. CM-A noted she expected staff to administer medications in accordance with physician orders. In an interview on 11/14/24 at 2:06 p.m., LPN-A confirmed R1's current PRN oxycodone order stated it could be given every four hours as needed with a maximum of 15 mg a day. LPN-A stated staff can give a maximum of three doses in 24 hours because that equals 15 mg total and noted it would be a medication error if R1 was given four doses in one day. In an interview on 11/14/24 at 2:15 pm., RN-B stated R1 took oxycodone every four hours as needed and noted the order said there was a 15 mg maximum of the medication in a day which means she can only have three in a day. RN-B confirmed R1 received five doses on 11/9/24, four doses on 11/10/24, and four doses on 11/11/24 and she shouldn't have had fourth and fifth doses. RN-B stated those doses should have been reported as medication errors. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/14/24 at 2:31 p.m., CM-A stated for R1 excessive doses of the medication could be given if staff weren't reading the fine print of the order. CM-A noted R1 receiving fourth or fifth doses of the medication was a medication error and that is too much medication. I would expect nurses to follow the provider orders. CM-A stated four or five doses should not be administered, per what the order said it was over the maximum dose, and she was not aware R1 had been receiving extra pain medication. CM-A identified the breakdown in the process as the lack of an alert in the charting system notifying nurses the maximum daily administration had been reached. CM-A stated the provider should have been notified and it should have been reported to herself and the director of nursing (DON). CM-A stated R1 had not received the medication in accordance with physician orders. In an interview on 11/14/24 at 3:21 p.m., nurse practitioner (NP)-A stated he worked for a rehabilitation and pain management practice and managed and prescribed R1's oxycodone. NP-A stated R1's oxycodone was to be given as needed for a maximum of three doses a day only and noted many things factor into how orders are written. NP-A noted when we prescribe narcotics, the first thing first is safety. If safety is not first, then we might be doing harm and not good to the patients. NP-A stated he was not aware R1 had received excess doses. NP-A stated the nurse that is giving it is not following the order. That is not acceptable. NP-A stated nurses have to follow the order and if her pain was increasing, he should be notified and giving excess doses of the medication was a safety concern. NP-A stated preventing addiction was one concern with the administration of narcotics like oxycodone and staff giving excess medication was not good and they should contact me. In an interview on 11/14/24 at 3:59 p.m., the DON stated medications should be administered as written in physician orders. The DON stated for a 5 mg medication with a maximum dose of 15 mg per day there would be a maximum of three doses that could be given. If more than three doses were given it would be a medication error. The DON identified administration of medication beyond a maximum daily total dose or number of administrations as a medication error, that would be going above provider orders, nurses can't do that. The DON stated he was not previously aware that R1 had received excess doses of PRN oxycodone. The DON that it was possible the nurses administering the medication were not looking back at when R1 had last received the medication and looking at the orders accurately to see she can only receive so many on that day. The DON stated if R1 was asking for pain medication and the full daily dose had already been given, nurses should call the physician. The DON stated he did not think the charting system had a way of alerting nurses when a daily administration maximum was reached but thought it would be a lot safer to have something like that instead of relying on a person under pressure. R2 R2's admission MDS dated [DATE], indicated R2 admitted on [DATE] with diagnoses including heart failure, pain, and gastrostomy status (presence of a surgical opening into the stomach). R2 received scheduled pain medication and took diuretic (a class of medications that reduce fluid build-up in the body) medication. R2's care plan included an alteration in comfort dated 9/6/24, with intervention of pain medication as ordered by MD. R2's physician orders included an order for furosemide (a diuretic) oral tablet 20 mg with start date 11/1/24. Instructions were give 20 mg via G-tube [gastrostomy tube, a tube inserted through the abdomen into the stomach] in the morning for edema [fluid build-up]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's physician orders included an order for gabapentin (an anti-epileptic medication also used to treat nerve pain) oral capsule 300 mg with start date 9/4/24. Instructions were give 600 mg via G-tube three times a day related to pain, unspecified with administrations scheduled at 6:00 a.m., 4:00 p.m., and 8:00 p.m. daily. R2's medication administration record (MAR) for November 2024, identified scheduled administrations of the furosemide and gabapentin. R3's MAR lacked documentation of the scheduled administrations of furosemide 20 mg and gabapentin 600 mg on 11/6/24 at 6:00 a.m. Documentation for these administrations was blank with no indication the medications were administered or documented reasons the medications were not administered. R3 R3's facesheet dated 11/14/24, indicated R3 admitted on [DATE]. R3 had diagnoses including acute and chronic respiratory failure (a condition where blood has too much carbon dioxide or not enough oxygen), unspecified viral hepatitis B, quadriplegia (paralysis affecting the body from the neck down), locked-in state (neurologic condition where someone is aware but cannot move or communicate due to paralysis), disorder of the autonomic nervous system, hypertension, dysphagia following cerebral infarction (difficulty swallowing after a stroke), gastroesophageal reflux disease (GERD, acid reflux), gastrostomy status, and tracheostomy status (presence of an artificial opening in the windpipe/trachea to help with breathing). R3's care plan included a risk for aspiration related to presence of a feeding tube dated 8/13/24, with intervention to administer tube feedings as ordered and free water and tube flush per facility protocol. R3's nutrition care plan dated 8/12/24, identified R2's nutritional status was nothing by mouth and he received tube feedings. Interventions included tube feeding and flushes per physician orders, medication per physician orders, and medication for gastrointestinal upset per physician orders. R3's physician orders included the following: - Order for ammonium lactate external cream 12% (a skin cream) with start date 10/4/24. Instructions were to apply to affected areas topically two times a day for dry itchy skin. - Order for aspirin oral tablet chewable 81 mg with start date 10/5/24. Instructions were to give 81 mg via G-tube one time a day related to hypertension. - Order for carboxymethylcellulose sodium ophthalmic solution (lubricating eye drops) with start date 10/4/24. Instructions were to instill one drop in both eyes four times a day for dry eyes. - Order for Claritin oral tablet 10 mg (an antihistamine) with start date 10/5/24. Instructions were to give 10 mg via G-tube one time a day for hay fever. - Order for entecavir oral tablet 0.5 mg (an antiviral medication) with start date 10/5/24. Instructions were to give one tablet via G-tube one time a day related to unspecified viral hepatitis B. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Order for enteral feed (tube feeding) order with start date 8/9/24. Instructions were free water flushes (water administered through a feeding tube) of 50 ml every three hours. - Order for gabapentin oral tablet 600 mg with start date 10/4/24. Instructions were to give 600 mg via G-tube three times a day related to disorder of the autonomic nervous system, give with feeding. - Order for glycopyrrolate 1 mg (a medication that helps reduce respiratory secretions) tablet with start date 10/4/24. Instructions were to give 1 tablet via G-tube two times a day related to tracheostomy status. - Order for guaifenesin oral liquid 100 mg/5 milliliters (ml) (a medication that helps to thin respiratory secretions) with start date 10/4/24. Instructions were to give 20 ml via G-tube three times a day related to tracheostomy status. - Order for lansoprazole oral suspension 3 mg/ml (a medication to reduce stomach acid) with start date 10/5/24. Instructions were to give 10 ml via G-tube one time a day for GERD related to dysphagia following cerebral infarction. - Order for Miralax oral powder 17 grams/scoop (a laxative medication) with start date 10/5/24. Instructions were to give 17 grams via G-tube one time a day for constipation. - Order for white petrolatum-mineral oil ophthalmic ointment (a lubricating eye ointment) with start date 10/4/24. Instructions were to instill 0.25 inches in both eyes four times a day for dry eyes. Review of R3's MAR dated months of October and November 2024, identified scheduled administrations of the above listed medications. R3's MAR lacked documentation of scheduled administrations as follows: - On 10/25/24 at 6:00 a.m.: aspirin oral tablet chewable 81 mg, Claritin oral tablet 10 mg, entecavir oral tablet 0.5 mg, lansoprazole oral suspension 10 ml, Miralax oral powder 17 grams, glycopyrrolate tablet 1 mg, gabapentin oral tablet 600 mg, guaifenesin oral liquid 20 ml, and free water flush 50 ml - On 11/8/24 at 8:00 a.m.: ammonium lactate external cream, carboxymethylcellulose sodium ophthalmic solution, and white petrolatum-mineral oil ophthalmic ointment - On 11/8/24 at 9:00 a.m.: free water flush 50 ml - On 11/10/24 at 3:00 a.m.: free water flush 50 ml - On 11/10/24 at 6:00 a.m.: aspirin oral tablet chewable 81 mg, Claritin oral tablet 10 mg, Entecavir oral tablet 0.5 mg, lansoprazole oral suspension 10 ml, Miralax oral powder 17 grams, glycopyrrolate 1 mg tablet, gabapentin oral tablet 600 mg, guaifenesin oral liquid 20 ml, and free water flush 50 ml. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Documentation for these administrations was blank with no indication the medications were administered or documented reasons the medications were not administered. During Interview and Observation on 11/14/24 at 2:41 p.m. of medication cart with certified nurse manager (CM-A), CM-A reported that the medication for R2 was still in the package and was missed. Upon review of R3's medication was unsure about R3's over the counter medication, but confirmed there were anticipated to be missed. In an interview on 11/14/24 at 3:59 p.m., the DON stated medications should be administered as written in physician orders. The DON noted nurses know what medications to administer because they have an electronic MAR that tells them what medication is due and when it is due. The DON stated if the documentation on the MAR was blank, he believed the corresponding medication administration had been missed. The DON stated he was not able to confirm medications were administered in accordance with physician orders if the documentation on the MAR was blank. He noted a missed administration of a medication would constitute a medication error, should be reported, and the physician should be notified. Facility policy titled IIB1: Administration Procedures for All Medications dated May 2022, included: Review 5 Rights (3) times: 1) Prior to removing the medication package/container from the cart/drawer; a. Check MAR/TAR for order. b. Note any allergies or contraindications the resident may have prior to drug administration. c. If unfamiliar with the medication, consult a drug reference, manufacturer package insert, or pharmacist for more information. d. Check for vital signs, other tests to be done during/prior to medication administration. e. Prepare resident for medication administration. 2) Prior to removing the medication from the container a. Check the label against the order on the MAR. b. Note any supplemental labeling that applies (fractional tablet, multiple tablets, volume of liquid, shake well, give with another medication, etc.). c. Due to the complexity and length/amount of instructions, some medications may be labeled use as directed. Refer to the MAR for instruction details. 3) After the dose has been prepared and before returning the medication to storage . L. If resident refuses medication, document refusal on MAR or TAR. Research refusals for possibility of dry mouth, resident reluctance, development of swallowing difficulty. M. When administering an as needed (PRN) medication, document reason for giving, observe for medication actions/reactions and record [on the PRN effectiveness sheet/nurse's notes] . P. Notification of Physician/Prescriber 1) Persistent refusals. 2) Held medications for pulse, blood pressure, low or high blood sugar, or other abnormal test results, vital signs, resulting in medications being held. 3) Suspected adverse drug reactions. Facility policy titled Medication Error Procedure dated 1/2020, included Medication errors should be assessed, documented, and reported according to federal and/or state guidelines as appropriate. Medication errors will be rectified according to standard of practice and the facilities pharmacy policy for preventing and detecting adverse consequences and medication errors . When a medication error occurs, the person responsible for the error or the person finding the error will complete the Medication Error Reconciliation Report . 2.) Contact the Medical Provider to inform them of the error a.) Give Description of the Error b.) Document provider comments and follow-up 3.) Notify resident/family/POA 4.) Notify Pharmacist if error is the result of a Pharmacy Error; document pharmacy follow-up 5.) Document Medication Error in the Medical Record.