STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING _____ B. WING _____	04/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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** Based on interview and document review, the facility failed to report allegations of abuse timely to the State Agency (SA) for 3 of 3 residents (R1, R3, R2) reviewed for abuse. Findings include: R1's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R1 had moderate cognitive impairment. R1 required physical assistance of two staff with bed mobility, transfer, and toileting. A facility reported incident, submitted 4/7/20, at 3:20 p.m. indicated R1 had told staff the night shift nursing assistants said they would rape her. On 4/13/20, at 1:55 p.m. trained medication aide (TMA)-A stated on 4/7/20 during morning cares, R1 made an allegation that two lady staff members raped her. TMA-A stated R1 was scared. TMA-A stated that nursing assistant (NA)-A had told her that R1 had made the same comment earlier. TMA-A stated she told the social service assistant (SS)-A about R1's comment a little bit before lunch because SS-A was the first management person she saw. On 4/13/20, at 2:12 p.m. SS-A stated NA-A told her about R1's statements around 11:30 a.m. on 4/7/20. SS-A stated she spoke with R1 and then told the director of nurses (DON) of the grievance before noon. On 4/13/20, at 2:21 p.m. DON verified R1's statements of attempted rape was reported to the SA at 3:20 p.m. The DON stated this should have been reported within two hours of R1 making the comment at 5 a.m. The DON verified NA-C did not tell the night shift nurse of R1's allegation. R3's admission MDS dated [DATE], indicated R3 had moderate cognitive impairment and required physical assistance of two staff with bed mobility, transfer, and toileting. A Facility Grievance Concern form dated 3/19/20, indicated R3 felt some staff thought he was an inconvenience. R3 indicated he felt he was taunted all night by the staff and the staff turned his call light off when he put it on. R3 also indicated staff hid his recliner remote A facility reported incident, submitted 3/20/20, at 3:20 p.m. indicated R3 told the assistant director of nursing he did not feel safe around an evening nurse and overnight NA. R3 stated staff tried to keep things away from him and hid things from him. On 4/13/20, at 1:31 p.m. the assistant director of nursing (ADON) stated R3 approached her on 3/20/20, at approximately 8:30 a.m. R3 had told her that he had reported concerns to the social worker (SS)-B the previous afternoon. ADON stated SS-B should have made a progress note and reported the incident on 3/19/20. ADON verified the abuse report was not made until 3/20/20, which was greater than eight hours from when she was informed of the concern and almost 24 hours from when SS-B was informed. SS-B no longer worked at the facility. 4/14/20, at 11:25 a.m., Administrator stated it was the expectation abuse or neglect would immediately be reported to the DON or administrator. Administrator stated expected reports would be made to the SA within two hours. Administrator stated some have 24 hours, tried to stick to the two hour time frame. R2's quarterly MDS dated [DATE], indicated R2 was cognitively intact. A facility reported incident, submitted 3/11/20, at 6:45 p.m. indicated R2 stated during a care conference that staff verbally abused her and other residents. A care conference signature sheet dated 3/11/20, indicated the care conference for R2 was held at 12:45 p.m. The DON was interviewed on 4/14/20, at 12:53 p.m., and verified the care conference for R2 was held at 12:45 p.m. The DON further verified the allegation of abuse was reported to the State Agency (SA) at 6:45 p.m. which was outside the 2 hour reporting requirement for allegations of abuse. The facility policy titled Abuse Prohibition/Vulnerable Adult Plan, revised 7/5/19, indicated the facility administrator or supervisor should be notified immediately of any incident of alleged or suspected abuse. The policy further stated suspected abuse shall be reported to the SA not later than 2 hours after forming the suspicion of abuse.
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** Based on observation, interview and document review the facility failed to thoroughly investigate 2 of 3 residents' (R1, R2) allegations of abuse. Findings include: R1's quarterly Minimum Data Set ((MDS) dated [DATE], indicated [REDACTED]. R1's MDS indicated moderate cognitive impairment and a [DIAGNOSES REDACTED]. On 4/13/20, at 10:47 a.m. trained medication aide (TMA)-A and nursing assistant (NA)- D were observed to provide incontinence cares and assist R1 to get ready for lunch. TMA-A asked R1 how things were going R1 said, everything is OK except for that rough aide with the California lips. She says things like me getting raped. On 4/13/20 at 10:58 R1 was interviewed. R1 initially had difficulty to stay on track throughout the interview and some answers did not match the questions. When questions were typed in large font on computer R1 was able to stay on track and responded clearly. RI stated the aid who provided rough cares worked on the night shift. R1 stated the aides were not always careful and would lean on her legs when they moved them and caused pain. R1 stated she did not think that was deliberate. R1 stated the one with the California lips was just mean and made comments. R1 stated the comments might be jokes but they hurt. R1 stated no one raped her but thought it was a strange comment for the staff to say to her. During interview on 4/13/20 at 1:55 p.m., TMA-A stated that she reported R1's statement to social service (SS)-A when R1 first said it to her on 4/7/20. TMA-A said R1 was scared. TMA-A stated no one had interviewed her further about the report and no one has told her to do anything different for R1. On 4/13/20, at 2:12 p.m., SS-A stated as part of the investigation she interviewed resident and staff. SS-A stated resident's were asked the same questions; did they feel safe, did they know who to report concerns and if any staff or resident made them feel uncomfortable. SS-A stated staff were asked two questions, have you had any concerns reported to you that included NA-C or NA-G or any other staff members. SS-A reviewed Employee Interview form dated 4/7/20, and stated she did not interview NA-C or NA-G or LPN-A. SS-A stated she had spoke to R1 since 4/7/20, but did not do follow up about statements that R1 made because she was not instructed to. On 4/13/20, at 2:21 p.m. the director of nurses (DON) stated she interviewed NA-C and NA-G. DON stated based on interviews with employees she unsubstantiated the complaint. DON stated she had no idea if anyone offered a rape assessment or did a skin assessment at time of the event. She stated that the investigation did not look at possibility of male residents who wandered into rooms or in the hallways. The DON stated she was unaware R1 still made comments about it, and that social services had not followed up with R1 about the allegations and if she felt safe. The DON verified the care plan had not been updated with new interventions since 4/7/20. On 4/14/20 the administrator stated the summary of interviews might not include everything asked. The administrator verified the investigation for R1 was not very thorough. R2's quarterly MDS dated [DATE], indicated R2 was cognitively intact. A facility reported incident, submitted 3/11/20, at 6:45 p.m. indicated R2 stated during a care conference that staff verbally abused her and other residents. A five day nursing home investigation report (NHIR), submitted 3/12/20, indicated R2 and the alleged perpetrator, Trained Medication Aid (TMA)-A were interviewed as part of the facility investigation of the incident. No further interviews were indicated on the report. Documentation of other staff and witness interviews was requested and not provided. During an interview on 4/14/20, at 12:53 p.m. the DON stated they did not have documentation of staff interviews done for this investigation, but

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING _____ B. WING _____	04/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) would provide documentation of resident interviews. An undated list of resident interviews was provided, but lacked any indication if it was related to the incident alleged by R2. The facility policy titled Abuse Prohibition/Vulnerable Adult Plan, revised 7/5/19, indicated an investigation of an abuse allegation would begin immediately and may include interviewing staff, residents, and other witnesses to the incident.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure staff and visitor's temperatures were obtained in accordance with manufactures guidance for the RediScan thermometer, resulting in 26 of 62 screenings that indicated body temperatures of less than 97 degrees Fahrenheit. This had the potential to affect all 64 residents that resided in the facility. In addition the facility failed to ensure appropriate hand and glove hygiene infection control measures were implemented to prevent cross-contamination during incontinent cares for 2 of 3 residents (R5, R1) who were observed during personal cares. Findings include: Screening: On 4/13/20, at 8:40 a.m. the screener at the reception desk was notified by surveyors they were there to conduct a survey. The screener had each surveyor fill out screening form. The screener used an infra-red thermometer to check surveyor (S)-1 's temperature and focused the thermometer to the center of the forehead. S-1's surface temperature was 95.0 Fahrenheit (F). S-2' temp was 96-F. Screener made no comments or questioned the low readings. Outside temperature at time of entrance was 28 degrees Fahrenheit. There were instruction on desk for use of temporal thermometer (thermometer that takes the temperature via the ear) but not for the intra-red thermometer. Review of COVID-19 Screening Tool revealed a total of 62 forms dated 4/13/20. Of the 62 forms, 26 forms had temperatures that read below 97 degrees. Four forms were for 96.5-96.9 degrees, Nine forms were for 96.0-96.4 degrees, five forms were for 95-95.9 degrees, and eight forms were for temperatures less than 95 degrees. The lowest form had a temperature that read 92.6 degrees. 4/13/20, at 10:40 a.m. nursing assistant (NA)-F stated when she arrived at the facility she would do the screening until the screener arrived. NA-F stated staff would fill out the form and she would use the thermometer that scans the forehead but does not touch the forehead. Then NA-F would read the screening form and notify the nurse in charge if the temperature is 100.0 or greater. NA-F stated there were no lower limits to notify the nurse. 4/13/20, at 12:27 p.m., the screener said in the morning they would have several people come in whose temperatures were very cold. The screener stated that she only notified the nurse if the temperature was greater than 100 or someone checked yes to a question on the form. The screener stated staff were to use the temporal thermometer if she was not there. The screener said there was no policy for using the infra-red thermometer . 4/13/20 12:35 p.m. the director of nurses (DON) stated they just put the temporal thermometer at the desk. The DON stated they started to use the distant thermometer last week because the temporal thermometers did not last long. The DON stated her temperature would run 96 so a temperature of 95 would depend on the person. The DON stated she had been unaware of manufactures guideline to wait 30 minutes from coming inside before a temperature was taken. RediScan Infrared Thermometer manufactures guidebook indicated measurements were comparable to oral readings. The guidebook indicated temperatures can vary from 97.0 F-99.0 F and still be considered normal. The guidebook also indicated For accurate results, wait at least 30 minutes after exercising, bathing or returning from the outdoors. Hand Hygiene R5's admission Minimum Data Set ((MDS) dated [DATE], indicated R5 had moderate cognitive impairment and required physical assistance of two staff with bed mobility, transfer, and toileting. On 4/13/20, at 9:13 a.m. R5 was observed to be transferred with a standing lift from the recliner to the bathroom by NA-E and NA-F. Both staff members washed their hands and put on gloves. NA-E removed R5's incontinence product. NA-E changed gloves and washed her hands. NA-F wiped R5's bottom and removed gloves, washed hands and lowered R5 onto the toilet. NA-E returned to R5's recliner and rolled up the soiled linens with her bare hands and put them in a bag. At 9:19 a.m., NA-E and NA-F left R5 on the toilet attached to mechanical lift. R5 held on to the call light. At 9:21 a.m., R5's call light alerted. NA-F returned to R5's room, washed her hands and put on gloves. At 9:23 a.m., NA-E arrived and removed standing lift from the bathroom. NA-F wiped R5 from the front toward the side. NA-F removed gloves and put on new gloves without hand hygiene (washing hands with soap and water or using an alcohol based hand sanitizer). NA-F wiped R5's bottom. Soft yellow stool was observed on wipes and tips of glove. NA-E washed hands and put gloves on. NA-E wiped R5 from the front, no stool observed. NA-E removed gloves and her washed hands. NA-E brought the standing lift to the bathroom and reattached the straps. NA-F wiped the floor, toilet seat and then removed her gloves. NA-E applied brief without gloves and started to pull pants up with bare hands while R5 stood in the lift. NA-E washed her hands and applied gloves then took R5 to the recliner and had her sit down. NA-E removed pants. NA-F put clean pants on R5 without washing hands. When done NA-F washed hands and took the standing lift out of the room. On 4/13/20, at 10:40 a.m. NA-F stated she was to change gloves if she touched something dirty and before she touched something clean. NA-F stated she was to wash her hands before she put on gloves and after she removed them. NA-F stated she thought she had washed her hands after she cleaned R5's bottom. On 4/13/20, at 11:34 a.m. NA-E stated there were to wash their hands before and after our shift, whenever we go to the bathroom, meals, or change gloves. R1's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R1 had moderate cognitive impairment and required physical assistance of two staff with bed mobility, transfer, and toileting. On 4/13/20, at 10:47 a.m. trained medication aide (TMA)-A and nursing assistant (NA)-D were observed to provide incontinence cares and assist R1 get ready for lunch. R1 refused to get up for lunch. TMA-A put on a bed jacket behind R1. TMA-A went to the bathroom, washed hands and put gloves on. When the nursing assistants pulled back the blanket, R1 commented on not having pants on (only wore an incontinence product). NA-D obtained gloves from the bathroom and put them on and did not wash her hands. NA-D washed R1's perineum. TMA-A removed right glove and did not do hand hygiene. NA-D removed gloves did not do hand hygiene. NA-D pulled the back of the bed jacket down. TMA-A and NA-D lifted R1 up in bed and put a pillow behind her back, they had not yet washed hands from the incontinence cares. There was no hand sanitizer in room. NA-D went to bathroom door. The door was locked and a voice was heard to say, just a minute, then, I'm done. Both staff members went into the bathroom and washed their hands and left the room. 4/13/20, at 1:55 p.m., TMA-A stated she was to wash hands every time she removed her gloves. TMA-A acknowledged she did not wash her hands between glove changes. 4/13/20, at 2:07 p.m., NA-D stated she was to wash hands after she took off her gloves off. NA-D verified she did not sanitize or wash her hands between gloves or prior to the start of care and before she put on gloves. On 4/13/20, at 2:21 p.m., the director of nursing stated staff were expected to wash their hands any time they were soiled, before and after the entered a room, before and after the ate and before and after every glove change. Monarch Healthcare Management Handwashing policy dated 11/2019, indicated proper hand washing techniques should be used to protect the spread of infection. Hand washing shall be completed, after changing incontinent products or cleaning up after someone who has used the toilet. Policy also indicated proper handwashing should be completed before donning gloves and after removing gloves. Alcohol-based hand sanitizers may be used if hands are not visibly soiled or soap and water are not available.