Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 30, 2026

Administrator
The Emeralds at Faribault LLC
500 SOUTHEAST FIRST STREET
FARIBAULT, MN 55021

RE: CCN:245067
Cycle Start Date: June 12, 2026

Dear Administrator:

On June 12, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable 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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 12, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 12, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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Administrator
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500 SOUTHEAST FIRST STREET
FARIBAULT, MN 55021

Re: State Nursing Home Licensing Orders
Event ID: 235135-H1

Dear Administrator:

The above facility survey was completed on June 12, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

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.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emeralds at Faribault LLC	**500 SOUTHEAST FIRST STREET , FARIBAULT, Minnesota, 55021**

(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
F0000	INITIAL COMMENTS On 6/9/26, 6/10/26, 6/11/26, and 6/12/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H50672826C (3037247), H50672720C (3030093), H50679500C (2963656), and H50672826C (3039521) with deficiencies issued at: F584, F677, F684, and F880. 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 that substantial compliance with the regulations has been attained.	F0000		07/09/2026
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F0584	Wet floor signs were placed in the affected areas, and staff ensured the floors were allowed to dry to reduce the risk of slips, trips, or falls. All residents have the potential to be affected by wet floors without proper signage. Housekeeping and facility staff were educated on placing wet floor signs when floors are wet and keeping signs in place until floors are dry to ensure safety. Audits will be completed weekly for four (4) weeks to evaluate resident care areas, common areas, and other applicable spaces for wet floors and proper use of signage. Audit results will be reviewed at QAPI meetings. Any deficiencies will be identified and corrected at the time of	07/09/2026

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: 245067	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2026

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F0584 SS = D	Continued from page 1 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to maintain a safe environment for 2 of 2 residents (R4, R5) who were observed with wet floors and no indication that floor was wet while either residing in room or when returning to room. Findings include: R4 R4's face sheet dated 6/12/26, identified diagnoses of left femur osteonecrosis (bone cell death), difficulty in walking, and urinary incontinence. R4's admission Minimum Data Set (MDS) dated 5/19/26, identified R4 had no difficulties with hearing or speech. R4 had no cognition issues. R4 had behavioral issues directed at others one to three days. R4 required supervision/touch assist with transfers. R5	F0584	Continued from page 1 occurrence. Corrections will be monitored by: Administrator/designee	07/09/2026

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F0584 SS = D	Continued from page 2 R5's face sheet dated 6/12/26, identified diagnoses of unspecified dementia, and weakness. R5's admission MDS dated 4/27/26, identified R5 had minimal hearing difficulties and wore glasses. R5 had no cognition issues. R5 required supervision/touch assist with transfers. During a continuous observation on 6/9/26 from 11:50 a.m. through 12:22 p.m., the following was observed: 11:50 a.m.- R4's room floor was visibly wet. No wet floor sign in front of room. R4 was not in the room. R5's room floor was also visibly wet. R5 was asleep in a recliner chair in room. No wet floor sign was noted in front of R5's room. 11:53 a.m.- R4 had propelled herself to the entrance to her room with her walker, saw the floor was wet and did not enter the room. During an interview and observation on 6/9/26 at 11:54 a.m., registered nurse (RN)-A and R4 were present. RN-A stated she would expect the housekeeper to have a wet floor sign in front of R4 and R5's doors. R4 was verbally upset there was not a wet floor sign and no fan to dry her room. RN-A stated R5 did not know the floor was wet. RN-A explained to R5 the floor was wet and she should call if she wanted to move from the recliner. R5 stated understanding. R4 stated, "Why doesn't this place have fans? That is a lawsuit waiting to happen." RN-A walked into R4's room and put R4's small personal fan on the floor and turned it on. RN-A asked R4 if she knew who the housekeeper was as she had not returned and the housekeeping cart was in the hallway. At 11:59 a.m., R4 wheeled into her room on her walker and called RN-A a, "dumbass," picked up the fan and pointed it to the floor. "I might as well just fucking sit here and dry it. A lot of useless assholes around here the government is paying them to be here." At 12:00 p.m., R4 stated it was, "humid as hell," in here. R4 stood up without locking the brakes on the walker and walked to her window and opened it. The floor was still wet. R5's floor was also wet. At 12:02 p.m., physical therapist (PT)-A was by R4's room. R4 requested her room door be shut with her in the room and the floor still wet. At 12:13 p.m., Administrator in training came to R4's and R5's rooms and placed wet floor signs in front of them. At 12:14 p.m., RN-A stated R4's and R5's floors were still wet. R4 had been standing in her doorframe and shut the door on RN-A. At 12:22	F0584		07/09/2026

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F0584 SS = D	Continued from page 3 p.m., R5's floor was dry. It is unknown if R4's floor was dry as her door was shut and she did not want to be disturbed again. During an interview on 6/9/26 at 12:04 p.m., PT-A stated it is a fall risk if the floors are wet and the residents are in the room with a wet floor. Rooms should have wet floor signs after being mopped. R4 and R5 are both at risk for falling if they would attempt to transfer on a wet floor. During an interview on 6/12/26 at 1:53 p.m., director of nursing (DON) stated she would expect housekeepers to place wet floor signs in front of wet floors so residents and staff were aware the floor was wet. The facility Walls and Floors policy dated 9/2012, identified Floors: sweep well, wash with hot water and non-sudsing cleaning solution, rinse well using mop, remove as much water as possible. Wipe with sanitizing solution, permit to air dry. Place "wet floor" signs to warn others of potential danger.	F0584		07/09/2026
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 record review the facility failed to provide oral hygiene to 1 of 3 residents (R2) observed for oral hygiene cares. Findings include: R2's face sheet dated 6/11/26, identified diagnoses of displaced bicondylar fracture (break of both sides of tibia below knee which compromises knee weight bearing surface) of right tibia, displaced bicondylar fracture of left tibia, muscle weakness, and chronic pain. R2's annual Minimum Data Set (MDS) dated 5/27/26, identified R2 had some difficulty with understanding and wore glasses. R2 had moderate problems with thinking and memory. R2 had no behaviors. R2 had no natural teeth and was on a mechanically altered diet. R2 was dependent on staff for oral hygiene. R2's care plan dated 6/24/25, identified R2 had	F0677	R2's care plan was reviewed to ensure oral care needs, including denture care and gum care, were clearly identified in the resident's care sheet. A full-house audit was completed to identify residents who require assistance with oral care, including residents who are edentulous, have dentures, or have specific oral care needs such as denture cream. Care Sheets were reviewed and updated as needed to ensure oral care needs are clearly identified for staff. Nursing staff were educated on the facility's ADL Policy, including providing oral hygiene for dependent residents, cleaning gums prior to denture placement, cleaning dentures, using denture cream when ordered or care planned. Audits will be completed weekly for four (4) weeks by observing five (5) residents who require assistance with oral care to ensure oral hygiene is completed according to resident needs and facility expectations. Audit results will be reviewed at QAPI meetings. Any deficiencies will be identified and corrected at the time of occurrence. Corrections will be monitored by: DON/designee	07/09/2026

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F0677 SS = D	Continued from page 4 alteration in dental care related to edentulous (no natural teeth or tooth fragments) status. Interventions included dental visits as needed, monitor if R2 was tolerating current diet, oral cares a.m./h.s (hour of sleep) and per R2's request. During an observation on 6/11/26 at 7:52 a.m., nursing assistants (NA)-B and NA-C were providing morning cares for R2. NA-C put on gloves and took dentures from denture cup. NA-C went to the sink and rinsed dentures. NA-C handed R2 the bottom denture and placed in her mouth without denture paste. NA-C handed R2 the top denture and there was a translucent substance coming off the dentures hanging down in a glob that came off the dentures. NA-C took the top denture and denture cup back to the sink and rinsed it off. NA-C returned and put top denture in R2's mouth. NA-C did not clean R2's mouth prior to denture insertion. During an interview on 6/11/26 at 8:27 a.m. NA-B stated R2's gums should have been brushed prior to putting dentures in her mouth. During an interview on 6/11/26 at 8:36 a.m., NA-C stated R2's gums should have been brushed prior to putting dentures in her mouth. During an interview on 6/11/26 at 10:54 a.m., NA-D stated oral care for dentures included cleaning the dentures and providing gum care to the residents. "A little sponge is used to clean overnight saliva and the mouth to freshen it before putting dentures in." During an interview on 6/12/26 at 1:53 p.m., director of nursing (DON) stated she expected staff to complete oral cares on residents in the morning and before bed, including cleaning the gums before inserting dentures. The facility Oral Care Assistance procedure undated, identified to assist the client with maintaining and promoting a healthy mouth environment, minimizing the change of tooth decay and bad breath. This included brushing teeth and tongue, brushing dentures, and assisting patients to use toothbrush or mouth swab to clean gums.	F0677		07/09/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F0684	R1's wound treatment orders and documentation were reviewed to ensure wound care was completed according to physician orders, and that provider notification occurred as appropriate. R2 was assessed following the choking incident, and provider notification expectations were reviewed.	07/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2026

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F0684 SS = D	Continued from page 5 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to follow physician's orders for negative pressure wound therapy (wound vac) (device that applies gentle suction to help complex, large, or slow-healing wounds close) care for 1 of 2 residents (R1) who did not receive wound vac changes as scheduled. In addition, the facility failed to update the physician when attempt to reapply the wound vac failed for 1 of 2 residents (R1) reviewed for wound care and failed to update the physician for 1 of 1 residents (R2) who had a choking incident and required the Heimlich maneuver. Findings include: R1 R1's face sheet dated 6/11/26, identified R1 had diagnoses of atherosclerosis of native arteries (progressive buildup of fatty plaque inside original, non-surgical arteries) of other extremities with ulceration, non-pressure chronic ulcer of other part of unspecified foot with unspecified severity, atherosclerosis of native arteries of extremities with intermittent claudication (muscle pain, cramping or fatigue that occurs during physical activity and resolves with rest) of right leg, peripheral vascular disease, and unspecified open wound right foot. R1's Perspective Payment System (PPS) Minimum Data Set (MDS) dated 5/29/26, identified R1did not have memory issues, and was able to communicate effectively. R1 required partial/moderate assistance with dressing and toileting. R1 was independent with rolling, lying to sitting on side of bed, and rolling left/right. R1 was dependent on staff to walk and move in wheelchair. R1 had surgical wounds. R1's care plan dated 6/1/26, identified alteration in skin integrity. Interventions included to document on skin condition and keep physician informed of changes. R1's hospital discharge summary dated 5/26/26, identified R1 had been hospitalized from 5/15/26-5/26/26 for dehiscence (splitting or	F0684	Continued from page 5 Residents with wound vac/negative pressure wound therapy and significant changes requiring provider notification have the potential to be affected by this deficient practice. A review of like residents was completed to identify residents with wound vac/negative pressure wound therapy and significant changes requiring provider notification. As of 7/6/26, no residents currently have wound vac treatments. The facility reviewed its wound Management and Notification of Changes policy and no revisions were required at this time. Licensed nurses were educated on wound vac treatment expectations, including following physician orders, completing treatments as scheduled, documenting treatment completion, implementing alternate dressing orders when applicable, and notifying the provider when a wound vac cannot be applied, cannot maintain suction, or when there is a change in wound condition. Licensed nurses were also educated on provider notification expectations following significant resident events, including choking episodes requiring intervention. Audits will be completed weekly for four (4) weeks on five (5) residents with wound vac/negative pressure wound therapy treatments to ensure orders are entered correctly, and treatments are completed as ordered. Audits will also be completed on all significant resident events for four (4) weeks, including choking episodes requiring intervention, to ensure provider notification was completed as required. Audit results will be reviewed at QAPI. Any issues will be corrected at the time of occurrence. Corrections will be monitored by: DON/designee	07/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2026

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F0684 SS = D	Continued from page 6 bursting open) of wound. R1 had a negative pressure wound vac system placed on the right groin and right lower extremity to improve healing time and increase compliance in dressing changes and wound management. Current wound measurements were right groin 7.0 centimeters (cm) length X 5.0 cm width X 1.5 cm depth and right lower extremity calf measured 11 cm X 3.0 cm X 0.5 cm depth. Instructions included: sponge to be placed in the wound and sealed with the plastic clear paper. The drain is to be set to low continuous suction at 125 millimeters of mercury (mmHg), wound vac system to be changed every 48 hours on a Monday, Wednesday, and Friday schedule, if the device becomes non-functional or cannot tolerate the wound vac system, moist to dry dressing changes should be performed. Kerlix should be used for wound packing. Kerlix to be soaked in normal saline and squeezed hard to remove most of moisture. Kerlix should be only slightly moist. Moist kerlix should be packed in the wound and covered with dry gauze. Dressing changes should be performed three times daily (TID). If the wound gets too moist and liquid is seen pooling in the wound, convert to dry dressing TID. The dry kerlix should also be packed in the wound. Wound vac is to continue until re-evaluation by surgical team and will most likely continue for many weeks, possibly up to a few months. Hospital surgical phone numbers for business hours and emergency situations were provided. R1's Admission/Initial Data Collection V-9 dated 5/26/26 at 12:29 p.m., identified Skin: groin and right inner ankle. No type or measurements identified. Narrative identified R1 had a surgical site present to the going area and lower portion of right leg above ankle. Surgical incision sites were assessed and monitored. No concerns noted. Staff will continue to monitor surgical sites for signs and symptoms of infection, drainage, increased redness, warmth, or swelling. R1 had a wound vac placed. Staff will update provider with any changes or concerns. R1's treatment administration record (TAR) for May 2026, identified: Wound care: right groin and thigh with wound vac. Change Monday, Wednesday, and Friday in the evening with a time of 4:00 p.m. Administration for 5/27/26, had a "9" and for 5/29/26, a checkmark for completed. R1's TAR chart code legend identified "9" as other/see nurse note. Wound vac: monitor for signs and symptoms of	F0684		07/09/2026

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F0684 SS = D	Continued from page 7 infection around wound vac site. Update provider as needed every shift. These correlated with check boxes for day, evening, and night to sign when completed. These were completed every shift. R1's default progress note for electronic medication record dated 5/27/26 at 3:20 p.m., identified wound care: right groin and thigh with wound vac. Change Monday, Wednesday, Friday in the evening. Wound care and wound vac dressing changed last night. During a phone interview on 6/10/26 at 3:15 p.m., registered nurse (RN)-C stated he had never changed R1's wound vac but was aware and had been taught how to change it. RN-C stated he consulted with the nurse manager on 5/27/26, as R1 had just returned from the hospital and had the wound vac placed. RN-C stated the nurse manager directed him to not change the wound vac on 5/27/26 as it was scheduled on the TAR. R1's TAR for June 2026, identified: Wound care: right groin and thigh with wound vac. Change Monday, Wednesday, and Friday in the evening with a time of 4:00 p.m. On 6/1/26, a "9" was marked, on 6/3/26, a checkmark for completed, and on 6/5/26, a "9" was marked. R1's default progress note for electronic medication record dated 6/1/26 at 7:42 p.m., identified wound care: right groin and thigh with wound vac. Change Monday, Wednesday, and Friday in the evening. Wound care and wound vac dressing to be changed tomorrow. During an interview on 6/11/26 at 1:17 p.m., licensed practical nurse (LPN)-A stated he worked 6/1/26. LPN-A consulted about changing the wound vac with RN-F who told him it would be changed on 6/2/26. The wound vac was working and had no leakage. Pressure was maintained at 125 [mmHg]. R1's Wound Evaluation dated 6/3/26 at 7:06 p.m., identified RN-F completed the assessment. Wound measured 3.80 centimeters (cm) length by (x) 3.94 cm width on the right anterior (toward the front) groin. Tissue had exposed muscle. Yellow fibrin (shiny layer that forms during early phase of wound healing) present in wound, tissue temperature cool, tissue firmness was soft. Wound was blanchable (temporarily skin turns white when pressure applied), no evidence of infection, heavy serosanguineous (thin, watery fluid) drainage, wound edges not attached to base, no odor from wound. Non-pitting edema (swelling related to accumulation of fluid) >	F0684		07/09/2026

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F0684 SS = D	Continued from page 8 (greater than) 4 cm around wound. Anterior right lower leg wound measured 10.85 cm length x 4.86 cm depth. Tissue had exposed muscle. Periwound (surrounding) skin condition “at risk”. Yellow fibrin present in wound, tissue cool, blanchable, heavy serosanguineous drainage. Wound edges not attached to wound base. No odor. Skin color surrounding wound was bright red and blanches to touch. Non-pitting edema extends < (less than) 4 cm around wound. Interventions for both wounds were negative pressure wound therapy. R1’s progress note dated 6/5/26 at 1:00 a.m., identified wound vac was changed early this morning by LPN-B and RN-D. During assessment, R1’s “leg was” noted to be red, warm to the touch, and leaking fluid. R1 complained of pain during cares. Nurses attempted multiple times to reapply and troubleshoot the wound vac; however, the drape film would not adhere properly, causing a continuous leak. Due to inability to maintain suction, RN-D removed the wound vac, packed the wound and wrapped the leg until the morning shift could further assess and address the wound vac concerns. During an interview on 6/11/26 at 8:30 a.m., LPN-B stated R1’s leg was red on 6/5/26 but thought it could have come from the film being taken off for the wound vac dressing. During a follow-up interview on 6/10/26 at 1:05 p.m., LPN-B stated RN-D was the other nurse who assisted with R1’s wound vac change on 6/5/26. LPN-B could not recall if the physician was notified and could not find notification to physician in R1’s record about the wound vac not being successfully changed on 6/5/26. LPN-B stated RN-D explained that the facility had 12 hours where they could pack the wound and not use the wound vac. LPN-B stated she left the facility after she assisted RN-D to remove the wound vac and gave the night nurse report. LPN-B stated she reported the incident to RN-F and director of nursing (DON). During an interview on 6/10/26 at 1:13 p.m., RN-D stated when he and LPN-B were unsuccessful getting the wound vac changed, he packed the wound with gauze. RN-D did not notify the physician that they were not able to apply the wound vac. RN-D notified the DON between 1:00 a.m. and 2:00 a.m. and was told LPN-B and RN-F would attempt to reapply in the morning. RN-D stated he followed the hospital discharge orders for dressing when wound vac could not be applied. During an interview on 6/11/26 at 11:20 a.m., RN-E	F0684		07/09/2026

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F0684 SS = D	Continued from page 9 stated on 6/5/26, at shift report it was reported the wound vac was off. Staff had tried to change it and could not get it to adhere so placed a dressing over it. RN-E notified medical doctor (MD)-A midmorning as MD-A was at the facility. RN-E had not observed R1's leg until after MD-A had examined him. RN-E thought someone was going to put the wound vac on but had wanted MD-A to examine it first. R1's wound on the groin looked red, and some irritation and slough. The leg wound was just red and irritated. RN-E did not think R1 had a lot of edema to his leg it, "just looked like it was angry." RN-E stated MD-A was not happy the wound vac was off and had not been done on the proper schedule. RN-E did not notify the surgeon that the wound vac was off. During a phone interview on 6/11/26 at 11:21 a.m., RN-F stated she had been the nurse manager at facility. RN-G, another nurse manager, completes wound management on resident. The floor nurses are supposed to complete the Wednesday; Friday wound dressing changes and RN-G would complete Monday. On 5/29/26, RN-F completed wound vac change with RN-D. On 6/1/26, RN-F was given instructions that RN-G would complete wound vac change. RN-G told RN-F that wound care could not follow R1. RN-F reported the information to DON. DON informed RN-F that RN-G would look at the wound. RN-F stated she requested to get the wound care done and DON told her to wait until 6/2/26. RN-F stated RN-B was available and could help with dressing change on 6/1/26 but DON was insistent that it wait until 6/2/26 so RN-G could look at the wound. On 6/2/26, RN-F requested to DON that RN-D was available and could change the wound vac with her. DON stated to wait until 6/3/26, so RN-G could look at the wound as RN-G was not available on 6/2/26 and they could get pictures of the wounds. On 6/3/26, RN-F "went in with initiative" and changed the wound vac. R1 had a lot of drainage from the wounds. Drainage did not smell or look like an infection was present. R1 had edema and his leg was irritated from the dressing. On 6/5/26, LPN-B and RN-D attempted to change the wound vac. The vac was not suctioning so they applied a dressing. MD-A was onsite 6/5/26, and RN-F wanted MD-A to see R1's wound. RN-F stated she would expect the nurses to do their job and follow physician orders. During an interview on 6/11/26 at 1:46 p.m., RN-G stated she completed weekly wound rounds with the wound care provider. RN-G told RN-F on 6/1/26, that they could not look at R1's wounds because R1 did not meet the criteria as he was still followed by	F0684		07/09/2026

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F0684 SS = D	Continued from page 10 a surgeon so Medicare would not cover the facility wound care staff. RN-G told RN-F she could help her later with changing the wound vac but RN-F stated she was fine and did not need help. RN-G had not heard the wound vac had not been changed until 6/5/26 around 10:00 a.m. RN-G had never visualized R1's wounds. During a phone interview on 6/11/26 at 11:18 a.m., LPN-C stated he began work around 2-2:30 p.m. on 6/5/26. LPN-B had been informed in shift report by RN-E, "something about wound dressing not changed," but was unsure of how many days or what the issue was. RN-F assisted LPN-C with removing the dressing that was applied during the evening shift on 6/4/26. LPN-C and RN-F put an abdominal pad (large, soft dressing) and wrapped the wound with gauze. LPN-C stated there was minimal drainage to the wounds. The groin was open and deep. The one on the leg looked superficial and not too deep. Drainage was pink and a little yellow in color from both. During an interview on 6/10/26 at 11:58 a.m., DON stated the wound vac did not get changed from 5/29/26-6/3/26. Nurse managers are expected to change the wound vacs. A follow-up interview on 6/12/26 at 1:53 p.m., DON expected physician to be notified when wound vac was not able to be changed as ordered. During an interview on 6/12/26 at 11:29 a.m., MD-A stated she would have expected a call from facility on 6/5/26 during normal business hours, at least by 7:00 a.m., that the wound vac was off R1. MD-A would expect the next shift to try and apply the wound vac and if that would not work to go to, "plan C." If the wound would have been, "goopy, yucky, or festering," she would have expected a phone call immediately. R2 R2's face sheet dated 6/11/26, identified diagnoses of encounter for palliative care, non-pressure chronic ulcer of unspecified part of unspecified lower leg with unspecified severity, and muscle weakness. R2's annual MDS dated 5/27/26, identified R2 had some difficulty with understanding others and wore glasses. R2 had some cognitive issues. R2 had no behaviors. R2 had no teeth and a mechanically altered diet. R2 had impairment on both sides of lower extremities and was dependent on staff for activities of daily living.	F0684		07/09/2026

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F0684 SS = D	Continued from page 11 R2's care plan dated 5/21/26, identified R2 had a texture modified diet due to choking incident. Interventions included R2 ate meals in the main dining room with direct supervision, staff to assist with cutting up meals, diet per physician order. R2's progress note dated 5/21/26 at 9:38 p.m., identified nursing assistant (NA) alerted RN-F that R2 was choking. RN-F performed "CPR" on R2 and cleared two big chunks of bread with peanut butter. Advised staff not administer food without consulting nurse first. R2's physician order dated 6/9/26 at 3:59 p.m., identified an order to start minced and moist diet with think liquids per facility starting on 5/28/26. During a phone interview on 6/11/26 at 1:10 p.m., RN-H stated on the evening of 5/21/26 between 8:30 p.m. and 9:00 p.m., she was told to come to the R4 who was unresponsive. R4 was in a Broda (specialized wheelchair designed for people who need advanced positioning, support and comfort) wheelchair. RN-H saw a small tray with peanut butter bread and assumed choking had started. RN-H lifted R4 up and used her legs to support her and began abdominal thrust with both hands folded on abdomen with R4's back to RN-H's chest. R4 vomited two boluses (round mass) of bread with peanut butter and a big lump of bread during the Heimlich. RN-H stated she called the DON and hospice provider but found out later she had the wrong contact information for the hospice provider, so they were not updated. During an interview on 6/12/26 at 10:24 a.m., team director for hospice (TD)-A reviewed hospice information. On 5/21/26, there was no record of a triage call. On 5/23/26, the facility reported an incident of choking from 5/21/26. On 5/28/26, hospice received an updated diet order for minced and moist. TD-A notified R4's family member of incident on 5/23/26. Hospice prefers to be notified immediately of any incidents that occur with residents in their care for continuity of care between hospice and providers. During an interview on 6/12/26 at 1:53 p.m., DON stated she would expect the physician to be notified immediately of a change of condition. The facility Notification of Changes policy dated 3/2024, identified changes in a residents condition or treatment be reported to attending physician or delegate.	F0684		07/09/2026

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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 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	F0880	R2 and R4 were assessed following the identified concerns and had no signs or symptoms of infection. Education was provided to the Director of Nursing regarding enhanced barrier precautions and infection control expectations when providing care or having direct resident contact with residents requiring enhanced barrier precautions. The concern related to the outside laboratory provider was identified, and education was provided to the laboratory staff member regarding infection control expectations, including the use of gowns when providing services for residents requiring enhanced barrier precautions. Residents requiring enhanced barrier precautions or other infection control precautions have the potential to be affected by this deficient practice. A full-house audit was completed to identify residents requiring enhanced barrier precautions to ensure appropriate signage, personal protective equipment, and infection control supplies were available and in place. The facility's Enhanced Barrier Precautions policy was reviewed and revised to include that education will be provided to outside providers and vendors regarding applicable infection control expectations when providing services in the facility. Education was completed with all staff on the facilities Enhanced Barrier Precautions policy, including following enhanced barrier precautions, using appropriate PPE, performing hand hygiene, and following posted precaution signage and care expectations. Audits will be completed weekly for four (4) weeks on five (5) residents who are on enhanced barrier precautions to ensure proper infection prevention and control protocols are being followed. Audit results will be reviewed at QAPI meetings. Any deficiencies will be identified and corrected at the time of occurrence. Corrections will be monitored by: ADON/designee	07/09/2026

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F0880 SS = D	Continued from page 13 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 follow infection prevention protocols including enhanced barrier precautions (EBP) when providing care to 2 of 3 residents (R2 and R4) observed during cares. Findings include: According to the Centers for Disease Control (CDC): EBP is primarily intended to apply to care that occurs within a resident's room where high-contact resident care activities, including transfers, are bundled together with other high-contact activity, such as part of morning or evening care. This extended contact with the resident and their environment increases the risk of a MDRO (multi-drug resistant organism) (type of bacteria or microbe resistant to multiple antibiotics) spreading to staff hands and clothes. Outside the resident's rooms, Enhanced Barrier Precautions should be followed when performing transfers and assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility. Hand hygiene is recommended before and after resident contact. R2	F0880		07/09/2026

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F0880 SS = D	Continued from page 14 R2's face sheet dated 6/11/26, identified diagnoses of non-pressure chronic ulcer of unspecified part of unspecified lower leg with unspecified severity, displaced bicondylar fracture (break of both sides of tibia below knee which compromises knee weight bearing surface) of right tibia, and displaced bicondylar fracture of left tibia. R2's annual Minimum Data Set (MDS) dated 5/27/26, identified R2 had some difficulty with understanding and wore glasses. R4 had moderate problems with thinking and memory. R2 had no behaviors. R2 had impairment on both sides of lower extremities and was dependent on staff for activities of daily living. R2's treatment administration record (TAR) for 6/2026, identified follow EBP while providing wound cares and other high contact care activities every shift. During an observation and interview on 6/11/26 at 7:52 a.m., nursing assistants (NA)-B and NA-C went to R2's room and performed morning cares which included dressing, grooming, changing incontinent product, and transferring. NA-B and NA-C did not wear EBP while completing tasks. During an interview on 6/11/26 at 8:27 a.m., NA-B stated EBP is worn if a resident has a wound, catheter, or colostomy. NA-B stated EBP should have been worn while providing cares on R2 as she has wounds. During an interview on 6/11/26 at 8:36 a.m., NA-C stated EBP should have worn EBP during cares with R2 because she had wounds. R4 R4's face sheet dated 6/12/26, identified diagnoses of left femur osteonecrosis (bone cell death), difficulty in walking, and urinary incontinence. R4's admission MDS dated 5/19/26, identified R4 had no difficulties with hearing or speech. R4 had intact cognition. R4 had behavioral issues directed at others one to three days. R4 required supervision/touch assist with transfers. R4's care plan dated 5/19/26, identified R4 was on EBP related to [left blank]. Interventions included staff to follow EBP; "use appropriate communication to follow EBP"; explain reason for use of EBP; staff to put on/remove EBP per enhanced barrier precautions when providing high contact cares.	F0880		07/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0880 SS = D	Continued from page 15 R4's physician order dated 6/3/26, identified negative pressure wound therapy (wound vac) in place for 14 days from surgery. R4's TAR for 6/2026, identified follow EBP while providing wound cares and other high contact care activities every shift. During an observation and interview on 6/10/26 at 7:55 a.m., registered nurse (RN)-B went to R4's room. R4 was sitting in her recliner watching television. RN-B applied a pair of gloves and assessed for edema, redness, and warmth on R4's legs. RN-B did not wear a gown while performing high contact care. RN-B removed gloves and left R4's room without sanitizing hands. RN-A walked out of a resident room with the vital sign machine, did not disinfect the machine, and RN-B took the machine to R4's room with an ipad to call the physician. RN-B did not apply EBP or disinfect vitals machine before placing blood pressure cuff, and oximeter on R4. While on the ipad video call with the physician, RN-B again checked R4's edema in legs, redness, and warmth. RN-B did not wear EBP. R4 ended the phone call, left R4's room with the vital sign machine, sanitized hands outside the door, and brought the vital sign machine to the medication cart at the nurses station. RN-B did not disinfect the machine. RN-B stated he should have worn EBP and disinfected the vital signs machine before and after using it for R4. During an observation on 6/10/26 at 8:23 a.m., director of nursing (DON) entered R4's room as R4 was screaming very loudly. DON sat on R4's bed while R4 was in the recliner and rubbed R4's back and hair to soothe R4. DON was not wearing EBP during this contact. DON stood up from the bed, walked to the door, removed a gown and gloves from the EBP station on the door, asked R4 if she could shut the door, and shut the door. During an interview on 6/10/26 at 9:49 a.m., DON stated she did not have to wear EBP when she was with R4 because she was just touching her. After reviewing CDC EBP recommendations with the DON, she stated, "Oh, yeah, I would have to." During an observation on 6/10/26 at 10:05 a.m., hospital lab (HL)-A entered R4's room to draw blood. HL-A wore gloves but no gown. HL-A drew blood from R4's right arm. HL-A removed gloves, sanitized hands, and left room. During an interview on 6/10/26 at 10:16 a.m., HL-A	F0880		07/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245067	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2026

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F0880 SS = D	Continued from page 16 stated she was told by the DON not to wear a gown today, “because state was in the building and I can’t wear gowns in the hallways." HL-A said technically she was supposed to have a lab coat because she is drawing blood. HL-A drew blood on approximately 20 residents this day and was very upset that she could not wear her lab coat. HL-A usually does not have to worry about EBP because she wears a gown for every patient. HL-A stated the DON was going to call HL-A’s manager and talk about the issue. During an interview on 6/12/26 at 1:53 p.m., DON stated she would expect that staff followed EBP precautions when performing high contact cares on residents. The facility Enhanced Barrier Precautions policy dated 4/1/24, identified the facility implemented EBP for the prevention of transmission of multi-drug resistant organisms. High contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care: any skin opening requiring a dressing.	F0880		07/09/2026

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 14, 2026

Administrator
THE EMERALDS AT FAIRBAULT LLC
500 SOUTHEAST FIRST STREET
FARIBAULT, MN 55021

RE: CCN: 245067
Cycle Start Date: June 12, 2026

Dear Administrator:

On July 27, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 14, 2026

Administrator
THE EMERALDS AT FAIRBAULT LLC
500 SOUTHEAST FIRST STREET
FARIBAULT, MN 55021

Re: Reinspection Results
Event ID: 235135-H2

Dear Administrator:

On July 27, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 12, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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