Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 2, 2025

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

RE: CCN: 245067
Cycle Start Date: July 9, 2025

Dear Administrator:

On July 28, 2025, we notified you a remedy was imposed. On August 29, 2025, the Minnesota Department of Health 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 20, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 9, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 28, 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 July 9, 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,

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

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July 28, 2025

Administrator
The Emeralds at Faribault LLC

500 SOUTHEAST FIRST STREET
FARIBAULT, MN 55021

RE: CCN: 245067
Cycle Start Date: July 9, 2025

Dear Administrator:

On July 9, 2025, 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 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 delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 9, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 9, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 9, 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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Emeralds at Faribault LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 9, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit. Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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.

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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health

Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

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 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 location and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 9, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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. 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,

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

An equal opportunity employer.

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 07/09/2025

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 6/30/25, 7/1/25, 7/7/25, 7/8/25, and 7/9/25 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: H50677627C (MN113974), H50678087C (MN114144 & MN114187), H50678407C (MN114248), and H50679032C (MN114449) with deficiencies cited at F602, F607, F609, F610, & F732. The above findings constituted substandard quality of care, and an extended survey was conducted on 7/9/25. 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		08/06/2025
F0602 SS = SQC-F	Free from Misappropriation/Exploitation CFR(s): 483.12 §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. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure four of five residents (R1, R4, R2, and R5) reviewed for financial exploitation were free	F0602	Please accept this Plan of Correction as the facility's credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567. AFFECTED RESIDENTS: The facility assisted the affected residents (R1, R4, R2, R5) in contacting banks/financial institutions to cease any ongoing misappropriation. Affected residents were offered support services, lockboxes, and access to locked storage in a new facility safe.	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

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

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F0602 SS = SQC-F	Continued from page 1 from misappropriation of personal property and financial exploitation when facility staff stole resident credit/debit cards or card information and made unauthorized transactions totaling over $5,000. This had the potential to affect all residents residing at the facility. Findings include: R1 R1's quarterly Minimum Data Set (MDS) assessment dated 5/1/25, indicated R1 had moderately impaired cognition and required partial to substantial assistance from staff for most activities of daily living (ADL's). R1's facesheet dated 7/9/25, indicated he was his own responsible party and his emergency contact was his spouse, R4. R1's diagnoses included unspecific dementia. R1's care plan dated 6/11/25, identified he was a vulnerable adult and at risk for decreased cognitive and physical abilities. Interventions included: staff will continue to follow the facility vulnerable adult and abuse reporting policy; and local ombudsman, adult protection, police, and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed. R1's progress note dated 6/12/25, indicated the business office manager (BOM) alerted the social services direct (SDD) of suspicious activity on R1's banking statement and a large amount of missing money. R1 stated he had not given his banking information to anyone or made any new purchases. BOM and R2 called the bank and communicated there were many purchases on the account R1 didn't make. The bank put a stop on the account. Police were called and a report filed. Police spoke to the bank and stated a bank employee would come to the facility to assist R1 with filling out paperwork related to the fraudulent purchases. R1's bank form titled Cardholder Statement of Disputed Items dated 6/12/25, included a list of disputed transactions with dates, dollar amounts, and merchants for cardholder name of R1. Disputed transactions marked as unauthorized/counterfeit transactions (cardholder did not authorize or engage in the transaction) dated	F0602	Continued from page 1 The interdisciplinary team (IDT) will review all affected residents who manage their own finances to determine if the resident has the capacity to do so, including having the ability to identify fraudulent activity. If the IDT concludes that the resident does have the capacity to manage their own finances, the resident will be educated on identifying fraudulent activity and steps to take if fraudulent activity is identified (e.g., notify facility Administrator, Social Services, Business Office Manager, Charge Nurse, or other trusted staff member; and seek assistance from facility to contact the financial institution(s) and file a police report). If the IDT concludes that a resident does not have the capacity to manage their own finances, the facility will work with the resident to identify a financial responsible party. Affected residents who do not manage their own finances had their financial responsible party educated on identifying fraudulent activity and steps to take if fraudulent activity is identified (e.g., notify facility Administrator, Social Services, Business Office Manager, Charge Nurse, or other trusted staff member; and seek assistance from facility to contact the financial institution(s) and file a police report). Resident care plans will be updated to reflect the IDT review and education. LIKE RESIDENTS: According to the CMS-2567, all residents have the potential to be affected. The IDT will review all residents who manage their own finances to determine if the resident has the capacity to do so, including having the ability to identify fraudulent activity. The facility will follow the same process set forth under bullet point 3 of the "Cited Residents" section for these residents. The facility will follow the same process set forth under bullet point 4 of the "Cited Residents" section for all residents who do not manage their own finances. Resident care plans will be updated to reflect the IDT	

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F0602 SS = SQC-F	Continued from page 2 5/19/25 through 6/11/25. There were 65 disputed transactions totaling $4,040.18. R1's bank statement dated 5/30/25, included the following transactions: - $279.61 on 5/23/25 to "LULULEMONCOM" - $136.56 on 5/27/25 to "VALLEYFAIR ONLIN[E]" - $168.00 on 5/27/25 to "LULULEMONCOM" R1's bank statement dated 6/30/25, included the following transactions: - $75.06 on 6/4/25 to "eBay" - $108.00 on 6/6/25 to "Nike.com" - $225.00 on 6/6/25 to "Nike.com" - $39.99 on 6/9/25 to "SUGARBABYCARE" - $69.80 on 6/9/25 to "SUGARBABYCARE" - $129.00 on 6/9/25 to "LULULEMONCOM" - $168.00 on 6/9/25 to "LULULEMONCOM" - $263.80 on 6/9/25 to "Nike.com" - $223.45 on 6/10/25 to "VF Outdoor, LLC" (a subsidiary of VF Corporation, an apparel, footwear, and accessories company that owns brands including Timberland) - $27.75 on 6/11/25 to "TIKTOK SHOP" - $35.94 on 6/11/25 to "eBay" - $168.00 on 6/11/25 to "LULULEMONCOM" - $198.00 on 6/11/25 to "VF Outdoor, LLC" - $198.00 on 6/11/25 to "VF Outdoor, LLC" a second time - $65.76 on 6/12/25 to "eBay" Nursing Home Incident Report submitted to the state agency (SA) dated 6/17/25, identified an allegation of financial exploitation for R1. Description of the	F0602	Continued from page 2 review and education. PREVENT RECURRENCE: The facility has ordered enhanced security measures including security cameras and a new facility safe for the safe storage of resident valuables/financial resources. All staff will be educated on preventing, responding to, and reporting allegations or instances of misappropriation of resident property or financial exploitation. All staff will further be educated on the facility's cell phone policy, which prohibits employees from carrying, having, or using cell phones during working time. See also the education provided to residents and to the financial responsible parties of residents described above. All newly admitted residents will be offered lockboxes and the opportunity to store valuables/financial resources in the facility safe. The IDT will review any newly admitted residents who manage their own finances if concerns arise regarding their ability to identify fraudulent activity. MONITORING: The Administrator or designee will audit 5 residents per week for 4 weeks to ensure the the IDT review, education, offering of prevention services, and care-planning described above is completed. Audit results will be forwarded to the QAPI committee to determine whether to increase, decrease, or discontinue audits. DATE OF COMPLIANCE: August 20, 2025	

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F0602 SS = SQC-F	Continued from page 3 incident included, “On June 12, 2025, facility identified $4,047.67 in unauthorized transactions on resident [R1’s] bank account, occurring between May 16 through June 12, 2025. [R1] did not approve these charges. Today, we confirmed the address linked to the transaction belongs to a facility employee.” Alleged perpetrators identified in the report included one nursing assistant (NA), NA-A. Investigation follow-up report submitted to the SA dated 6/23/25, identified NA-A was interviewed after a Valley Fair (local amusement park) purchase made with R1’s card was traced to NA-A’s first name and a separate purchase from Sugar Baby Crush was linked to the same street address as NA-A’s documented address, but with a one-digit difference in the apartment number. NA-A denied involvement in the transactions. NA-B was interviewed when online orders under his name were linked to the unauthorized use of another resident, R2’s, financial information with shipments sent to NA-B’s address on file. NA-B stated this was his previous address and he now lived at the address linked to the Sugar Baby Crush on R1’s bank statement. NA-B denied involvement. Staff members with linked address were suspended pending further investigation. Investigation conclusion noted, “the allegation was verified based on evidence collected during the investigation.” During an interview on 7/1/25 at 11:16 a.m., R1 stated he was not sure of the exact amount, but people had taken his money without him knowing or authorizing this. His card was not taken, but money was taken out of his associated checking account some way or another. He previously kept his card in his wallet and wallet in his pocket or on the dresser. Now he kept it in a lockbox. R1 had worried this would continue to happen, but now had a new card. He was upset that his money was disappearing without him knowing and worried he might try to go shopping and have his card declined. He did not realize anyone was using the card prior to the BOM telling him about it, she ran the account statement and showed him. During a joint interview on 6/30/25 at 3:42 p.m., the BOM stated she noted unusual transactions on R1’s bank statement on 6/12/25. She saw purchases from that day and assisted R1 with cancelling his card immediately. The administrator in training (AIT) stated staff later noticed some of the purchases were related to an address of a staff member. The AIT stated NA-A was the	F0602		

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F0602 SS = SQC-F	Continued from page 4 name that appeared on one transaction and NA-B, who worked at the facility through a staffing agency, had an order shipped in his name from another transaction. Both were suspended. The facility called places where transactions occurred to get associated names and addresses. Staff were suspended as soon as they were identified. 14 or 15 people had been suspended pending investigation. Statements were taken from the suspended staff members who all denied involvement. The investigating police detective provided the facility with photographs of people at Valley Fair traced back to the Valley Fair transaction. The facility reviewed the images and identified three staff members. The facility was not sure how staff got access to R1's card because it was not missing, it could potentially have been added to Apple Pay as this is what R2's bank reported happened with his card. During an interview on 7/7/25 at 10:44 a.m., the administrator stated nursing assistant in training (NAIT)-B's employment was terminated because of the Valley Fair footage, the Valley Fair tickets being sent to his email address, and because his home address fit with other purchases made. That information came from the police detective (PD). NA-B was barred from working at the facility through the staffing agency because a purchase made on R1's account was sent to NA-B's address. NAIT-B did not respond when contacted for interview. During an interview on 7/8/25 at 2:44 p.m., NA-B stated he had picked up a few shifts at the facility through a staffing agency and his last shift was on 4/28/25. There was currently an investigation going on about fraud at the facility and he was now suspended from picking up shifts through the agency. NA-E stated a friend working at the facility, NAIT-B, had come around their friend group saying he "had a way to get clothes and stuff like that" and something had happened with a credit card. NAIT-B put card information into an application used to buy clothes from "Lulu gear" on NA-B's cell phone. NA-B stated NAIT-B never told him he was not using his own money so NAIT-B made purchases not knowing the card belonged to someone else. NA-B used the card for transactions at "Lulu, Nike Tech, and shoes" and stated those were the three items he bought. NA-B was working with police and gave them the purchased items. NA-B stated police informed him the card belonged to a resident at the facility and he did make purchases with the card but was unaware the card	F0602		

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F0602 SS = SQC-F	Continued from page 5 belonged to a resident at the time. He endorsed making at least three purchases with the card for clothes and shoes from approximately June 12th through June 15th. R4 R4's quarterly MDS assessment dated 6/11/25, indicated R4 had moderately impaired cognition and was dependent on staff or required substantial staff assistance for most ADL's. R4's facesheet dated 7/9/25, indicated her spouse, R1, was her responsible party and emergency contact. R4's diagnoses included unspecified dementia, disorientation, other signs and symptoms involving cognitive functions and awareness, and adjustment disorder with depressed mood. R4's care plan dated 5/5/25, identified she was at risk for abuse and or neglect and at risk for decreased cognitive and physical abilities. Interventions included: staff will continue to follow the facility vulnerable adult and abuse reporting policy; and local ombudsman, adult protection, police, and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed. R4's progress note dated 6/16/25, indicated the SSD followed up with R4 "due to the fina[n]cial concern" and she had no further questions or concerns. Bank statements for period ending 5/30/25 and 6/30/25 identified the statements were for an account under both R1 and R4's names. The account number was the same as the account number on R1's Cardholder Statement of Disputed Items. During an interview on 7/1/25 at 10:48 a.m., R4 stated a "good amount" of money was taken out of her and R1's account. She was not sure when or how this happened, but it was scary and overwhelming. She was tearful and concerned about her husband, she felt more sorry for him than herself. It bothered him and she worried about him. R1 was a veteran and had worked hard for his money, he "went through hell and high water in the war." She had noticed him crying in his sleep and this hurt her to hear. R4 stated stealing was "one of the lowest things" a person could do and she hoped the	F0602		

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 07/09/2025

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F0602 SS = SQC-F	Continued from page 6 people who took their money without authorization were kicked out of the facility. During a joint interview on 6/30/25 at 3:42 p.m. the AIT stated R4 was the spouse of R1 and R1 made financial decisions for her, though was not a power of attorney. The AIT stated the facility became aware R4's name was on the same account as R1's. The BOM stated the fraudulent charges linked to R1's debit card were on a checking account shared by both R1 and R4 and the money in the account belonged to them both. During an interview on 7/7/25 at 10:44 a.m., the administrator stated the facility became aware of allegations of financial exploitation of R4 on 6/26/25 during a monthly billing-related review phone call with the corporate business office. R1 was discussed and the BOM brought up R4 and stated a hold needed to be placed on her collection to the facility until the fraudulent charges were reimbursed by the bank. The administrator stated she had not previously realized R1's bank account was shared with R4 and given that they were on the same account the financial exploitation affected R4 too. The administrator reviewed a copy of R1's bank statement dated 5/30/25 provided to the surveyor by the facility and confirmed both R1 and R4's names were listed on the account. R2 R2's quarterly MDS assessment dated 5/23/25, indicated R2 had moderately impaired cognition and required supervision/touching assistance to no assistance from staff with most ADL's. R2's facesheet dated 7/9/25, indicated he had a financial power of attorney (POA). R2's diagnoses included Parkinson's disease. R2's care plan dated 5/20/25, identified he was a vulnerable adult and at risk for decreased cognitive and physical abilities. Interventions included: staff will continue to follow the facility vulnerable adult and abuse reporting policy; and local ombudsman, adult protection, police, and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed.	F0602		

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F0602 SS = SQC-F	Continued from page 7 R2's progress note dated 6/20/25, indicated the AIT assisted R2 and POA with a meeting with the police regarding unauthorized transactions on R2's bank account. A police case was filed, bank card was cancelled, and bank initiated the refund process. R2's bank statement dated 5/16/25, identified transactions from the previous 30 days. Notations on the statement identified the following: on 5/4/25 the card was added to Apple Pay (mobile payment and digital wallet service), on 5/15/25 a Cash App (an application for peer-to-peer money transfers) transaction included NA-B's first name, on 5/15/25 the card was blocked by the bank, the bank would send a letter about fraud/amount reimbursed and a new debit card in 10 days, and fraudulent charges totaled $709.97. Cash App transactions listed as "CASHAPP*[NA-B's first name]*" included eight separate transactions on 5/15/25 for amounts of $10 and $15 totaling $110 in charges. Additional transactions included: - $82.18 on 5/7/25 to "Nike.com" - $50.80 on 5/12/25 to "WAL-MART" Investigation follow-up report submitted to the SA dated 6/23/25, was the follow-up report for the Nursing Home Incident Report about R1. It identified there was now an additional case regarding R2. NA-E was interviewed after online orders under his name were linked to the unauthorized use of R2's financial information with shipments sent to his address on file with the staffing agency. He denied involvement. R2's POA, POA-A, had confirmed there were purchases on R2's account that he did not authorize beginning around 5/15/25. Police were notified, bank contacted, and card cancelled. Nursing Home Incident Report submitted to the SA dated 6/25/25, identified an allegation of financial exploitation for R2. Description of the incident noted suspected fraudulent activity was identified on review of R2's bank statements. Alleged perpetrators identified in the report included seven NA's (NA-A, NA-C, NA-D, NA-E, NA-F, NA-G, and NA-H) and three NAIT's (NAIT-A, NAIT-B, and NAIT-C). During an interview on 7/1/25 at 2:10 p.m., R2 stated his debit card information was taken and someone took money out of his account. Someone used his card and a	F0602		

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F0602 SS = SQC-F	Continued from page 8 police report had been filed. The bank noticed some funny transactions and previously put a stop on his account. He was not sure how much money was taken, but thought it was around $740 in charges. He was told the suspected perpetrators worked at the facility and the police had a suspect, but he did not know who it was. R2 stated he had his wallet and checkbook at the facility, but did not recall getting any information about how to protect his valuables. He used to keep his wallet in his pocket or on his nightstand, but now kept it in a lock box. He did not like that his money was taken, felt a little upset, and felt the perpetrators invaded his personal space. During an interview on 7/3/25 at 1:41 p.m., R2's family member and POA, POA-C, stated fraudulent charges were identified on R2's card on 6/19/25 when she and R2's other power of attorney, POA-A, tried to use the card's information to obtain a storage unit for R2. The card was declined and marked as fraud. POA-A went to the facility the next day and notified the SSD of the fraud issue. POA-C stated R2's bank statement had a facility staff name on it and apparently the person used Apple Pay which could be done using a picture of the card without the card itself. The bank had previously texted a fraud alert to R2 but R2 did not text and never saw it. The fraudulent charges looked like they went from 5/5/25 through 5/16/25. POA-C's understanding was the charges were made by someone who worked at the facility. During an interview on 7/7/25 at 7:55 a.m., R2's friend and POA, POA-A, stated she identified the fraudulent activity on R2's card on 6/19/25 and notified the facility the next day on 6/20/25. At the time, she had no idea the fraudulent activity involved anyone at the facility. When she notified the facility, the SSD informed her there was an investigation as this had happened to other residents. POA-A gathered an employee was responsible for the fraudulent charges because you could see the name on the bank statement. Fraudulent activity was identified on the statement from 5/4/25 when Apple Pay was added through 5/15/25 when the bank shut off the card. R2 now had a lock box for his valuables but POA-A had taken his checkbooks and new debit card received from the bank because POA-C didn't want it there, lacked trust, and just didn't know what was going on. During a joint interview on 6/30/25 at 3:42 p.m., the BOM stated the bank reported R2's card was put on Apple	F0602		

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F0602 SS = SQC-F	Continued from page 9	F0602		

Pay. The SSD stated the facility found out about the fraudulent charges when POA-A stopped by her office and said they saw some suspicious activity on his bank statement. The SSD noted the card had been cancelled on the 15th by the bank due to unusual purchases.

During an interview on 7/7/25 at 10:44 a.m., the administrator stated the facility identified unauthorized charges on R1's account with transaction information linked to employees. Upon becoming aware of concerns of financial exploitation of R2 on 6/20/25, R2's bank statement was reviewed and the facility identified similar charges as those on R1's statement, such as transactions at the same merchants. Some staff were suspended because they were identified by name in bank statement transactions, were identified in footage provided by the police, or had an associated address. NA-B was barred from working at the facility through the staffing agency because Cash App payments were sent in his name on R2's account.

During an interview on 7/8/25 at 2:44 p.m., NA-B stated he made transactions using Cash App with payment to himself. This was done utilizing a photo of a credit card sent to him by NAIT-B which NAIT-B said he found on the ground. NA-B used the photo to enter the card's information into Cash App on his phone and transferred $150 to himself. NA-B did not remember the name on the photographed card but noted it was not NAIT-B's name, the card was blue, and he no longer had the photo. He "wasn't really thinking about" the name on the card at the time he transferred the money, he "just put the information in." He had already made other purchases using this card because NAIT-B entered the card information into NA-B's phone. NA-B stated NAIT-B had "convinced" him he had a place to buy good quality clothes and stuff for low prices and NA-B was blindsided by everything apart from the Cash App payments. NA-B denied awareness when he made fraudulent transactions of the misappropriation of resident property or financial exploitation of residents. The cops told him the card belonged to a resident, but he did not know who. NA-B stated he made transactions using card information from NAIT-B from approximately 6/12/25 to 6/15/25.

R5

R5's significant change MDS assessment dated 6/25/25, indicated R5 was cognitively intact, receiving hospice care, and was dependent on staff for most ADL's.

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F0602 SS = SQC-F	Continued from page 10 R5's facesheet dated 7/9/25, indicated she had a financial POA. R5's diagnoses included encounter for palliative care, major depressive disorder, need for assistance with personal care, and dependence on enabling machines and devices. R5's care plan dated 7/8/25, indicated she was a vulnerable adult and at risk for decreased cognitive and physical abilities. Interventions included: staff will continue to follow the facility vulnerable adult and abuse reporting policy; and local ombudsman, police, and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed. R5's progress note dated 7/7/25, indicated her POA, POA-B, was called. POA-B stated she took R5's bills home and noticed charges that shouldn't be there on a bank statement. POA-B had only used the card for two medical rides for R5. POA-B stated the card went missing on 6/27/25 and she called the bank and had the card stopped. She was aware of $500 in fraudulent charges and took R5's valuables home. POA-B notified police and police stated the facility was aware of what was going on, so POA-B did not inform the facility at that time. POA-B had not made R5 aware of the situation as R5 was at the end of life and POA-B and family did not want R5 "upset and thinking about who stole from her while she is here." R5's bank statement dated 5/21/25 through 6/19/25, included a list of 22 transactions with total purchases and charges of $651.95. Charges dated 5/29/25 and 6/12/25 were for $77 each to "School Services." Additional transactions included: - $28.62 on 6/6/25 to "Target" - $7.49 on 6/6/25 to "KWIK TRIP" (a gas station) - $49.32 on 6/7/25 to "SPEEDWAY" (a gas station) - $1.60 on 6/7/25 to "KWIK TRIP" - $5.99 on 6/7/25 to "KWIK TRIP" - $47.05 on 6/10/25 to "CASEY'S" (a gas station) - $37.30 on 6/10/25 to "CASEY'S"	F0602		

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F0602 SS = SQC-F	Continued from page 11 - $45.00 on 6/10/25 to “FAMS BARBERSHOP AND A Faribault” - $52.84 on 6/11/25 to “KWIK TRIP” Nursing Home Incident Report submitted to the SA dated 7/7/25, identified an allegation of financial exploitation for R5. Description noted the police detective (PD) informed the facility R5’s family member reported a missing credit card that went missing on 6/27/25 with approximately $500 in unauthorized charges. The facility followed up with the family member, POA-B who noted she had previously reported the incident to the police and planned to submit the bank statement to the facility the following day. There were no identified alleged perpetrators. During an interview on 7/7/25 at 3:26 p.m., the AIT stated he spoke to the PD handling the financial exploitation investigations that morning. The PD notified the facility of another resident, R5, who was a potential victim of financial exploitation as R5’s family notified the PD she had a missing bank card. The SSD followed up with R5’s family who confirmed her credit card was missing. During an interview on 7/9/25 at 7:50 a.m., the administrator stated she had met with POA-B who provided a copy of R5’s bank statement. POA-B indicated the charges from “School Services” were authorized charges for medical rides, but did not identify any other authorized charges on the statement. Total unauthorized charges were $497.95. The administrator reviewed the bank statement and transactions and noted merchants were the same or similar as those seen on the statements for R1, R2, and R4’s accounts. The transactions were also from the same time frame at the beginning of June and ended when the facility identified concerns about R1’s card. Charges made to a gas station and two fast food restaurants were especially similar, and the administrator thought the same people made the purchases with R5’s card as did so with R1 and R2’s cards. During an interview on 7/8/25 at 1:42 p.m., R5’s family member and POA, POA-B stated R5’s credit card was missing and there were fraudulent charges on the account. POA-B had taken R5’s bills home to review and looked through the credit card statement and saw “all	F0602		

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F0602 SS = SQC-F	Continued from page 12 this fraud." On 6/28/25 she cancelled the card, went to the facility and noted the card was missing from R5's wallet, and reported it to the police. She did not know when the card went missing, but the fraudulent charges were between 6/5/25 and 6/11/25, totaling $497.95. There were two legitimate charges on the card from medical rides with a transport company that showed as "School Services." There were no further fraudulent charges on the account after the date on the statement. She guessed the card was stolen around 6/5/25. The detective, PD, had informed POA-B on 7/2/25 she was already working on an investigation and working with the facility, so POA-B did not notify the facility because she thought they knew about R5. The PD reported the suspects had already been suspended from the facility and were going to be charged and the police had video footage of a suspect. POA-B noted R5 was not aware of the financial exploitation concern. POA-B and R5's significant other had decided not to tell R5 because she was declining, in the end days of life, and "would be so upset" and was starting to get confused. They did not want her to know and POA-B was sure she would be upset thinking someone in the facility that was there to care for her was actually stealing from her. She used to keep her purse with checkbook and credit cards in it on the nightstand which POA-B had removed from the facility. POA-B thought R5's sense of trust would probably be impacted by the events and "she would always be wondering" if whatever aide came in to help her was the person that stole from her. R5 would expect her valuables to be safe and it would be upsetting because she trusts people and someone violated her personal belongings. During an interview on 7/7/25 at 8:33 a.m., police detective (PD) stated she was the detective handling the investigation into financial exploitation cases at the facility. PD stated that, due to the open nature of the investigation, she could not share victim or suspect names at this time. The PD stated she had two suspects, the facility had suspended multiple staff members, and she was confident the suspects were not currently working at the facility. She had three victims. The first victim was reported to the police on 6/12/25 by the facility, second victim reported on 6/20/25 by the facility, and third victim reported by their POA on 6/28/25. The PD stated she had "more than enough" evidence and would be filing charges against the two suspects. The fraudulent charges for all three victims stopped on either 6/11/25 or 6/12/25. All the fraudulent charges were made in May and June. The first and second victims had photos taken of their cards, whereas the third victim's physical card was taken. It	F0602		

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F0602 SS = SQC-F	Continued from page 13 was undetermined who had taken the card, but she thought it was one of the suspects who shared the card and card information with “a bunch of people.” The PD identified the two suspects as facility staff. So far, she had determined one suspect was connected to all three victims’ cases and the second suspect was connected to two victims’ cases. During a follow-up interview on 7/17/25 at 10:52 a.m., PD stated she had completed her suspect interviews and would be closing the case and filing charges. There were three victims, R1, R2, and R5. PD was not aware R1’s card used for fraudulent charges was linked to a bank account shared with R4. Estimated totals in fraudulent transactions for the victims were approximately $4,000 for R1, $550 for R2, and $497 for R5. The PD identified three suspects, two of whom were facility employees, NAIT-B and NA-B. The PD had interviewed both NAIT-B and NA-B multiple times. During the interviews, NAIT-B informed the PD of the following: NAIT-B took a picture of a card identified by the PD as belonging to R1; NAIT-B used the card for purchases of Lulu Lemon, sweatshirts, Valley Fair tickets, and ordering food with NA-B and the third suspect. NAIT-B reported the third suspect used the card for eBay purchases; NAIT-B took a picture of a card identified by the PD as belonging to R2. NAIT-B put the card into Apple Pay and used it at Walmart; NAIT-B took a picture of and took a card identified by the PD as belonging to R5. The card was used to buy stuff at gas stations and NAIT-B confirmed his identity in video footage the PD obtained from Kwik Trip associated with the transactions. NAIT-B also used the card at Target and a barbershop; NAIT-B sent pictures of R1 and R5’s cards to NA-B, and of R1’s card to the third suspect. During interviews, NA-B informed the PD of the following: NA-B received pictures of cards from NAIT-B identified by the PD as belonging to R1 and R2; NA-B used R1’s card for multiple purchases including Sugar Baby Care, Lulu Lemon, Nike, Timberland shoes, and TikTok. NA-B stated NAIT-B purchased and sent him a ticket for Valley Fair; NA-B used R2’s card for Cash App transactions made to himself of about $250; NA-B stated he did not have information about a third card. The PD stated she had no suspicions that anyone else was knowingly involved and did not think anyone else spent money on R1, R2, and R5’s cards other than the three suspects. Both NAIT-B and NA-B were to be charged with felony level financial transaction card fraud. Facility policy titled Abuse Prohibition/Vulnerable Adult Policy dated 2/2023, identified the purpose	F0602		

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F0602 SS = SQC-F	Continued from page 14 included “to protect residents against abuse by anyone” including but not limited to facility staff and staff of other agencies serving the individual. Incidents to be reported to the state agency noted a list including “mistreatment – inappropriate treatment or exploitation of a resident,” “misappropriation of resident property,” and “financial exploitation” including but not limited to residents providing gifts to staff or volunteers, residents or families providing any payment in cash or checks to staff or volunteers, and having residents sign over POA to staff. Facility policy titled Resident Right Policy dated 1/2024, identified it was the practice of the facility to uphold the rights of all residents. Residents had access to these rights including via a copy of the Combined Federal and State Bill of Rights provided in the admission process. Facility document titled Combined Federal and State Bill of Rights with State Agency logo dated 6/18/19, included “The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.”	F0602		
F0607 SS = SQC-F	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in	F0607	Please accept this Plan of Correction as the facility’s credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567. CITED EMPLOYEE: The facility's abuse prevention plan was reviewed and remains current. NAIT-A was removed from the schedule on 6/24/2025. NAIT-A is no longer employed by the facility. LIKE EMPLOYEES: This deficient practice pertained to an employee. An audit of all employee personnel files was completed to ensure a background study was conducted and clearance was received and on file.	08/20/2025

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(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
F0607 SS = SQC-F	Continued from page 15 accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to implement its policy to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of property when pre-employment background screening procedures were not completed for one of 11 staff members reviewed for background screening. This had the potential to affect all 71 residents residing in the facility as the staff member worked on all units. Findings include: Findings include: Untitled undated facility personnel document, identified nursing assistant in training (NAIT)-A was a new hire for position of NAIT with start date of 1/29/25. NAIT-A's employee status was full time. Criminal Background Study Information form undated, contained personal and demographic information required to complete a criminal background study for NAIT-A. A box on the form labeled "office use only" contained "date results received" space for date to be written in. This space was blank. Review of NAIT-A's employee file did not identify a completed pre-employment background screening. Review of NAIT-A's timesheets indicated she worked shifts at the facility from 1/29/25 through 6/24/25. During an interview on 7/8/25 at 11:26 a.m., NAIT-A stated she began working at the facility at the end of January as an NAIT. She stated she "worked everywhere" including the facility's unit on the second floor and both units on the first floor.	F0607	Continued from page 15 PREVENT RECURRENCE: The facility has implemented a tracking system to ensure all new hires have received a background study clearance prior to being placed on the schedule. The facility's Director of Nursing, Staffing Coordinator, and Human Resources staff were re-educated on the background study requirement. MONITORING: The Administrator or designee will audit all newly hired staff members for 4 weeks to ensure background study clearances are received and on file prior to the employee beginning work. Audit results will be forwarded to the QAPI committee to determine whether to increase, decrease, or discontinue audits. DATE OF COMPLIANCE: August 20, 2025	

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 07/09/2025

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F0607 SS = SQC-F	Continued from page 16 During an interview on 7/1/25 at 1:26 p.m., the director of nursing (DON) stated keeping residents safe included the hiring process. Background screening was done and references checked to ensure whoever was brought into the facility to care for residents was cleared. This was part of the hiring process for everyone in the facility. During an interview on 7/7/25 at 2:33 p.m., the administrator stated the requested background clearance for NAIT-A could not be located. She noted NAIT-A had completed a background study form online but never went for fingerprinting, so there was no background clearance in NAIT-A's file. The administrator was not previously aware NAIT-A's background screening procedure was not completed, and facility procedure was to complete this prior to an employee starting work. This needed to be done to ensure the facility brought in individuals who were competent, safe, and allowed to work in healthcare. Facility policy titled Abuse Prohibition/Vulnerable Adult Policy dated 4/2025, identified the purpose of the policy included protecting residents against abuse by anyone, including facility staff. The "Prevention" section included employee screening and noted, "The Minnesota Department of Health requires Criminal Background Studies to be completed on all facility employees (Sections 144.40 to 144.58). Potential employees are screened for a history of abuse, neglect, or mistreating residents. Licensing verification checks, and Nursing Assistant Registry checks are completed on facility employees when indicated." Facility policy titled Background Study Policy dated 12/2016, identified it was the facility's policy to complete criminal background studies on all employees. Upon hire or facility transfer, employees completed a facility background study form. The Human Resources Director would verify the information was correct and submit an online background study request. Further, "The employee may not begin working until the results of the request are received and indicate the applicant is not disqualified or may work unsupervised while a study is being completed." If an employee was not disqualified, the applicant could then be scheduled to work and results were filed in employee personnel file. Staff personnel files containing study results were maintained by the Vice President of Human Resources.	F0607		
F0609 SS = E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F0609	Please accept this Plan of Correction as the facility's credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be	08/20/2025

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F0609 SS = E	Continued from page 17 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure allegations of financial exploitation were reported to the State Agency (SA) within 24 hours for four of five residents (R1, R2, R3, and R4) reviewed for allegations of financial exploitation. Findings include: Findings include: R1 R1's facesheet dated 7/9/25, indicated he admitted to the facility on 11/30/22 and was his own responsible party. R1's emergency contact was his spouse, R4. R1's care plan dated 6/11/25, identified he was a vulnerable adult. Interventions included: staff will continue to follow the facility vulnerable adult and abuse reporting policy; and local ombudsman, adult	F0609	Continued from page 17 construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567. CITED RESIDENTS: Nursing Home Incident Reports (NHIR) were submitted to the state agency for all cited residents. LIKE RESIDENTS: All residents at risk of misappropriation of resident property have the potential to be affected by the deficient practice. PREVENT RECURRENCE: All staff were reeducated on timely reporting requirements. The Administrator, Administrator in Training, Director of Nursing, and Social Services Director were re-educated on timely reporting through the NHIR portal, ensuring a new report is submitted for each alleged violation, and the circumstances when a report should be made to the Minnesota Adult Abuse Reporting Center vs. the NHIR portal. An audit was conducted to ensure the Administrator, Administrator in Training, Director of Nursing, and Social Services Director have access to the facility's NHIR portal. MONITORING: The Administrator or designee will audit all allegations of abuse, neglect, and financial exploitation for 4 weeks to ensure they are reported timely to the state agency. Audit results will be forwarded to the QAPI committee to determine whether to increase, decrease, or discontinue audits. DATE OF COMPLIANCE:	

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F0609 SS = E	Continued from page 18 protection, police, and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed. Nursing Home Incident Report #360867 was submitted to the SA on 6/17/25 at 2:57 p.m. The report identified an allegation of financial exploitation for resident R1. The business officer manager (BOM) was the initial reporter and became aware of the incident on 6/17/25 at 2:00 p.m. Details included, “facility found out that resident’s bank statement has unauthorizes purchases which is linked to employee’s address.” Description included, “On June 12, 2025, facility identified $4,047.67 in unauthorized transactions on resident [R1’s] bank account, occurring between May 16 through June 12, 2025. [R1] did not approve these charges. Today, we confirmed the address linked to the transaction belongs to a facility employee.” During a joint interview on 6/30/25 at 3:42 p.m., the BOM stated she assisted R1 monthly to check his bank account and print the statement. She noticed unusual activity on R1’s bank statement on 6/12/25 and notified administration right away. The administrator in training (AIT) stated he filed a Minnesota Adult Abuse Reporting Center (MAARC) report initially and then when the facility later noticed that some of the transactions were linked to employee names, an Office of Health Facility Complaints (OHFC)/State Agency (SA) report was filed. During an interview on 7/7/25 at 10:44 a.m., the administrator stated the facility first became aware of concerns regarding suspicious activity on R1’s bank account on 6/12/25 when the facility identified $4,047.67 in unauthorized charges. A police report and MAARC report were filed on 6/12/25 but the report to the SA was not filed until 6/17/25 when addresses linked to the transactions were identified as belonging to employees. She was not present on 6/12/25 and did not know why it was not reported to the SA at that time, she would expect the allegations to have been reported to the SA on 6/12/25. The administrator stated alleged financial exploitation should be reported to the SA within 24 hours. R2 R2’s facesheet dated 7/9/25, indicated he admitted to the facility on 2/20/25 and had a financial power of attorney. R2’s care plan dated 5/20/25, identified he was a	F0609	Continued from page 18 August 20, 2025	

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F0609 SS = E	Continued from page 19 vulnerable adult. Interventions included: staff will continue to follow the facility vulnerable adult and abuse reporting policy; and local ombudsman, adult protection, police, and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed. Investigation Report with submission date 6/23/25 at 4:06 p.m., was submitted to the SA as the follow-up for Nursing Home Incident Report #360867 regarding R1. The investigation report noted similar incidents had been identified including a case involving R2. Unauthorized transactions had been discovered on R2's bank account beginning around 5/15/25. The BOM had confirmed this with R2's power of attorney (POA), POA-A. Police were notified and investigation ongoing. Nursing Home Incident Report #360946 was submitted to the SA on 6/25/25 at 11:48 a.m. The report identified an allegation of financial exploitation for resident R2. The BOM was the initial reporter and became aware of the incident on 6/20/25 at 1:30 p.m. Description included, "upon review/investigation of an open OHFC [report] relating to financial exploitation, business office manager reviewed resident's bank statement and discovered suspected fraudulent activity." During an interview on 7/1/25 at 1:07 p.m., the BOM stated she became aware of the concerns when POA-A spoke to the social services director (SSD) who came and got her. The SSD told her POA-A noticed some things on R2's bank statement. The BOM reviewed the bank statement with POA-A and identified concerns for fraudulent activity like that seen on R1's account. During an interview on 7/7/25 at 7:55 a.m., POA-A stated she identified concerns with R2's credit card on 6/19/25 when she tried to use the card to obtain a storage unit for R2 and it was declined due to fraudulent activity. POA-A went to the facility the next day on 6/20/25 and mentioned this to the SSD. R2 had his bank statements, which POA-A reviewed with facility staff who stated there was an investigation going on and this had happened to another resident. The facility notified the police, who came and spoke with R2 regarding the fraudulent activity. During an interview on 7/7/25 at 10:44 a.m., the administrator stated the facility became aware of concerns about financial exploitation related to R2 on 6/20/25 when his bank statement was reviewed with the BOM and suspected fraudulent activity identified. This was reported to the SA on 6/23/25 when it was included	F0609		

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F0609 SS = E	Continued from page 20 in the investigation report submitted as follow-up on the allegations of financial exploitation of R1. A separate report specific to R2 was then submitted to the SA on 6/25/25. The administrator stated the facility was aware of the allegations regarding financial exploitation of R2 on 6/20/25 and she would expect this to have been reported to the SA within 24 hours. She confirmed this should have been reported right away and should have been filed as a separate report, not included in the follow-up investigation report for R1. R3 R3's facesheet dated 7/9/25, indicated she admitted to the facility on 6/16/25 and was her own responsible party. R3's care plan focus dated 6/17/25, identified she was a vulnerable adult. Interventions included: staff will continue to follow the facility vulnerable adult and abuse reporting policy; and local ombudsman, adult protection, police, and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed. Investigation Report with submission date 6/23/25 at 4:06 p.m., was submitted to the SA as the follow-up for Nursing Home Incident Report #360867 regarding R1. The investigation report identified similar incidents had been identified including a case involving R3. R3 reported a missing bank card but experienced no financial loss and had cancelled the card. Nursing Home Incident Report #360948 was submitted to the SA on 6/25/25 at 12:17 p.m. The report identified an allegation of financial exploitation for resident R3. The report identified the social services designee (SS) was the initial reporter and became aware of the incident on 6/24/25 at 12:00 p.m. Description of the incident included, "during facility investigation of open OHFC relating to financial exploitation, resident informed social services of missing debit card 6/16/25. Debit card found 6/24/25 and resident confirmed there was no fraudulent activity on the account." Untitled facility resident interview document dated 6/18/25, indicated an interview was conducted with R3 by facility staff with note that R3 admitted to the facility on 6/16/25. Question "Have you noticed any unusual transactions on your bank account recently?" had answer "No. Froze card." Question "Have you noticed any missing valuables, money, checks, credit cards, or	F0609		

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F0609 SS = E	Continued from page 21 debit cards recently?" had answer "Debit card is missing – lost since first day here. Froze Card. [Bank name] – blue debit card. Had it when she left hospital. Says son doesn't have it." R3's progress note dated 6/18/25, indicated the AIT followed up with R3 regarding her missing card. R3 stated she cancelled the card and there were no unauthorized charges. During an interview on 7/7/25 at 10:44 a.m., the administrator stated she became aware of concerns regarding financial exploitation of R3 on 6/20/25 when she received an email for R3's son stating her debit card had gone missing but then it showed up the following morning on 6/21/25 and there were no fraudulent charges on the account. R3 was included in the investigation report for R1 submitted 6/23/25 and then filed as a separate report with the SA on 6/25/25. The administrator then reviewed R3's progress notes and confirmed the facility was aware of R3's missing debit card on 6/18/25, stated this should have been reported to the SA within 24 hours, and confirmed it had not been reported within that time frame. R4 R4's facesheet dated 7/9/25, identified she admitted to the facility on 9/10/20, and her spouse R1 was her responsible party and emergency contact. R4's care plan dated 5/5/25, identified she was at risk for abuse and or neglect. Interventions included: staff will continue to follow the facility vulnerable adult and abuse reporting policy; and local ombudsman, adult protection, police, and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed. During a joint interview on 6/30/25 at 3:42 p.m. the AIT stated R4 was R1's spouse and R1 made financial decisions for her, though was not her power of attorney. The AIT stated the facility became aware R4's name was on the same account as R1's so they filed a MAARC report as part of the process of trying to obtain a financial conservator for them both. The BOM stated the fraudulent charges linked to R1's debit card were on a checking account shared by both R1 and R4 and the money in the account belonged to them both. During an interview on 7/1/25 at 9:11 a.m., the SSD stated she submitted a MAARC report regarding R4 after the facility found out R1's account was shared with R4. She was made aware of this and submitted the report on	F0609		

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F0609 SS = E	Continued from page 22 6/26/25. The SSD confirmed the concern for R4 was an allegation of financial exploitation as the money in the account belonged to both R1 and R4 who were financially independent. The SSD stated she only knew how to file MAARC reports, and the administrators were responsible for filing reports to the SA. During an interview on 7/7/25 at 10:44 a.m., the administrator stated the facility became aware of allegations of financial exploitation of R4 on 6/26/25 during a monthly billing-related review phone call with the corporate business office. R1 was discussed and the BOM brought up R4 and stated a hold needed to be placed on her collection to the facility until the fraudulent charges from R1's card were reimbursed by the bank. The administrator had not previously realized R1's bank account was shared with R4 and given that they were on the same account the financial exploitation affected R4 too. The administrator reviewed a copy of R1's bank statement dated 5/30/25 provided to the surveyor by the facility and confirmed both R1 and R4's names were listed. The administrator stated R4's name was clearly on the account and she would expect allegations of financial exploitation of R4 to have been identified and reported to the SA on 6/12/25 when the facility identified fraudulent activity on the account. The administrator confirmed allegations of financial exploitation were also not reported within 24 hours of the facility becoming aware of the allegations for R1, R2, and R3. The allegations needed to be reported because all residents were vulnerable adults and any alleged or confirmed abuse or any sort needed to be reported to the SA within two hours if there was physical harm or 24 hours for all others. Facility policy titled Abuse Prohibition/Vulnerable Adult Policy dated 4/2025, identified the purpose of the policy included to promptly report, document, and investigate all incidents of alleged or suspected abuse/neglect. All staff were responsible for reporting any situation that was considered abuse or neglect. The policy identified incidents that must be reported to the State Agency including: mistreatment (inappropriate treatment or exploitation of a resident), misappropriation of resident property, and financial exploitation (including but not limited to: residents provide gifts to staff or volunteers, residents or families provide any payment in cash or checks to staff or volunteers, having residents sign over POA to staff). Section titled "How and when to report to the Minnesota Department of Health (MDH)/ Office of Health Facility Complaints (OHFC)" included, "2.) Suspicion of Neglect, Exploitation, or Misappropriation of resident property must be reported to OHFC online reporting	F0609		

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F0609 SS = E	Continued from page 23 process not later than 2 hours if the incident resulted in serious bodily injury. 3.) If the suspected Neglect, Exploitation, or Misappropriation of resident property did not result in serious bodily injury, the reports must be made within 24 hours… 6.) Notify the Minnesota Department of Health (MDH) on the notification website immediately after discovery of incident." Additional direction included "Utilizing the Minnesota Adult Abuse Reporting Center (MAARC)." The policy directed the following scenarios should be reported directly to MAARC: "a.) If the Vulnerable Adult is not a facility resident. b.) The Vulnerable Adult discharges from facility against medical advice, including residents who do not return from a Leave of Absence. *All discharges that are against medical advice need to be reported to MAARC within 24 hours. c.) The alleged maltreatment occurred prior to facility admission."	F0609		
F0610 SS = E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to identify and protect all residents at risk of financial exploitation during investigations into 4 of 4 residents (R1, R2, R3, R4) reviewed who made allegations of financial exploitation. This had the potential to affect all 67 other residents who were residing in the facility, including R5, whose representative subsequently identified and reported	F0610	Please accept this Plan of Correction as the facility's credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567. CITED RESIDENTS: The facility developed measures to protect the affected residents: the facility assisted residents in contacting banks/financial institutions and making a police report to ensure any ongoing misappropriation ceased and the facility offered lockboxes and access to a facility safe to store valuables/financial resources. Any suspected staff members were suspended pending investigation. Investigations have been conducted for all cited residents, with the final investigative report submitted to the state agency. LIKE RESIDENTS: All residents and family members were notified of misappropriation of resident property at the facility. Residents and family members were educated to monitor	08/20/2025

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F0610 SS = E	Continued from page 24 additional allegations of financial exploitation. Findings include: Untitled resident questionnaire documents dated 6/17/25 and 6/18/25, included dates, resident names, interviewer signatures, and three questions. Questions included: have you noticed any unusual transactions on your bank account recently; Have you noticed any missing valuables, money, checks, credit cards or debit cards recently; and do you know how to report facility concerns, lost, missing, or damaged items. Questionnaires were completed for 29 residents. One questionnaire had a resident name written down and crossed out with no further information, and one questionnaire had a resident name, R5, date of 6/17/25, and note at the bottom indicating R5 was hospitalized/on a leave of absence. Facility document titled Attendance Record dated 6/18/25, identified it was for “resident education on storing valuable items.” The record included resident names/signatures or staff signatures on behalf of residents unable to sign and resident room numbers. The record identified education was completed with 47 residents, per listed room numbers. Facility document titled Resident Education Regarding Valuables in the Facility undated, was a one-sheet page with printed information. The information included, “It is important to be aware that while residing in the facility, there will be multiple staff that frequently enter and exit residents’ private living spaces. Checkbooks, cash, credit cards, and valuable jewelry should not be left unsecured in residents’ private living space. Residents may wish to obtain a lockbox to secure items should they decide to keep these items at the facility. It is recommended that valuables be kept with family if possible. It is important to be aware that physical credit cards do not need to be taken, thieves have taken pictures of credit cards and used the images to permit theft. You should never share your financial PIN [personal identification number] numbers or passwords with anyone. If you suspect a crime has occurred, report it immediately to staff.” During an interview on 7/7/25 at 10:44 a.m., the administrator stated the facility first became aware of allegations of financial exploitation on 6/12/25 when the facility identified $4,047.67 in unauthorized	F0610	Continued from page 24 bank statements for fraudulent activity and to report any concerns to the facility. PREVENT RECURRENCE: All staff were educated on preventing, reporting, and responding to abuse, neglect, or misappropriation of resident property, including immediate person-centered protective measures to take to protect residents while the investigation is ongoing. Staff responsible for conducting investigations will be educated on procedure to assess the risk group when conducting an investigation into abuse, neglect, or misappropriation of resident property. MONITORING: The Administrator or designee will audit all investigations into allegations or suspicions of abuse, neglect, or misappropriation for 4 weeks to ensure the risk group was assessed correctly and adequate protective measures were implemented. Audit results will be forwarded to the QAPI committee to determine whether to increase, decrease, or discontinue audits. DATE OF COMPLIANCE: August 20, 2025	

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 07/09/2025

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
F0610 SS = E	Continued from page 25 charges/suspicious activity on R1's bank account statement reviewed by the business office manager (BOM). On 6/17/25, the facility identified addresses linked to the transactions belonged to employees. The facility became aware of concerns regarding financial exploitation of R3 on 6/18/25, when an interview was conducted with R3 who reported her debit card was missing but had no fraudulent transactions because she had cancelled the card. The facility became aware of concerns about financial exploitation related to R2 on 6/20/25 when his bank statement was reviewed with facility staff and suspected fraudulent activity identified. The facility became aware of concerns about financial exploitation related to R4 on 6/26/25 when they realized R1's bank account was shared with R4, her spouse. The administrator would expect the allegations of financial exploitation of R4 to have been identified on 6/12/25 when the facility identified the fraudulent activity on the account because R4's name was clearly on the bank statement/account. In a follow-up interview at 3:32 p.m., the administrator stated the fraudulent charges on R2's account totaled $709.97. During a joint interview on 6/30/25 at 3:42 p.m., the administrator in training (AIT) stated after the facility identified potential financial exploitation of R1 was linked to employee addresses and names via transactions, identified staff members were suspended. In addition, the facility "checked in" with other residents who managed their own finances to see if they "had issues." The social services director (SSD) stated she completed this along with the social services designee and the receptionist. This was a list of questions, a safety questionnaire, she discussed with about 20 to 30 residents. The AIT stated this was when R3 notified the facility she had a missing bank card. During an interview on 7/1/25 at 9:11 a.m., the SSD stated after the BOM noticed fraudulent activity on R1's bank account, staff including herself completed questionnaires with residents and asked them if they had noticed anything similar. Education was provided that "if they wished to purchase a lock box they could." She stated secure storage for resident valuables was not offered to residents unless they asked for it, and the admission contract contained information about storage of valuables. During a follow-up interview on 7/7/25 at 12:11 p.m., she confirmed safety questionnaires were completed on 6/17/25 and 6/18/25. She was advised to complete them only with residents who oversaw their own finances. Staff also rounded with an educational paper given to	F0610		

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F0610 SS = E	Continued from page 26 all residents about lock boxes and keeping personal items safe. It did not notify residents of the financial exploitation concerns or need to check their finances for potential fraudulent charges. The SSD stated all residents were “probably not” capable of understanding this education and she had not followed up with any families or representatives of the residents educated. She did not know of other actions taken to notify all residents and representatives of the concerns. During an interview on 7/7/25 at 10:44 a.m., the administrator stated she was aware of concerns related to financial exploitation for four residents, R1, R2, R3, and R4. An all-staff meeting was held on 6/30/25 with education about the facility’s abuse prohibition and vulnerable adult policy but was not mandatory. She was unable to articulate what was done to follow up with staff not present at the meeting. Staff rounded with residents on 6/17/25 and 6/18/25 to complete safety questionnaires. She thought this should have been done with every resident. Questionnaire papers indicated rounding was done with 31 residents and she did not know how they were selected. She identified one completed with a resident with dementia who might not understand the questions and whose family should have been notified, and one with a resident (R5) who was in the hospital at the time. The administrator was not aware of follow-up completed with these residents and their representatives. She stated there were “at least 40” residents (those who did not get questionnaires) who were not talked to about concerns for financial exploitation or were talked to but not documented. She was unable to articulate what was done to protect these residents from potential financial exploitation. To protect residents, she would expect every resident in the building and their family/representatives to have been notified of the concerns as soon as the facility found out there was a second resident involved in the alleged financial exploitation. The administrator stated all residents should have been followed up with because even if someone had a POA (did not manage their own finances) they could still have something (such as a credit or debit card) at the facility that could be utilized to make unauthorized purchases. She had not yet notified all families of the potential financial exploitation and did not see evidence all residents had been informed. She would expect safety interviews with residents, meetings with residents if they wanted assistance reviewing bank statements, and communication with families and POA's to see if they had noticed fraudulent activity for all residents. Additionally, staff interviews and all staff education. During a	F0610		

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F0610 SS = E	Continued from page 27 follow-up interview on 7/7/25 at 12:20 p.m., the administrator stated the education sheet provided to all residents communicated it was important to be aware of personal items, but it did not say the facility had “something like this” happen. Further, all residents were not capable of understanding the information as presented and regardless of if a resident was their own representative, the facility should have followed up with every resident to ensure they understood. Residents would not be aware of the risk of potential financial exploitation if the facility did not explain it. During an interview on 7/7/25 at 3:26 p.m., the AIT stated he had spoken to the police detective (PD) handling the financial exploitation investigations that morning. The PD notified the facility of another resident, R5, who was a potential victim of financial exploitation as R5’s family had notified the PD she had a missing bank card. The SSD followed up with R5’s family who confirmed her credit card was missing. During a joint interview on 7/8/25 at 8:22 a.m., the administrator stated R5’s POA, POA-B, indicated R5’s credit card went missing on 6/27/25 and there were about $500 in fraudulent charges. The administrator confirmed the safety questionnaire for R5 completed on 6/17/25 indicated she was in the hospital at the time. The administrator did not see any follow-up completed with R5 or her family/representatives to provide the information in the questionnaire. The regional director of operations (RDO) stated the facility had initially determined to notify only residents who managed their own credit cards of the concerns. He confirmed residents who did not manage their own finances could also have cards in the facility. He confirmed every resident was not able to understand and follow up on the information presented in the resident education sheet and facility would have followed up with POA's for these residents. He was not able to identify evidence of this follow up. During an interview on 7/8/25 at 1:42 p.m. POA-B stated she was R5’s family member and POA. POA-B stated R5’s credit card was missing and had fraudulent charges on the account. She identified this on 6/28/25 when reviewing R5’s credit card statement. She cancelled the card right away, went to the facility and noted the card was missing from R5’s wallet, and reported it to the police. She did not know when the card went missing, but the fraudulent charges were between 6/5/25	F0610		

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F0610 SS = E	Continued from page 28 and 6/11/25, totaling $497.95. The detective, PD, had informed POA-B on 7/2/25 that she was already working on an investigation and working with the facility, so POA-B did not notify the facility because she thought they knew about R5. POA-B stated she spoke to facility staff yesterday and they had not known about R5. POA-B stated she received an automated voice message from the facility that morning regarding financial fraudulent activity in the facility, but had not received previous communication from the facility notifying her about potential concerns. POA-B stated she did not know when the facility became aware of the concerns, but thought they should have let people know sooner if they knew sooner. During an interview on 7/3/25 at 1:41 pm., POA-C stated she was R2's family member and one of his POA's. Fraudulent charges were identified on R2's card on 6/19/25 when she and R2's other POA, POA-A, tried to use the card's information for a transaction and it was declined and marked fraud. POA-C stated she thought the facility was going to send out a letter or communication to all guardians or individuals this financial exploitation pertained to, and she had received nothing. This was concerning. There were vulnerable people at the facility who didn't have someone like herself or POA-A watching their backs and some didn't have the capacity to do so on their own. This made her sick as there was "nothing sicker" in her mind than elder abuse and what happened was criminal. During an interview on 7/7/25 at 7:55 a.m., POA-A stated she identified the fraudulent activity on R2's card on 6/19/25 and notified the facility on 6/20/25. At the time, she had no idea the fraudulent activity involved anyone at the facility. When she notified the facility, the SSD informed her there was an investigation as this had happened to other residents. POA-A gathered an employee was responsible for the fraud. POA-A was informed the facility would send a letter to all residents that these activities were going on. POA-A had not received such communication. POA-A stated people needed to know this was happening so they could check their funds and be aware. It has been two weeks since she first notified the facility of the activity on R2's account and she thought this communication should have gone out. POA-A was concerned this may have happened to other residents and thought the facility should notify every resident because, otherwise, how would residents and guardians know to look at bank statements. POA-A stated if she had not stopped by the facility on 6/20/25 and mentioned the	F0610		

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F0610 SS = E	Continued from page 29 fraudulent activity on R2's card to staff, she would never have known it was connected to the facility, no one had contacted her. POA-A stated she was upset and felt very strongly about this as she would still have no idea what was going on if she hadn't happened to mention it to the SSD on 6/20/25. During an interview on 7/7/25 at 8:33 a.m., the police detective (PD) handling the investigation into multiple reports of financial exploitation at the facility stated the investigation was on-going. The first case was reported to the police by the facility on 6/12/25. The PD had enough evidence to file charges against two employees of the facility related to the financial exploitation. She stated there were currently three residents who were victims but felt there could be more cases. She thought it would "be good" for the facility to "get something out" to notify people to make sure they were checking their bank accounts often in case there were additional victims. Facility policy titled Abuse Prohibition/Vulnerable Adult Policy dated 4/2025, identified the purpose of the policy, including "To protect residents against abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals, or self-abuse," "to promptly report, document and investigate all incidents of alleged or suspected abuse/neglect," and "to identify and remedy any potentially abusive situations." Policy interpretation and implementation section indicated all staff were responsible for reporting any situation considered abuse, neglect, injuries of unknown origin, misappropriation of resident property, or involuntary seclusion. Further, "A supervisor will be notified immediately and will assess the situation to determine if any emergency treatment or action is required. Immediately, upon learning of the incident, staff will take necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated." Investigation/protection section included, "Staff will take immediate and appropriate actions to prevent further abuse, neglect, exploitation, and mistreatment from occurring while the investigation is in progress," and "The facility will provider proper follow up communication related to the incident across all shifts and to practitioners and resident representatives as applicable."	F0610		
F0732 SS = C	Posted Nurse Staffing Information	F0732	Please accept this Plan of Correction as the facility's	08/20/2025

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F0732 SS = C	Continued from page 30 CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by:	F0732	Continued from page 30 credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567. CITED DEFICIENT PRACTICE: The facility updated its nurse staffing posting to include the required content, including total and actual hours worked. POTENTIAL TO AFFECT: The deficient practice had the potential to affect any person who wished to view the nurse staffing information. PREVENT RECURRENCE: The nurse staffing posting process was reviewed and the Staffing Coordinator will ensure the data is posted on a daily basis at the beginning of each shift. In the event the Staffing Coordinator is absent, the Director of Nursing will designate a staff member to make the posting. MONITORING: The Administrator or designee will audit the nurse staffing posting 3 times per week for 4 weeks to ensure it is posted on a daily basis at the beginning of each shift. Audit results will be forwarded to the QAPI committee to determine whether to increase, decrease, or discontinue audits. DATE OF COMPLIANCE: August 20, 2025	

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F0732 SS = C	Continued from page 31 Based on observation and interview, the facility failed to post accurate data reflecting the total number and actual hours worked per shift by nursing staff directly responsible for resident care on a daily basis. This had the potential to affect all 71 residents residing in the facility and their visitors who may wish to review the information. Findings include: On 7/9/25 at 8:50 a.m., the facility's nurse staff posting form dated 7/9/25, was located on top of a chest of drawers by the front desk. The posting included the daily resident census, total number of nursing staff hours, and sections for the facility's three units and section labelled "agency." Each section was further broken down into sections of day shift, evening shift, overnight shift, and adjustments with spaces in each for registered nurse (RN), licensed practical nurse (LPN), trained medication aide (TMA), certified nursing assistant (NA), and nursing assistant in training (NAIT). Information written on the paper indicated the number of staff working in each role on each shift on each unit with corresponding number of total staff hours worked per role per shift per unit (i.e. one RN and eight hours or two LPN's and 16 hours). The sheet did not identify the actual hours worked for any of the identified nursing staff roles. During an interview on 7/9/25 at 8:50 a.m., the director of nursing (DON) reviewed the nurse staff posting form dated 7/9/25. The DON indicated the posting was written to show how many people were working in each role for the shift and then the total hours worked by those people. The DON stated the actual hours worked by nursing staff were reflected in the schedules for staff posted at the nursing stations. He acknowledged those schedules were not the facility's nurse staff posting. He confirmed the actual hours worked by nursing staff were not included in the facility's daily nurse staff posting. Facility policy titled Nursing Hours Posting dated 10/2/2022, identified it was facility policy to post nursing staffing data on a daily basis at the beginning of each shift. The posting was to include facility name, current date, resident census, and "the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift." Categories included registered nurses, licensed practical nurses or licensed vocational nurses, and	F0732		

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F0732 SS = C	Continued from page 32 certified nursing assistants. Policy interpretation and implementation identified federal law required Medicare and Medicaid certified nursing homes to post the number of staff who are directly responsible for resident care in the facility on each shift.	F0732		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 28, 2025

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

Re: Event ID: SRUK11

Dear Administrator:

The above facility survey was completed on July 9, 2025 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/29/2025**

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER 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. 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. 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. INITIAL COMMENTS: On 8/28/25 and 8/29/25, an offsite revisit was conducted to follow up on deficiencies issued related to a licensing survey exited on 7/9/25, by the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.	20000		

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/29/2025**

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20000	Continued from page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		