



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 28, 2025

Administrator
The Emeralds at St Paul LLC
420 MARSHALL AVENUE
SAINT PAUL, MN 55102

RE: CCN: 245295

Cycle Start Date: June 25, 2025

Dear Administrator:

On July 17, 2025, we notified you a remedy was imposed. On August 22, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 21, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 12, 2025 will be discontinued as of August 21, 2025. (42 CFR 488.417 (b))

In our letter of July 17, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 25, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 14, 2025

Administrator
The Emeralds at St. Paul LLC

420 MARSHALL AVENUE
SAINT PAUL, MN 55102

RE: CCN: 245295
Cycle Start Date: June 25, 2025

Dear Administrator:

On July 28, 2025, we informed you of imposed enforcement remedies.

On July 30, 2025, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 12, 2025.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 12, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 12, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of July 17, 2025, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 25, 2025.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 25, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written

request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies. A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
E0000	Initial Comments On 7/27/25-7/30/25, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			08/20/2025	
F0000	INITIAL COMMENTS On 7/27/25-7/30/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52951041C (MN00108996), H52951042C (MN00108825), H52951043C (MN00108317), H52951044C (MN00108056), H52951045C (MN00107619), H52951046C (MN00107503), H52951047C (MN00106466), H52951048C (MN00104179) with NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.		F0000			08/20/2025	
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)		F0558	R61's call light was placed within easy reach. All residents have the potential to be affected by this deficient practice. All resident care plans were		08/20/2025	

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 reverse for further 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 CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0558 SS = D	Continued from page 1 §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure call light was accessable for 1 of 1 residents (R61) reviewed for call lights. Findings include: R61's quarterly Minimum Data Set)MDS) dated 4/25/25, indicated R61 was cognitively intact and had diagnoses of respiratory failure and quadriplegia (unable to move arms or legs). Furthermore, R4 was dependent on staff for all cares. R61's care plan revised 6/5/25, indicated R61 was a risk of falls and staff were to ensure R61's call light was within reach. An observation on 7/27/25 at 12:39 p.m., R61 was laying in bed. R61's head was on a pillow and on the right side of the pillow was a tent call light. R61 was unable to move his head to hit the call light if staff assist was needed. When interviewed on 7/27/25 at 12:42 p.m., R61 was able to answer yes and no questions and mouthed words. R61 indicated it was sometimes hard to breath and they waited on staff for help. R61 shook their head no when asked if able to turn on the call light from where it was located. An observation on 7/28/25 at 1:54 p.m., R61 was laying in his bed watching their tablet. To the right of R61's pillow was a tent call light. R61 indicated no when asked if he could turn it on if assistance was needed. When interviewed on 7/28/25 at 2:05 p.m., registered nurse (RN)-B stated R61 was able to use the call light to alert staff for assistance. R61 was able to nudge it with his head. RN-B verified R61 was not able to reach their call light. RN-B placed the tent call light on R61's pillow close to their head and asked R61 to put it on to ensure it was in reach. When interviewed on 7/28/25 at 2:23 p.m., RN-C stated call lights should be placed where residents could use them. RN-C further stated that is an important part of how residents let staff know they need help.	F0558	Continued from page 1 reviewed and updated to reflect call light within reach. Staff to be educated on the facility's expectations of staff to assure the accessibility of call lights in resident rooms at all times, and to utilize care plan if needed. DON or designee to conduct random checks of call light placement weekly x4 weeks, then monthly x2 months. Audit results will be reviewed by QAPI for further recommendations. 8/20/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0558 SS = D	Continued from page 2 When interviewed on 7/30/25 at 10:59 p.m., the Director of Nursing (DON) expected staff to ensure call lights were in reach for all residents. DON further stated this was needed to ensure residents can get assistance when needed. A facility policy titled Call Light Policy revised 5/16/23, directed staff to ensure call lights, cords or other communication devices must be placed where they are within reach of each resident.	F0558		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.	F0578	R7 POLST was reviewed upon return from the hospital and updated accordingly. All residents that have selected DNR/Selective Treatment that go to the hospital and return needing a vent have the potential to be affected by this deficient practice. All current vent resident population POLSTs were reviewed and updated accordingly. Nurses and IDT to be educated that POLST needs to be reviewed at care conference and upon re-admission. They will also be educated on why we would select full treatment vs selective treatment when on a vent. DON or designee to conduct random checks of residents POLST to make sure the procedure is being followed weekly X4, then monthly X2. Audit results will be reviewed by QAPI for further recommendations 8/20/2025	08/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0578 SS = D	Continued from page 3 (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure a Provider Order for Life Sustaining Treatment (POLST) was updated to reflect the current wishes for 1 of 1 residents (R7) reviewed for advanced directives. Findings include: R7's Minimum Data Set (MDS) dated 5/14/25, indicated R7 had severely impaired cognition and never made decisions. R7's diagnoses included chronic respiratory failure, quadriplegia (inability to move arms and legs) and locked in state (lacked motor responses used to measure responsiveness). Furthermore, R7 had a tracheostomy (a surgical incision into the windpipe to assist with breathing) and required mechanical ventilation. R7's provider order dated 8/9/24, indicated R7 did not want resuscitation and was Do Not Resuscitate (DNR). R7's POLST dated 9/4/24, indicated R7 was DNR with selective treatment. Selective treatment included no intubation, advanced airway and no mechanical ventilation. Along side of the selective treatment section read "per brother DNR/Do not Intubate (no advanced airway). R7's provider order dated 8/9/24, indicated R7 did not want resuscitation and was Do Not Resuscitate (DNR). R7's hospital discharge summary dated 12/169/24, indicated R7 was hospitalized with acute on chronic hypoxic respiratory failure (an exacerbation of respiratory failure that led to low oxygen saturations). The summary further indicated R7 had been dependent on a tracheostomy prior to hospitalization and had not required oxygen supplementation or mechanical ventilation. R7 now needed mechanical ventilation as needed during the day and be placed on mechanical ventilation at night upon discharged. R7's care conference form dated 3/21/25, indicated R7's POLST was reviewed with resident/representative. When interviewed on 7/28/25 at 1:47 p.m., licensed		F0578				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0578 SS = D	Continued from page 4 practical nurse (LPN)-C stated the nurse manager reviewed the POLST with the resident or family when admitted. LPN-C wasn't sure how often a POLST was reviewed after that. When interviewed on 7/28/25 at 2:24 p.m., registered nurse (RN)-C stated a POLST was reviewed with the resident or family upon admission and then should be reviewed with any changes, at care conferences and hospitalizations. Full recusation and DNR was explained to the resident/family to help them decide what was wanted. They sign and then the nurse practitioner signed. RN-C verified R7's current POLST indicated R7 wanted to be DNR/DNI, however R7 had a tracheostomy and used a mechanical ventilator. RN-C further stated this did not make sense and R7 had a change after a hospitalization and had been using the ventilator for a while. RN-C stated R7's brother who was the medical decision maker, would need to be notified so R7's POLST could be clarified as R7's brother was involved and knew the status of the ventilator use. RN-C further stated during care conferences, while the POLST was discussed, the actual form was not reviewed for accuracy. When interviewed on 7/30/25 at 10:59 a.m., the Director of Nursing (DON) expected the resident's wishes and POLST to be verified and completed during admission and reviewed as needed, which included when residents returned from the hospital. Furthermore, the DON stated this was important to ensure the residents received the care they wanted. A facility policy titled POLST Documentation Procedure revised 4/2025, directed staff to complete a routine audit of POLST documentation to ensure consistent and accurate documentation of the POLST form, provider orders and care plan entry.		F0578				
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the		F0605	R3 psychotropic medications were reviewed, and target behavior monitoring order added to demonstrate effectiveness of psychotropic medications. All residents with an active order for psychotropics medications have the potential to be affected by this deficient practice. All residents with an active psychotropic medication order were reviewed and target behavior monitoring orders were added or updated as needed. Nursing and IDT to be educated on how to read communication of anxiety for non-verbal residents or residents who are unable to communicate their anxiety. Target Behavior meetings will be implemented and		08/20/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0605 SS = D	Continued from page 5 resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or		F0605	Continued from page 5 routinely occurring. DON or designee to conduct random checks on residents that are on psychotropics have target behavior monitoring orders in place and they are being charted on accordingly to show effectiveness. Audits to take place weekly x4 and then monthly x2. Audit results will be reviewed by QAPI for further recommendations. 8/20/2025			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0605 SS = D	Continued from page 6 (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility		F0605				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0605 SS = D	Continued from page 7 failed to ensure target behaviors were monitored for 1 of 5 residents (R3) who received psychotropic medications (medications that affect mood, thoughts, or behaviors). Findings include: R3's quarterly Minimum Data Set (MDS) dated 5/8/25, indicated R3 was cognitively intact and had diagnoses of acute respiratory failure, Amyotrophic Lateral Sclerosis (disease that affects the spinal cord causing loss of muscle use), and major depressive disorder. R3 was ventilator dependent and was taking psychotropic medications. A review of R3's current provider orders indicated R3 required: -as of 4/3/2025, Clonazepam (psychotropic medication) 0.5 milligrams (mg) via gastrostomy tube (G-tube) at noon for anxiety. -as of 4/2/25, clonazepam .025 mg twice daily for anxiety related to major depressive disorder. R3's orders lacked monitoring for target behaviors for anxiety. R3's care plan revised 11/11/2024, indicated R3 had potential for psychotropic drug adverse drug reactions related to daily use of psychotropic medications. Interventions included to administer medications as ordered, monitor for adverse reactions, and pharmacy to review medications. However, R3's care plan lacked identification or monitoring of target behaviors. When interviewed on 7/28/25 at 10:20 a.m., registered nurse (RN)-D stated R3 took medications for anxiety and has for a while. RN-D stated staff look for restlessness. R3 had been very anxious at times, especially when needing suctioning. R3 had recently been declining and at one point was going to go onto hospice, however decided not to. RN-D verified there was no documentation of target behaviors related to R3's anxiety or psychotropic medications and stated there was no longer daily documentation of any specific anxiety behaviors or anything to that extent. Currently, nurses only document if R3 had a change in condition. When interviewed on 7/29/25 at 2:25 p.m., RN-C stated R3 had recently deteriorated and almost signed on to hospice a few months ago. R3 used to be able to mouth his words, and now he can only blink to communicate. R3		F0605				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0605 SS = D	Continued from page 8 used to be very anxious with repositioning and used to over breathe the vent. Currently, R3 had good days and bad days with the anxiety, breathing and repositioning. RN-C verified R3 had orders to monitor for side effects of the psychotropic medications, however there was no monitoring of target behaviors related to R3's anxiety and need for the medications. When interviewed on 7/30/25 at 10:19 a.m., the Director of Nursing (DON) expected residents who were taking psychotropic medications to have monitoring for target behaviors related to those medications. DON further stated it was important to understand if the medications were effective and if they were supporting a positive outcome for the resident. A facility policy titled Psychotropic Medication Use Policy revised 5/2025, directed staff to identify and monitor target behaviors when a resident was prescribed psychotropic medications.	F0605		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to provide nail care for 1 of 1 (R79) resident reviewed for activities of daily living (ADL). Findings include: R79's quarterly Minimum Data Set (MDS) dated 6/18/25, indicated moderately impaired cognition and diagnoses of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side and vascular dementia. It further indicated R79 had an impairment on one side of his upper extremities and required staff assistance with most ADL's and mobility.R79's care plan dated 6/18/25, indicated current functional performance was assist of 1 with ADLs. R79's skin assessments for the month of July 2025 (7/6/25, 7/13/25, 7/20/25, 7/27/25) indicated trimming fingernails was not necessary. During observation and interview on 7/27/25 at 3:01 p.m., R79's fingernails	F0677	R79 received nail care by DON on 8/13/25 and care plan updated to reflect behavior of nail care refusals. All residents that are dependent with nail care will be affected by this deficient practice. Care Plans were reviewed for like residents and updated to reflect staff to offer nail care weekly and PRN, and to document refusals. Nursing, nursing assistants, and the Therapeutic Rec director will be educated on proper nail care procedures, including timely interventions for dependent residents requiring nail trimming, cleaning, and treatment. Director of Nursing or designee will conduct random assessments for nailcare on dependent residents weekly X4, then monthly X2. Audit results will be reviewed by QAPI for further recommendations. 8/20/2025	08/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0677 SS = D	Continued from page 9 (on both hands) were approximately an inch long and he stated he wanted them cut. During observation on 7/28/25 at 8:08 a.m., R79 was sitting in his wheelchair, waiting in line to go outside to smoke. His fingernails were observed to be approximately one inch long. During observation and interview on 7/28/25 at 10:00 a.m., nursing assistant (NA)-E stated the nurses were responsible for cutting the residents nails, especially when they were diabetic and it should be done at least once a week on bath day. If the resident refused, it should be documented. NA-E also verified R79's nails were long, and they appeared to have not been trimmed in a few weeks. R79 repeatedly asked NA-E to cut his nails during this time. During interview on 7/28/25 at 10:46 a.m., licensed practical nurse (LPN)-B stated NA's and nurses were responsible for cutting the resident's fingernails unless they were diabetic. If the resident was diabetic, then the nurses were responsible for cutting them. This should be done weekly on bath day and refusals should be documented. During interview on 7/28/25 at 3:04 p.m., LPN-A stated the NA's or activities staff were responsible for cutting the resident's nails (unless they were diabetic). If they were diabetic, then the nurses were responsible for cutting them. The residents' nails should be cut once a week on bath day and refusals should be documented. During interview on 7/30/25 at 12:42 p.m., the director of nursing (DON) stated the nurses or podiatry were responsible for cutting residents nails if they were diabetic. If the resident was not diabetic, then the NAs were responsible for doing it. The DON further stated the resident's nails should be cut at least once a week on bath day, along with the skin assessment. The nurses were responsible for documenting it was completed, and refusals should be documented. The facility's policy regarding ADL's dated 3/31/23, indicated a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F0677		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F0688	R37 remains at the facility. R37's care plan and orders have been reviewed and updated as necessary. R37 has been added to therapy caseload. R37's splint has been added to Kardex for communication.	08/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0688 SS = D	Continued from page 10 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a hand splint/brace was used consistently for 1 of 1 resident (R37) reviewed for range of motion (ROM). Findings include: R37's annual Minimum Data Set (MDS) dated 7/17/25, indicated R37 has minimal cognitive deficit, had limited ROM with impairment of upper extremities on one side, dependent with upper body dressing, and received zero minutes of ROM or splint/brace assistance in the 7 day lookback period. R37's diagnoses included hemiplegia and/or hemiparesis (weakness/paralysis affecting one side of the body) following a stroke affecting left non-dominant side. R37's care plan dated 4/14/25, indicated R37 severe contractures (condition where muscles or tendons become permanently shortened, causing loss of movement) of extremity. R37's care plan indicated hand splint to left arm, on in a.m. up to six hours and off at 2:00 p.m. and to wash both hands every shift before applying left hand splint/hand protector. R71's provider order dated 7/10/25, indicated apply hand splint to left arm, on with a.m. cares. R71's provider order dated 7/10/25, indicated remove left arm splint at the end of day shift at 1400 [sic].	F0688	Continued from page 10 All like residents with ROM/splinting programs have the potential to be affected by this deficient practice. All like residents who have been identified for ROM/splinting have had their care plans and orders reviewed and updated to reflect current interventions. The DON or designee will provide re-education to nursing and nursing assistants on ROM, FMP, splinting, and appropriate documentation to reduce risk of worsened contractures. The DON or designee will complete audits on residents with ROM/splinting programs to ensure ROM/splinting program is followed. Audits will be conducted weekly X 4, and then monthly X 2. Audit results will be reviewed by QAPI Committee for further recommendation. 8/20/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0688 SS = D	Continued from page 11 After the electronic medical record reviewed on 7/29/25, no evidence in R37's progress notes of physician notification of potential pain during usage of the left hand splint. Further, no evidence of any therapy orders during the year of 2025. During observation on 7/27/25 at 1:00 p.m., R37 in bed with no splint noted to left hand/arm. During observation on 7/28/25 at 8:04 a.m., R37 was up in wheelchair (w/c) in room with no splint noted to left hand/arm. During observation on 7/28/25 at 11:49 a.m., R37 up in w/c in room with no splint noted to left hand/arm. During observation on 7/28/25 at 1:47 p.m., R37 in bed with no splint noted to left hand/arm. During observation on 7/29/25 at 7:14 a.m., R37 in bed with no splint noted to left hand/arm. During observation on 7/29/25 at 8:01 a.m., R37 in bed with no splint noted to left hand/arm. During an interview on 7/29/25 at 8:43 a.m., nursing assistant (NA)-F stated not being aware of R37 requiring a splint to either hand and further stated R37 only requires the blue boots to the legs/feet only. NA-F verified R37 did not have a splint on the left hand/arm. During an interview on 7/29/25 at 8:46 a.m., trained medication aide (TMA)-A stated being aware of the blue boots for R37's legs/feet however, was not aware R37 required "anything" for the hands/arms. TMA-A pulled up the point of care documentation and noted there was no area to document a splint for R37's left arm. TMA-A pulled up the kardex for R37 on the laptop and noted there was documentation which indicated R37 required a splint to left arm to be applied in the a.m. and to be removed at 2 p.m. on day shift. TMA-A verified R37 did not have a splint on the left hand/arm. During an interview on 7/29/25 at 8:50 a.m., registered nurse (RN)-F stated R37 used to wear a splint to the left arm however, the staff are unable to find the splint for "months". RN-F stated therapy was informed the splint was missing months ago however, denied following up on the missing splint status. During an interview on 7/29/25 at 8:54 a.m., RN nurse manager (RN)-G stated R37 refuses to wear the left arm splint due to pain however, further stated Health		F0688				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0688 SS = D	Continued from page 12 Partners was called and an order for therapy was received and therapy has been working with R37 regarding the splint. Further, RN-G stated R37 hadn't wore the splint to the left arm in "months". During an interview on 7/29/25 at 9:02 a.m., certified occupational therapy assistant (COTA)-A stated R37 hadn't been on case load for therapy since 2024 and at the time it was an evaluation only due to a return from a hospital stay. Further COTA-A stated the last time R37 had been on therapy case load for the splint to the left arm was during 2021. COTA-A verified R37 needed the splint for pain management and to maintain what movement R37 has in the left arm. During an interview on 7/29/25 at 9:08 a.m. director of nursing (DON) stated if a splint was missing or causing pain the provider should be notified and therapy orders obtained as well as a new splint should be reordered and fitted. DON verified it was important for R37 to utilize the splint to maintain as much range of motion to the area as possible. Splint usage policy requested on 7/29/25 however, was not provided.	F0688		
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on document review and interview, the facility failed to identify triggers to avoid potential re-traumatization and failed to develop the care plan to include individualized trauma-informed approaches for 1 of 1 resident (R6) who had a history of trauma. Findings include: R6's Comprehensive Minimum Data Set assessment (MDS) dated 6/3/25, indicated cognitively intact, had a diagnosis of major depressive disorder with anxiety and PTSD (post traumatic stress disorder) on admit on 4/22/25. R6 had a diagnosis of quadriplegia required	F0699	R6 care plan was updated accordingly with potential triggers related to PTSD. R6 consented to ACP services PRN 7/30/2025. All Residents with a PTSD dx were reviewed and received care plan updates as needed with triggers if identified. Nursing staff and Social Services to be educated on use of trauma informed care plans, and documenting triggers as verbalized by resident. Staff to also ensure ACP follows up with residents when ordered and to document refusal of services. Social services director or designee will conduct random checks of resident's care plan to ensure triggers are identified and ACP is documenting on refusal of services. Audits to be done weekly x4 and monthly x2. QAPI will review audit results for further recommendations. 8/20/2025	08/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0699 SS = D	Continued from page 13 full cares with bed mobility and transfers, unable to walk, and required total assistance with dressing and hygiene. R6's admission Psychosocial Assessment dated 4/22/25 was not triggered for a care area assessment, therefore, not placed on care plan. R6's admission Trauma Questionnaire dated 4/23/25, identified the resident had a diagnosis of PTSD and R6 declined to talk about it. R6's physician visit note dated 4/25/25, identified R6 had major depressive disorder with anxiety, aggressor identification syndrome and PTSD. R6's physician orders on 4/28/25 and 6/3/25, identified orders for ACP Psychiatry consult to evaluate and treat. R6's vulnerability care plan dated 7/24/25, lacked individualized trauma-informed approaches or interventions and lacked identification of triggers to avoid potential re-traumatization. During an interview on 7/27/25 at 6:09 p.m., R6 stated someone, thinks it was social work employee, came in and talked, but I didn't want to talk at that time," I should see someone, I have been in a panic mode," they stated "just trying to get everything all together." During an interview on 7/28/25 at 2:13 p.m., R6 spoke rapidly, changing subjects quickly" I'm a little depressed, and concerned about keeping things in order, phone in mothers name right now, I wanted own line. Social worker was here about 1.5 weeks ago, I need to see a therapist, social services was going to do it but hasn't happened yet. I am in kind of panic mode." R6 rambled about Lake City, Milwaukee, packing up stuff and wanting to leave. They mentioned Bayview, it closed. There is nothing to do around here, no shopping, no restaurants, nothing to do outside. They talked about being in restraints in an ambulance and hospital. They were unaware of why they were taken to the hospital nor any outbursts or behaviors that would have caused that to happen to them. They claimed they called KTTCP and had an administrator fired for embezzling money. They stated they raged on Facebook against family, for not helping them. R6 stated they are in constant pain, Oxy doesn't touch the pain, worried about getting hooked on drugs. R6 also mentioned had a hard time sleeping, severe insomnia. They stated they were an advocate and did community service in Lake City and Red Wing.		F0699				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0699 SS = D	Continued from page 14 During an interview on 7/29/25 at 8:48 a.m., certified nursing assistant (CNA)-A met R6 needs by doing everything they ask, clean them up, had items next to them. The behavioral health training provided by the facility is on Med Trainer, a computer program, no hands-on or teach back methods utilized. CNA-A was unable to give a specific time frame for education, they replied the education happened, “pretty often.” They stated R6 mood was fairly stable, if there were any behaviors they would mark “yes” in the electronic medical record (EMR). That was the only place and information documented, no interventions or what type of behaviors displayed. During an interview on 7/29/25 at 9:00 a.m., licensed practical nurse (LPN)-A stated a resident received mental and psychological counseling by calling provider, obtain an order, inform the nurse manager and the family of appointment. If a resident was a trauma survivor, it would be written in a report and communicated in shift report. The approach to a resident with PTSD would be different, if the environment is too loud, too bright, if the resident is stressed. The behavioral health training provided was on Med Trainer, a computer program. During an interview on 7/29/25 at 11:14 a.m., LPN-A manager stated the processes in place to provide individualized care for a resident was in the care plan. The types of communication were used to keep floor staff aware of cares, changes in condition, behavioral issues were in the nurse-to-nurse report, 24-hour book, and in EHR. The process for a resident to receive mental and psychological counseling was to have social worker put them on a list and will notify who they should see every morning. It is the expectation that doctors’ orders are to be followed. It is the expectation that a resident would be seen if two orders are placed. The interdisciplinary team (IDT) meets every morning with nurses, director of nurses, administrator, social worker, physical therapy, occupational therapy and speech, address behaviors, discuss upcoming meetings, update treatment administration record (TAR) and put in progress notes. During an interview on 7/30/25 at 8:47 a.m., social service director (SSD)-A stated to obtain mental and psychological counseling services, review hospital charts, there is a 48 admit process, notify provider, obtain orders, get consent from resident, referrals to ACP Psychiatry. Discuss with the resident provide effective listening, have the resident feel safe and to get to the underlying issues. The doctor’s orders		F0699				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0699 SS = D	Continued from page 15 absolutely should be followed, the expectation for two orders for a resident to be seen by ACP, should be completed. However, the resident needed to sign a consent for treatment. R6 stated they requested therapy, however declined signing consent when SSD-A approached them, it was not documented. The IDT meet every morning, all the disciplines administrator, nurses, business office, culinary, activities, MDS coordinator, infection control, health unit coordinators. They discuss discharges, changes of condition, falls, grievances, hospitalization, care conferences, MDS, any meetings, new admissions and behaviors. R6 behaviors/ trauma informed care was not discussed due to it not being triggered on care area assessment or care plan. The care plans are important to know the total picture of the resident; mobility, diet, psychosocial, nursing, medication, therapies, every staff member needs to review and look under every section on care plans to provide individualized care for each resident. The underlying causes of the resident's behavioral expressions or indications of distress, specifically included in the care plan were individual needs of each resident, such as, grief, a loner, anything effects them, psychosocial issues, past trauma, mood and behavior, financial issues, health reasons, triggers, history of substance or alcohol abuse, homelessness, can influence their cares and their dc planning, The behavioral health training is on the computer, Med Trainer. There was not role playing, teach back, hands on, classes outside of facility utilized. If resident was a trauma survivor, the process for providing care, you don't need to know what the trauma was but be aware of the triggers. Understand that PTSD affects behavior, be aware of their individualized needs. If resident a appears hopeless, loss of control, staff needed be present, be respectful and understanding of everyone, be extremely mindful of retraumatizing the resident. The policy titled Trauma Informed Care, dated 2/24/23, identified the purpose is to guide staff in appropriate and compassionate care specific to individuals who have experienced trauma. As part of the comprehensive assessment, staff will identity history of trauma when possible. Residents that have a history of trauma will have goals and interventions added to their care plan to address potential triggers and approaches to minimize or eliminate the effect of the trigger on the resident.		F0699				
F0742 SS = D	Treatment/Srvcs Mental/Psychosocial Concerns CFR(s): 483.40(b)(1)		F0742	R6 had a trauma-informed questionnaire completed on 8/11/25. Resident triggers identified and care planned. All residents with PTSD dx have the potential to be		08/20/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0742 SS = D	Continued from page 16 §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is NOT MET as evidenced by: Based on document review and interview, the facility failed to identify triggers to avoid potential re-traumatization and failed to develop the care plan to include individualized trauma-informed approaches for 1 of 1 resident (R6) who had a history of trauma. Findings include: R6's Comprehensive Minimum Data Set assessment (MDS) dated 6/3/25, indicated cognitively intact with depression. R6 had a diagnosis of major depressive disorder and PTSD (post-traumatic stress disorder) on admit on 4/22/25. R6 had a diagnosis of quadriplegia required full cares with bed mobility and transfers, unable to walk, and required total assistance with dressing and hygiene. R6's admission Psychosocial Assessment dated 4/22/25 was not triggered for a care area assessment, therefore, not placed on care plan. R6's admission Trauma Informed Care history dated 4/23/25, identified the resident had a diagnosis of PTSD and R6 declined to talk about it. Further, R6 responded yes to having been through anything life threatening or traumatic but did not give any further details on traumatic event. However, assessment lacked further details regarding triggers to prevent re-traumatization. R6's physician visit note dated 4/25/25, identified R6 had major depressive disorder with anxiety, aggressor identification syndrome and PTSD. R6's physician orders on 4/28/25 and 6/3/25, identified orders for ACP Psychiatry consult to evaluate and treat. R6's vulnerability care plan dated 7/24/25, lacked individualized trauma-informed approaches or	F0742	Continued from page 16 affected and received trauma evaluation and updated care plan for triggers. Nursing staff to be educated on use of trauma informed care plans, documenting triggers as verbalized by the resident. Staff also to ensure ACP follows up with residents when ordered and to document refusal of services in PCC. New admissions with a dx of PTSD will have trauma questionnaires reviewed in routine clinical meeting to ensure triggers are identified and care planned. Social Services Director or designee to complete audits x4 week on new admissions to ensure trauma questionnaire is complete, triggers identified, and care plan updated. 8/20/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0742 SS = D	Continued from page 17 interventions and lacked identification of triggers to avoid potential re-traumatization. During an interview on 7/27/25 at 6:09 p.m., R6 stated someone, thinks it was social work employee, came in and talked, but I didn't want to talk at that time, I should see someone, I have been in a panic mode, they stated "just trying to get everything all together." During an interview on 7/28/25 at 2:13 p.m., R6 was speaking rapidly, changing subjects quickly," I'm a little depressed, and concerned about keeping things in order, phone in mothers name right now. I wanted own line. Social worker was here about 1.5 weeks ago,to see a therapist, social services was going to do it but hasn't happened yet. I am in kind of panic mode." R6 rambled about Lake City, Milwaukee, packing up stuff and wanting to leave. They mentioned Bayview, it closed. There is nothing to do around here, no shopping, no restaurants, nothing to do outside. They talked about being in restraints in an ambulance and hospital. They were unaware of why they were taken to the hospital nor any outbursts or behaviors that would have caused that to happen to them. They claimed they called KTTCP and had an administrator fired for embezzling money. They stated they raged on Facebook against family, for not helping them. R6 stated they are in constant pain, Oxy doesn't touch the pain, worried about getting hooked on drugs. R6 also mentioned had a hard time sleeping, severe insomnia. They stated they were an advocate and did community service in Lake City and Red Wing. During an interview on 7/29/25 at 8:48 a.m., certified nursing assistant (CNA)-A met R6 needs by doing everything R6 asked, cleaned them up, had items next to them. The behavioral health training provided is on Med Trainer, a computer program, no hands-on or teach back methods utilized. CNA-A was unable to give a specific time frame for education, they replied the education happened, "pretty often." They stated R6 mood was fairly stable, if there were any behaviors they would mark "yes" in the electronic medical record (EMR). That was the only place and information documented, no interventions or what type of behaviors were displayed. During an interview on 7/29/25 at 9:00 a.m., licensed practical nurse (LPN)-A stated a resident received mental and psychological counseling by calling provider, obtain an order, inform the nurse manager and the family of appointment. If a resident was a trauma survivor, it would be written in a report and communicated in shift report. The approach to a resident with PTSD would be different, if the		F0742				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0742 SS = D	Continued from page 18 environment is too loud, too bright, if the resident is stressed. The behavioral health training provided was on Med Trainer, a computer program, no additional education provided. During an interview on 7/29/25 at 11:14 a.m., LPN-A manager stated the processes in place to provide individualized care for a resident was in the care plan. The types of communication were used to keep floor staff aware of cares, changes in condition, behavioral issues were in the nurse-to-nurse report, 24-hour book, and in EHR. The process for a resident received mental and psychological counseling was to have the social worker put them on a list and notify ACP of whom they should see every morning. It is the expectation that doctors' orders are to be followed. It is the expectation that a resident would be seen if two orders are placed. The interdisciplinary team (IDT) meets every morning with nurses, director of nurses, administrator, social worker, physical therapy, occupational therapy and speech, they address behaviors, discuss upcoming meetings, update treatment administration record (TAR) and put in progress notes. During an interview on 7/30/25 at 8:47 a.m., social service director (SSD)-A stated to obtain mental and psychological counseling services, they reviewed hospital charts, there is a 48 admit process, notify provider, obtain orders, get consent from resident, send referrals to ACP Psychiatry. The plan was to discuss with the resident, provide effective listening, have the resident feel safe and to get to the underlying issues. The doctor's orders absolutely should be followed, the expectation for two orders for a resident to be seen by ACP, should be completed. However, the resident needs to sign a consent for treatment. R6 stated they requested therapy, however R6 declined signing consent when SSD-A approached them. The care plans are important to know the total picture of the resident; mobility, diet, psychosocial, nursing, medication, therapies, every staff member needs to review and look under every section of care plans to provide individualized care for each resident. The underlying causes of the resident's behavioral expressions or indications of distress, specifically included in the care plan were individual needs of each resident, such as, grief, a loner, anything effects them, psychosocial issues, past trauma, mood and behavior, financial issues, health reasons, triggers, history of substance or alcohol abuse, homelessness, can influence their cares and their discharge planning, The behavioral health training is on the computer, Med Trainer. There was not role playing, teach back, hands on, classes outside of facility		F0742				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0742 SS = D	Continued from page 19 utilized. If resident was a trauma survivor, the process for providing care, you don't need to know what the trauma was but be aware of the triggers. Understand that it affects behavior, be aware of their individualized needs. If resident a appears hopeless, loss of control, staff need to be present, be respectful and understanding of everyone, be extremely mindful of retraumatizing the resident. The IDT meet every morning, all the disciplines administrator, nurses, business office, culinary, activities, MDS coordinator, infection control, health unit coordinators. They discuss discharges, changes of condition, falls, grievances, hospitalization, care conferences, MDS, any meetings, new admissions and behaviors. R6 behaviors/ trauma informed care was not discussed due to it not being triggered on care area assessment or care plan. The policy titled Trauma Informed Care, dated 2/24/23, identified the purpose is to guide staff in appropriate and compassionate care specific to individuals who have experienced trauma. As part of the comprehensive assessment, staff will identity history of trauma when possible. Residents that have a history of trauma will have goals and interventions added to their care plan to address potential triggers and approaches to minimize or eliminate the effect of the trigger on the resident.	F0742		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F0812	Food items identified on 4th floor 3rd floor and 2nd floor were removed from fridge and disposed. Refrigerators were cleaned. All residents have the potential to be affected by this deficient practice. No residents were identified to have had any food borne illnesses related to this deficient practice. Staff to be educated that open food needs to be dated and thrown out if it exceeds three days. Dietary to be educated on taking temps and housekeeping to be educated on cleaning refrigerators weekly. Culinary Director or designee to conduct random checks on open food to make sure it is dated and fridges are cleaned accordingly weekly X4, then monthly X2. Audit results will be reviewed by QAPI for further recommendations. 8/20/2025	08/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0812 SS = E	Continued from page 20 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure proper cleaning of snack/nourishment refrigerators maintained with food items are dated and labeled to prevent the potential for foodborne illness for 3 of 3-unit refrigerators. Findings include: During observation on 7/27/25 at 12:50 p.m., the refrigerator for residents on the 4th floor had an open gallon jug of milk, expiration date 7/9/25 no label on the container stating when milk was opened. A clear Tupperware container wrapped in a Macy's bag without a label. A Menards's bag with food container inside, had a resident's name, no date on item. A drawer contained: one open unlabeled package of saltine crackers, open bag of carrots and a peach. In the door of refrigerator there was an opened unlabeled chocolate pudding, a yogurt no label, expiration date 6/25, a bag with no label, open containers of Pace hot sauce, ketchup, Jalapenos, strawberry jam, Core Power beverage, Top of the Tator dip, expiration date 5/25, all items unlabeled. The bottom of the refrigerator, under the drawers had a red, dried liquid substance on it. The freezer had a Mason jar with a grayish substance in it, labeled with date 4/31/25 no name. An unlabeled open container of glycerin swabs sticks. A frozen unlabeled loaf of bread used by date 5/29/25. An unlabeled frozen bag of long grain white rice expiration 5/24. A bag from Culver's with resident's name, no date on it. Lastly, a frozen Celeste frozen deluxe pizza expiration date 3/22/25 no label on item. Observed nursing assistant (CNA)-D removed a plaid thermos from refrigerator and placed it on top of refrigerator. During observation on 7/27/25 at 1:41 p.m., the refrigerator for residents on the 3rd floor contained an open package of hot dogs with white, green and brown fuzzy coating on them, unlabeled, expiration 6/25. A white bag with food items in it, unlabeled. Lastly, a bottle of Bio salad dressing, expiration date 5/25. The freezer had a Styrofoam cup with frozen red substance, unlabeled. One cold compress, unlabeled. During observation on 7/27/25 at 2:02 p.m., the refrigerator for residents on the 2nd floor contained a TPN (Total Parenteral Nutrition) container unlabeled with an expiration date of 11/24. During observation on 7/28/25 at 8:35 a.m., the refrigerator on the 4th floor still had red, dried liquid substance on bottom of it,		F0812				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0812 SS = E	Continued from page 21 all remaining items are labeled and dated, no expired items, additionally, the plaid thermos was on top of refrigerator. During observation on 7/29/25 at 8:25 a.m., the refrigerator on the 4th floor still had red, dried liquid substance on the bottom of it, additionally, the plaid thermos remained on top of refrigerator. During observation on 7/30/25 at 10:28 a.m., fridge was cleaned, and plaid thermos was removed from top of 4th floor refrigerator. During interview on 7/27/25 at 1:11 p.m., certified nursing assistant (CNA)-B stated the housekeeping department was responsible for cleaning and the disposal of unlabeled and expired items. CNA-B verified items unlabeled and expired in the 4th floor refrigerator. During interview on 7/27/25 at 1:17 p.m., CNA-D stated the kitchen staff was responsible for cleaning and the disposal of unlabeled and expired items. CNA-D verified items unlabeled and expired. They removed items from the refrigerator and put into trash, however, did remove an unlabeled plaid thermos and placed it on top of refrigerator on the 4th floor. During interview on 7/27/25 at 1:53 p.m., CNA-C verified unlabeled and expired items in 3rd floor refrigerator. During interview on 7/27/25 at 2:11 p.m., registered nurse (RN)-A stated they were unsure of which department was responsible for cleaning and disposal of unlabeled or expired items. They verified the unlabeled and expired items in the 2nd floor refrigerator. They stated ice compresses were to be stored in the medication fridge, not in resident's refrigerator. During interview on 7/29/25 at 7:22 a.m., dietitian-A stated there is a policy for residents receiving food from outside of facility. During interview on 7/29/25 at 7:25 a.m., culinary director (CD)-A stated nurses and CNA's check dates on items and disposes of any unlabeled or expired items, the dietary staff check and document temperatures, and housekeeping is responsible for cleaning the inside and outside of resident refrigerators on each floor. During interview on 7/29/25 at 8:47 a.m., housekeeping-A stated refrigerators were cleaned every Wednesday on all floors, items not labeled, check with nurse manager before disposing of items. If a container is open for more than two days, it is to be disposed of. Also, no items are to be on top of refrigerators. During interview on 7/29/25 at 9:17 a.m., CNA-A stated kitchen staff or aides clean fridges on the floors. Items should have dates and name of resident. During interview on 7/29/25 at 9:25a.m., licensed practical nurse (LPN)-B stated mostly nurses and		F0812				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0812 SS = E	Continued from page 22 managers clean the fridges on the floors. Items need to be labeled with name and date. if an item is expired, inform resident that the item was disposed of. A facility policy titled "Food Receiving and Storage" implemented on 7/29/25, indicated the refrigerator and freezer cleanliness will be maintained by housekeeping services. The labeling, monitoring and assisting residents/family of incoming product labeling will be maintained by nursing staff. The maintaining of daily temp logs, monitoring dates of products stored will be maintained by dietary staff. The facilities policy titled, "Food Brought into a Monarch Healthcare Management Facility" policy revised 9/12 indicated the food must be in a closed, leak-resistant container, it must be labeled with: Resident name and date item was received. Food must be disposed of properly after 3 days.	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F0880	R7s transmission-based precaution orders were discussed with nurse practitioner who clarified R7 is to be on Enhanced Barrier Precautions only. PCP states that Hep B is chronic. R15, R21, and R78 were reviewed and did not have any negative health outcome from the deficient hand hygiene practice with med administration. Resident with transmission-based precaution (TBP) orders have the ability to be affected by this practice. All residents with an order for TBP were reviewed, care plan updated, and appropriate signage in place. All residents have the ability to be affected by failure to ensure hand hygiene during med administration. All current residents were reviewed and did not have any negative health outcomes as a result of this deficient practice. All staff to be educated on infection control practices related to TBP, and all nurses to be provided a med administration competency that incorporates hand hygiene expectation. Director of Nursing or designee will conduct random observations for med administration and TBP weekly X4, then monthly X2. Audit results will be reviewed by QAPI for further recommendations. 8/20/2025	08/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0880 SS = D	Continued from page 23 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure staff followed transmission-based precautions (TBP) for 1 of 2 residents (R7) reviewed for TBP. Furthermore, the facility failed to ensure hand hygiene was completed during medication administration for 3 of 11 residents (R15, R21, R78) observed for medication administration.		F0880				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0880 SS = D	Continued from page 24 Findings include: R7's Minimum Data Set (MDS) dated 5/14/25, indicated R7 had severely impaired cognition and diagnoses included chronic respiratory failure, quadriplegia (inability to move arms and legs) Furthermore, R7 had a tracheostomy (a surgical incision into the windpipe to assist with breathing) and hepatitis B (liver disease that was spread through infected blood and bodily fluids) and Carbapenem-Resistant Pseudomonas aeruginosa (CRPA, a multidrug resistant infection that is transmitted via contact). R7's provider orders dated 10/8/24, indicated R7 required enhanced barrier precautions (EBP) for colonized multidrug resistant organism (MRDO) while providing high contact cares every shift for CRPA. R7's electronic medical record banner special instructions no date, directed staff to follow EBP for CRPA and history of hepatitis B. R7's care plan revised 8/12/24, indicated R7 required EBP related to tracheostomy, history of hepatitis B, and wound care to left toe. Interventions included use of appropriate communication to follow RBP, explain reason for EBP use, and for staff to don/doff personal protective equipment when providing high contact care. An observation on 7/27/25 at 6:08 p.m., R7's door was open. On the door was an orange sign that read Contact Isolation. The sign directed all staff who enter the room to perform hand hygiene and don a gown and gloves. An observation on 7/28/25 at 1:19 p.m., R7 was laying in their bed with the door open. On the door was an orange sign that read Contact Isolation and directed all staff who enter to perform hand hygiene and don gown and gloves. Central supply staff- A performed hand hygiene and donned gloves and entered R7's room without donning a gown. Central supply staff-A brought a box of supplies into the room and exited with an empty box. With gloves in place, the empty box was broken down and placed on a cart. Central supply staff-A then removed gloves and performed hand hygiene before entering the next room. When interviewed on 7/28/25 at 1:23 p.m., Central supply staff-A stated gloves were worn when delivering supplies to resident rooms in case something was needing to be moved. Central supply staff-A stated a gown was needed if supplies were stored close to the resident or the resident belongings. Since R7's box was		F0880				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0880 SS = D	Continued from page 25 not near him or his personal items, a gown was not needed. Central supply staff-A verified R7's sign that read Contact Isolation and further stated she was told if going in and out and not touching resident or resident items, only gloves were needed. When interviewed on 7/29/25 at 2:04 p.m., nursing assistant (NA)-B verified the sign on R7's door and stated R7 was on contact isolation for an infection or bug they had and that was to protect staff from his infection. Furthermore, R7 required staff to don a gown and gloves when providing personal or hands on cares with the resident. NA-B stated it was fine to enter the room without a gown or gloves to turn off the light or open the blinds, but if the bed was going to be touched, then a gown and gloves must be worn. When interviewed on 7/29/25 at 2:15 p.m., registered nurse (RN)-C stated when residents were on EBP, staff can perform hand hygiene and enter the room. If staff were to provide any hands on cares, gloves and a gown was required. Contact isolation required gown and gloves each time staff entered the room. RN-C verified the discrepancy between R7's contact isolation sign on the door and the orders in R7's medical record indicating R7 was on EBP and stated staff should follow the contact isolation sign. RN-C believed the contact isolation was in place when R7 had been actively infected with something but had to clarify if R7 still required contact isolation. Follow up information was received and RN-C verified R7 required EBP for hepatitis C and CRPA. Medication administration: R15's significant change MDS dated 5/12/25, indicated was cognitively intact and diagnoses of chronic respiratory failure with tracheostomy, had trouble swallowing, and had a gastrostomy tube (G-tube, a tube placed in the stomach to help with nutrition/tube feeding). R15's providers orders lacked indication R15 required EBP. R15's electronic medical record banner special instructions no date, directed staff to follow standard precautions. R21's quarterly MDS dated 4/30/25, indicated R21 was cognitively intact and had diagnoses of R78's significant change MDS dated 5/20/25, indicated R had mild cognitive impairment and diagnoses of			F0880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0880 SS = D	Continued from page 26 A medication observation on 7/30/25 at 12:05 p.m., RN-E was preparing R15's medication before going to R15's room. R15 was lying in bed with the door open. A sign on the door read Enhanced Barrier Precautions and directed staff to don gown and gloves when providing contact cares such as transferring, ADLs and repositioning. RN-E performed hand hygiene, donned gloves and without donning a gown, entered R15's room. RN-E flushed R15's g-tube, administered the medication via the G-tube and flushed the tube again. RN-E then cleared out the supplies, removed gloves and without hand hygiene exited R15's room. RN-E returned to the medication cart and without hand hygiene, prepared medications for R21. R21's medication was placed into a medication cup and RN-E went into the dining area where R21 was sitting finishing up lunch. RN-E administered the medication, took the empty medication cup and returned to the medication cart. The empty cup was thrown away and without hand hygiene, RN-E reviewed and prepared medications for R78. Without hand hygiene, RN-E donned gloves and brought R78's medications to the dining area where R78 was finishing up lunch. RN-E gave the oral medications and asked if the ointment could be placed on R78's knee. R78's left pant leg was raised and ointment applied. RN-E lowered the pant leg and let R78 know the other ointment will wait until they were done with lunch. RN-E then removed the gloves and threw them away and performed hand hygiene. When interviewed on 7/30/25 at 1:03 p.m., RN-E verified R15's door had a sign that stated Enhanced Barrier Precautions and said a gown and gloves were normally worn, however since there was not a long time spent in the room and the only interaction was with the G-tube, it was ok to be without a gown. RN-E further verified hand hygiene was not completed in between residents when administrating medications and should have been completed. When interviewed on 07/30/25 at 9:45 a.m., the infection preventionist (IP) expected staff to follow TBP signs on the door. If there was a discrepancy between the banner and the sign on the door, the expectation was for the staff to follow the sign on the door and reach out to the nurse manager for clarification. If there was not a nurse manager in the building, then staff should reach out to the provider. When interviewed on 7/30/25 at 10:59 a.m., the Director of Nursing (DON) expected staff to perform hand hygiene before entering and exiting a room. If the resident had TBP/EBP signs in place, staff were expected to follow		F0880				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0880 SS = D	Continued from page 27 the sign on the door or seek clarification if there was conflicting information between what was on the door and in the medical record. This was important to minimize risk of spreading infection. A facility policy titled Transmission Based Precautions revised 7/31/23, directed staff to ensure resident who require TBP will have pertinent signage that alerts staff, visitors and vendors of personal protection equipment needed. Proper hand hygiene remains a key preventative measure regardless of what TBP were in place.			F0880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/29/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on July 29/2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Emeralds at St. Paul LLC, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us		K0000			08/20/2025	

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 reverse for further 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 CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/29/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K0000	Continued from page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: The Emeralds of St. Paul is a 4-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1968 and was determined to be of Type II(222) construction. In 1982, an addition was constructed to the East side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 100 beds and had a census of 85 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:		K0000				
K0225 SS = F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures		K0225	The stairwell door for the south stair in the basement has been ordered and will be replaced immediately upon arrival. Other stairwell doors will be reviewed to ensure they close and latch appropriately.		08/20/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/29/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K0225 SS = F	Continued from page 2 Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain emergency egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.1 and 7.2.1.4.5.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/29/2025 at 1:05 PM, it was revealed by observation that the stairwell door for the South Stair in the Basement failed to close and latch. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.		K0225	Continued from page 2 Maintenance Director will be educated on door closure requirements. Audits will be conducted weekly x4 weeks by the Facility Maintenance Director or designee. Audits will be brought to QAPI by Admin for review. 8/20/2025			
K0324 SS = F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2		K0324	The kitchen hood filters are properly sealed, leaving no gap between filters. Residents were not affected. Maintenance Director will be educated on cooking equipment being protected in accordance with NFPA 96 standard for ventilation control and fire protection for commercial cooking operations. Audits will be conducted weekly x4 weeks by the Facility Maintenance Director or designee. Audits will be brought to QAPI by Admin for review. 8/20/2025		08/20/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/29/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K0324 SS = F	Continued from page 3 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to protect the cooking ventilation system in accordance with the NFPA 96 per 9.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 07/29/2025, between 12:55 PM, observations and staff interview revealed that the kitchen hood filters were not properly sealed leaving a 1" gap between the filters.. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0324				
K0363 SS = F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered		K0363	Doors 412, 315, 316, 324 have been repaired. The fire door closer to the kitchen has been repaired. The Soiled Utility room door on third floor has been ordered and will be installed upon arrival. Other doors have been reviewed to ensure they close/latch appropriately. Maintenance Director will be educated on ensuring doors close/latch per Life Safety Code. Audits will be conducted weekly x4 weeks by Facility Maintenance Director or designee. Audits will be brought to QAPI by the facility Admin for review. 8/20/2025		08/20/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/29/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K0363 SS = F	Continued from page 4 compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3.5 and 19.3.6.3.10. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 07/29/2025, at 12:50 PM, it was revealed by observation the following:Patient room doors 412, 315,316 and 324 failed to close and latch when tested.The fire door to the kitchen failed to close and latch when tested.The Soiled Utility Room door on the 3rd floor failed to close and latch when tested.An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0363				
K0920 SS = A	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5		K0920			08/20/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/29/2025	
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0920 SS = A	Continued from page 5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/29/2025, at 12:40 PM, it was revealed by observation that on the 2nd floor, there was a battery charger plugged into a power strip. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0920			