

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** H50672500M

**Date Concluded:** June 17, 2026

**Compliance #:** H50676300C

**Name, Address, and County of Licensee**

**Investigated:**

The Emeralds of Faribault  
500 1<sup>st</sup> St SE  
Faribault, MN 55021  
Rice County

**Facility Type:** Nursing Home

**Evaluator's Name:**

Katherine Barnhardt, RN Special Investigator

**Finding:** Not Substantiated

**Nature of Investigation:**

The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.

**Initial Investigation Allegation(s):**

The facility neglected the resident when facility staff failed to summon an ambulance when requested by the resident.

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was not substantiated. A licensed staff conducted an initial cardiac assessment due to the resident's cardiac history and the resident's vital signs were stable. A short time later, a second licensed staff conducted an assessment. Licensed staff conducted two assessments and even though the resident's vital signs were stable, the resident stated a pain level 10 out of 10 and the resident was transported to the emergency room for evaluation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record(s), hospital records, pharmacy records, facility internal investigation, personnel files, staff schedules, related facility policy and procedures.

The resident resided in a skilled nursing facility. The resident's diagnoses included congestive heart failure, stroke and diabetes type II. The resident's care plan included assistance with activities of daily living and medication management. The resident's record indicated an extensive cardiac history and recent treatment for pneumonia.

The resident's progress notes indicated the resident reported sudden chest pain and shortness of breath. A licensed staff assessed the resident; vital signs were stable and within normal parameters. A second licensed staff was notified of the resident's reported symptoms and completed a second assessment. Licensed staff followed facility protocol and offered interventions including nitroglycerin (heartbeat stabilizing medication) and oxygen. The resident denied all offered interventions and requested an emergency transport to the hospital. Licensed staff notified the resident's provider of continued chest pain and reported shortness of breath. Emergency services were called, and the resident was transported to an emergency room for evaluation. Progress notes indicated the resident was hospitalized.

Hospital records indicated the resident was evaluated at an emergency clinic and transferred to a hospital for treatment of a gastrointestinal (GI) bleed and cardiac monitoring. Hospital records indicated the resident received several units of blood throughout a hospital stay. The resident returned to baseline and discharged back to the skilled nursing facility.

During an interview, licensed leadership stated she had left the facility for the day and later that afternoon received a text from the resident's family member requesting the resident be sent to an emergency room for evaluation. Licensed leadership stated she was unable to reach the supervising licensed staff and requested another licensed staff check on the resident. Licensed leadership stated she learned one assessment had been completed and the resident's vital signs were stable however the resident requested to be sent out for an evaluation. A second licensed staff completed an assessment, notified a provider and summoned emergency services to transport the resident to an emergency room for evaluation.

During an interview, licensed staff stated he was contacted by facility leadership, and he went to assess the resident. Licensed staff stated when the resident was assessed he reported chest pain, requested to use the bathroom and go to the hospital. Licensed staff stated he offered the resident a urinal and nitroglycerin for the chest pain which the resident initially refused to take. Licensed staff stated the residents vital signs were stable, he updated the provider and called 911. Licensed staff stated emergency paramedics convinced the resident to take the nitroglycerin and the resident was transported to the hospital for evaluation.

During an interview, the resident stated the incident was long ago and he couldn't remember much, however, he was denied an ambulance and a family member called 911. The resident stated he had three intestinal bleeds fixed and received several units of blood at the hospital. The resident stated when he discharged from the hospital he returned to the facility.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

**“Not Substantiated” means:**

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

**Neglect: Minnesota Statutes, section 626.5572, subdivision 17**

“Neglect” means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

**Vulnerable Adult interviewed:** Yes

**Family/Responsible Party interviewed:** No

**Alleged Perpetrator interviewed:** Not Applicable

**Action taken by facility:**

Facility licensed staff assessed the resident, notified a provider and called emergency services.

**Action taken by the Minnesota Department of Health:**

No further action taken at this time.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>06/04/2026</b>
NAME OF PROVIDER OR SUPPLIER <b>The Emeralds at Faribault LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 SOUTHEAST FIRST STREET , FARIBAULT, Minnesota, 55021</b>	
(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
20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS:</p> <p>The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H50672500M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.</p> <p>The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the</p>	20000		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

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