DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 14, 2025

Administrator
The Emeralds at St. Paul

420 MARSHALL AVENUE
SAINT PAUL, MN 55102

RE: CCN: 245295
Cycle Start Date: April 23, 2025

Dear Administrator:

On May 20, 2025, we notified you a remedy was imposed. On June 5, 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 May 22, 2025.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective June 4, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 20, 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 May 5, 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 14, 2025

Administrator
The Emeralds at St. Paul
420 Marshall Ave
Saint Paul, MN 55102

Re: Reinspection Results
Event ID: H42812 and HY5G12

Dear Administrator:

On June 2, 2025 and June 6, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on April 23, 2025 and May 5, 2025. At this time these correction orders were found corrected.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 14, 2025

Administrator
The Emeralds At St Paul LLC
420 Marshall Avenue
Saint Paul, MN 55102

RE: CCN: 245295
Cycle Start Date: April 23, 2025

Dear Administrator:

On April 23, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);

- Civil money penalty (42 CFR 488.430 through 488.444).

- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by July 23, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 23, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections

488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: **https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html**

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 14, 2025

Administrator
The Emeralds At St Paul LLC
420 Marshall Avenue
Saint Paul, MN 55102

Re: State Nursing Home Licensing Orders
Event ID: H43811

Dear Administrator:

The above facility was surveyed on April 21, 2025 through April 23, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT ST PAUL LLC	420 MARSHALL AVENUE SAINT PAUL, MN 55102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 4/21/25-4/23/25, 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: H52953109C (MN00112504). No deficiency issued. H52953109C (MN00112355), (MN00112345) with a deficiency cited at F684. Deficient practice was identified related to incidental finding at: F609 and F610. 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.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §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	F 609		4/25/25

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

Electronically Signed | 05/14/2025

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 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.

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F 609	Continued From page 1 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 observation, interview and document review, the facility failed to report an allegation of abuse and chemical ingestion for 1 of 3 residents (R1) reviewed for incidents and abuse allegations. Findings include: Gentell Dermal Wound Cleanser is a skin cleanser for all types of wounds. According to the gentell product information website, the ingredients include purified water, laurel glucoside, cocamidopropyl betaine, sorbitol, sodium laureth sulfate, polysorbate-80 lactic acid, triethanolamine, imidazolindinyl urea, disodium EDTA and methylparaben. The bottle indicates to seek medical attention or contact the poison control center if swallowed.	F 609	R1 discharged from facility on 4/13/2025. RN-A was suspended pending investigation and brought back to duty once completed education and having received corrective action. ACP Social Worker was provided education on reporting unusual occurrences during her visits, including if residents ingest something that is a non-food item. Skin audit completed on like-residents. Abuse audits conducted with like-residents. All residents have the potential to be affected by this deficient practice.	

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F 609	Continued From page 2 R1's quarterly Minimum Data Set (MDS) assessment dated 3/12/25, indicated R1 was severely cognitively impaired and was independent in activities of daily living besides toileting. R1's face sheet dated 4/21/25, indicated R1 had diagnoses of chronic respiratory failure, paranoid schizophrenia, tracheostomy status, and dependence on ventilator status. R1's care plan dated 4/21/25, indicated R1 "would benefit from having all cares done by a female staff to include bathing, showering, grooming and dressing due to past trauma history of sexual assault from a male." R1's progress notes lacked any documentation about staff-to-resident abuse allegations or investigation. There were no notes documenting R1 spray wound cleanser into her mouth, if the physician was notified of the event or if poison control was contacted for further instruction. R1's physician order dated 3/27/25, indicated to cleanse the wound on the top of the left foot with wound cleanser. Video footage from the camera in R1's room, dated 3/29/25 at 8:53 p.m., showed R1 in bed, family member (FM)-A, sitting in the room and registered nurse (RN)-A standing by the door and looking towards R1. R1 raised her right arm, FM-A pointed to R1's arm and said "What happened there? Ouch look at the back of your arm. There is a good size bruise. Is that from a fall?" RN-A asked, "Did you bump your arm somewhere?" RN-A walked to R1 and looked	F 609	Staff were educated on timely reporting, Sexual Abuse Allegations policy, MN Abuse policy and Reporting, and Notification of Change policy. DON or designee will conduct random audits to ensure proper assessment, monitoring, and implementation of interventions for residents with skin integrity issues and audits to ensure chemicals are not within reach of residents. Audits will be completed weekly x4 weeks. Audit results will be reviewed by QAPI Committee for further recommendations.	

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F 609	Continued From page 3 closely at the bruise and touched R1's arm. R1 stated "If men just leave me alone at night." FM-A asked, "who is bothering you at night?" R1 states "some guy." RN-A did not say anything, began walking away from R1, exited the room and closed the door. Video footage from the camera in R1's room, dated 4/3/25 unknown time, showed R1 in bed with a psychologist sitting in a chair next to her. There was a bedside table in between R1 and the psychologist. There was a spray bottle and a water bottle on the bedside table. R1 pointed to the spray bottle and the psychologist handed the bottle to her. R1 proceeded to put her mouth around the nozzle and spray it into her mouth. R1 grimaces and says "ick." The psychologist gave R1 the water bottle. Video footage from the camera in R1's room, dated 4/3/25 at 9:54 p.m., showed R1 lying in bed, FM-A and FM-B standing by the bed and RN-B standing by the door. FM-A stated "I've seen her take a drink of this [wound cleanser spray] and we have that on camera. I was reading it, and it says if swallowed seek medical attention and call the poison control center. Did anyone report today that she sprayed some in her mouth?" RN-B said, "I was not aware that she drank that, do you still have that on camera?" RN-B asks to see the camera footage. FM-A says she wants to get her mother's consent before sharing the video and she would rather report the concern to the nurse manager first. On 4/22/25 at 3:04 p.m., the nurse practitioner was interviewed. She could not remember if the facility updated her about the wound spray ingestion and she was not able to look in her	F 609		

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F 609	Continued From page 4 (R1's) electronic health record for any related notes. The nurse practitioner stated she would potentially call poison control if a resident swallowed wound spray. On 4/22/25 at 3:16 p.m., the psychologist was interviewed. She could not remember if she reported the wound spray ingestion incident to facility staff or not. On 4/23/25 at 8:35 a.m., RN-A was interviewed. She stated she was not aware that R1 sprayed wound cleanser in her mouth. RN-A stated she was not aware that R1 claimed a man gave her a bruise. On 4/23/25 at 10:00 a.m., the assistant director of nursing (ADON) was interviewed. The ADON said he was not aware of R1 ingesting wound spray. He would expect staff to call the provider and monitor vital signs. He did not know if poison control was called. The ADON stated R1 does have a history of delusions, but the nurse should not have made any assumptions, and staff should have looked into it further and reported . On 4/23/25 at 10:14 a.m., the administrator was able to verify R1 was using Gentell Dermal Wound Cleanser on 4/3/25 camera footage. On 4/23/25 at 10:26 a.m., the director of nursing (DON) was interviewed. In response to the wound spray incident, the DON stated there should have been follow up, the provider and poison control should have been notified to provide further direction. In response to the abuse allegation, the DON stated staff are in an environment with vulnerable adults, when they hear something, we must investigate it and find the cause of the	F 609		

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F 609	Continued From page 5 statement. The nurse should have asked more about it and she may have gotten an answer right away. The nurse should have reported incidents. RN-B was contacted for an interview but did not return the call. The facility Abuse Prohibition/Vulnerable Adult Policy dated 2/25, directed all staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin. A supervisor will be notified immediately and will assess the situation to determine if any emergency treatment or action is required. Staff will take steps to protect residents from subsequent incidents while the matter is being investigated.	F 609		
F 610 SS=D	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.	F 610		4/25/25

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F 610	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to investigate an allegation of abuse and chemical ingestion for 1 of 3 residents (R1) reviewed for incidents and abuse allegations. Findings include: Gentell Dermal Wound Cleanser is a skin cleanser for all types of wounds. According to the gentell product information website, the ingredients include purified water, laurel glucoside, cocamidopropyl betaine, sorbitol, sodium laureth sulfate, polysorbate-80 lactic acid, triethanolamine, imidazolindinyl urea, disodium EDTA and methylparaben. The bottle indicates to seek medical attention or contact the poison control center if swallowed. R1's quarterly Minimum Data Set (MDS) assessment dated 3/12/25, indicated R1 was severely cognitively impaired and was independent in activities of daily living besides toileting. R1's face sheet dated 4/21/25, indicated R1 had diagnoses of chronic respiratory failure, paranoid schizophrenia, tracheostomy status, and dependence on ventilator status. R1's care plan dated 4/21/25, indicated R1 "would benefit from having all cares done by a female staff to include bathing, showering, grooming and dressing due to past trauma history of sexual assault from a male." R1's progress notes lacked any documentation	F 610	R1 discharged from facility on 4/13/2025. RN-A was suspended pending investigation and brought back to duty once completed education and having received corrective action. ACP Social Worker was provided education on reporting unusual occurrences during her visits, including if residents ingest something that is a non-food item. Skin audit completed on like-residents. Abuse audits conducted with like-residents. MN Abuse Policy reviewed with no changes. All residents have the potential to be affected by this deficient practice. Staff were educated on thorough investigation of alleged abuse, Sexual Abuse Allegations policy, MN Abuse policy and Reporting, and Notification of Change policy. DON or designee will conduct random audits to ensure proper assessment, monitoring, and implementation of interventions for residents with skin integrity issues and audits to ensure chemicals are not within reach of residents. Audits will be completed weekly x4 weeks. Audit results will be reviewed by QAPI Committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING _____ B. WING _____	C 04/23/2025

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F 610	Continued From page 7 about staff-to-resident abuse allegations or investigation. There were no notes documenting R1 spray wound cleanser into her mouth, if the physician was notified of the event or if poison control was contacted for further instruction. R1's physician order dated 3/27/25, indicated to cleanse the wound on the top of the left foot with wound cleanser. Video footage from the camera in R1's room, dated 3/29/25 at 8:53 p.m., showed R1 in bed, family member (FM)-A, sitting in the room and registered nurse (RN)-A standing by the door and looking towards R1. R1 raised her right arm, FM-A pointed to R1's arm and said "What happened there? Ouch look at the back of your arm. There is a good size bruise. Is that from a fall?" RN-A asked, "Did you bump your arm somewhere?" RN-A walked to R1 and looked closely at the bruise and touched R1's arm. R1 stated "If men just leave me alone at night." FM-A asked, "who is bothering you at night?" R1 states "some guy." RN-A did not say anything, began walking away from R1, exited the room and closed the door. Video footage from the camera in R1's room, dated 4/3/25 unknown time, showed R1 in bed with a psychologist sitting in a chair next to her. There was a bedside table in between R1 and the psychologist. There was a spray bottle and a water bottle on the bedside table. R1 pointed to the spray bottle and the psychologist handed the bottle to her. R1 proceeded to put her mouth around the nozzle and spray it into her mouth. R1 grimaces and says "ick." The psychologist gave R1 the water bottle.	F 610		

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F 610	Continued From page 8 Video footage from the camera in R1's room, dated 4/3/25 at 9:54 p.m., showed R1 lying in bed, FM-A and FM-B standing by the bed and RN-B standing by the door. FM-A stated "I've seen her take a drink of this [wound cleanser spray] and we have that on camera. I was reading it, and it says if swallowed seek medical attention and call the poison control center. Did anyone report today that she sprayed some in her mouth?" RN-B said, "I was not aware that she drank that, do you still have that on camera?" RN-B asks to see the camera footage. FM-A says she wants to get her mother's consent before sharing the video and she would rather report the concern to the nurse manager first. On 4/22/25 at 3:04 p.m., the nurse practitioner was interviewed. She could not remember if the facility updated her about the wound spray ingestion and she was not able to look in her (R1's) electronic health record for any related notes. The nurse practitioner stated she would potentially call poison control if a resident swallowed wound spray. On 4/22/25 at 3:16 p.m., the psychologist was interviewed. She could not remember if she reported the wound spray ingestion incident to facility staff or not. On 4/23/25 at 8:35 a.m., RN-A was interviewed. She stated she was not aware that R1 sprayed wound cleanser in her mouth. RN-A stated she was not aware that R1 claimed a man gave her a bruise. On 4/23/25 at 10:00 a.m., the assistant director of nursing (ADON) was interviewed. The ADON said he was not aware of R1 ingesting wound spray.	F 610		

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F 610	Continued From page 9 He would expect staff to call the provider and monitor vital signs. He did not know if poison control was called. The ADON stated R1 does have a history of delusions, but the nurse should not have made any assumptions, and staff should have looked into it further and reported. On 4/23/25 at 10:14 a.m., the administrator was able to verify R1 was using Gentell Dermal Wound Cleanser on 4/3/25 camera footage. On 4/23/25 at 10:26 a.m., the director of nursing (DON) was interviewed. In response to the wound spray incident, the DON stated there should have been follow up, the provider and poison control should have been notified to provide further direction. In response to the abuse allegation, the DON stated staff are in an environment with vulnerable adults, when they hear something, we must investigate it and find the cause of the statement. The nurse should have asked more about it and she may have gotten an answer right away. The nurse should have reported incidents. RN-B was contacted for an interview but did not return the call. Facility Abuse Prohibition/Vulnerable Adult Policy dated 02/25, directs all staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin. A supervisor will be notified immediately and will assess the situation to determine if any emergency treatment or action is required. Staff will take steps to protect residents from subsequent incidents while the matter is being investigated.	F 610		
F 684 SS=D	Quality of Care	F 684		4/25/25

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F 684	Continued From page 10 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess and monitor a resident for bruises, pulse oximeter alarms and after ingesting wound spray for 1 of 3 residents (R1) reviewed for assessment and monitoring. Findings include: Gentell Dermal Wound Cleanser is a skin cleanser for all types of wounds. According to the gentell product information website, the ingredients include purified water, laurel glucoside, cocamidopropyl betaine, sorbitol, sodium laureth sulfate, polysorbate-80 lactic acid, triethanolamine, imidazolindinyl urea, disodium EDTA and methylparaben. The bottle indicates to seek medical attention or contact the poison control center if swallowed. R1's quarterly Minimum Data Set (MDS) assessment dated 3/12/25, indicated R1 was severely cognitively impaired and was independent in activities of daily living besides toileting. R1's face sheet dated 4/21/25, indicated R1 had	F 684	R1 discharged from facility on 4/13/2025. RN-A was suspended pending investigation and brought back to duty once completed education and having received corrective action. ACP Social Worker was provided education on reporting unusual occurrences during her visits, including if residents ingest something that is a non-food item. Skin audit completed on like-residents. Room audits of like-residents completed to ensure chemicals are out of resident reach. Skin Assessment and Wound Management & Notification of Change policies were reviewed with no changes. All residents have the potential to be affected by this deficient practice. Staff were educated on assessing skin, pulse oximeter alarms, and Notification of Change policy. DON or designee will conduct random	

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F 684	Continued From page 11 diagnoses of chronic respiratory failure, paranoid schizophrenia, tracheostomy (procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck) status and dependence on ventilatora (medical device used to help a person breathe when they are unable to do so on their own or when their breathing is inadequate) status. R1's care plan dated 4/21/25, indicated R1 "would benefit from having all cares done by a female staff to include bathing, showering, grooming and dressing due to past trauma history of sexual assault from a male." R1's progress notes lacked any documentation about a bruise on R1's right upper arm. The progress notes lacked documentation about staff-to-resident abuse allegations or investigation. There were no notes documenting R1 sprayed wound cleanser into her mouth, if the physician was notified of the event or if poison control was contacted for further instruction. R1's weekly skin assessments dated 3/28/25 and 4/4/25, lacked documentation about a bruise on R1's right upper arm. R1's respiratory therapy order dated 11/22/24, indicated R1's ventilator settings and to have the continuous oximeter on while using the ventilator to keep oxygen saturations at 92% or higher. R1's physician order dated 3/27/25, indicated to cleanse the wound on the top of the left foot with wound cleanser. Video footage from the camera in R1's room, dated 3/29/25 at 8:53 p.m., showed R1 in bed,	F 684	audits to ensure proper assessment, monitoring, and implementation of interventions for residents with skin integrity issues, skin audits, and audits to ensure chemicals are not within residents reach in room. Audits will be completed weekly x4 weeks. Audit results will be reviewed by QAPI Committee for further recommendations.	

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F 684	Continued From page 12 family member (FM)-A, sitting in the room and registered nurse (RN)-A standing by the door and looking towards R1. R1 raised her right arm, FM-A pointed to R1's arm and said "What happened there? Ouch look at the back of your arm. There is a good size bruise. Is that from a fall?" RN-A asked, "Did you bump your arm somewhere?" RN-A walked to R1 and looked closely at the bruise and touched R1's arm. R1 stated "If men just leave me alone at night." FM-A asked, "who is bothering you at night?" R1 states "some guy." RN-A did not say anything, began walking away from R1, exited the room and closed the door. A photo from FM-A dated 3/29/25 at 8:55 p.m., showed R1's right upper arm. The dark purple bruise was circular and measured at least one inch by one inch. Video footage from the camera in R1's room, dated 4/3/25 at unknown time, showed R1 in bed with a psychologist sitting in a chair next to her. There was a bedside table in between R1 and the psychologist. There was a spray bottle and a water bottle on the bedside table. R1 pointed to the spray bottle and the psychologist handed the bottle to her. R1 proceeded to put her mouth around the nozzle and spray it into her mouth. R1 grimaces and says "ick." The psychologist gave R1 the water bottle. Video footage from the camera in R1's room, dated 4/3/25 at 9:54 p.m., showed R1 lying in bed, FM-A and FM-B standing by the bed and RN-B standing by the door. FM-A stated "I've seen her take a drink of this [wound cleanser spray] and we have that on camera. I was reading it, and it says if swallowed seek medical attention	F 684		

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F 684	Continued From page 13 and call the poison control center. Did anyone report today that she sprayed some in her mouth?" RN-B said, "I was not aware that she drank that, do you still have that on camera?" RN-B asked to see the camera footage. FM-A says she wants to get her mother's consent before sharing the video and she would rather report the concern to the nurse manager first. Video footage from the camera in R1's room, dated 3/30/25 at 12:28 a.m., showed R1 lying in bed and sleeping. The pulse oximeter alarmed 32 times in the 5 minute and 22 second video. No staff responded to the alarm. The vitals on the pulse oximeter were unable to be read due to the glare of the camera. Video footage from the camera in R1's room, dated 3/30/25 at 12:58 a.m., showed R1 lying in bed and sleeping. The pulse oximeter alarmed 36 times in the 6 minutes and 3 second video. No staff responded to the alarm. The vitals on the pulse oximeter were unable to be read due to the glare of the camera. On 4/22/25 at 3:04 p.m., the nurse practitioner was interviewed. She could not remember if the facility updated her about the wound spray ingestion and she was not able to look in her (R1's) electronic health record for any related notes. The nurse practitioner stated she would potentially call poison control if a resident swallowed wound spray. On 4/22/25 at 3:16 p.m., the psychologist was interviewed. She could not remember if she reported the wound spray ingestion incident to facility staff or not.	F 684		

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F 684	Continued From page 14 On 4/23/25 at 8:35 a.m., RN-A was interviewed. She stated she was not aware that R1 sprayed wound cleanser in her mouth. RN-A stated R1 may have had a bruise that could have been from a fall or her insulin injections, but she was unsure of the cause. She stated the bruise was not new and she notified the nurse manager of the bruise. The nurse manager would decide if the bruise needed to be monitored or documented. RN-A stated she was not aware that R1 claimed a man gave her the bruise. On 4/23/25 at 10:00 a.m., the assistant director of nursing (ADON) was interviewed. The ADON stated there was no documentation for the bruise. The ADON stated since R1 has a history of bruises, she prefers to have her insulin injections on her arms and the bruise went away. The ADON said he was not aware of R1 ingesting wound spray but he would expect staff to call the provider and monitor vital signs. The ADON did not know if poison control was called. The ADON stated R1 does have a history of delusions, but the nurse should not have made any assumptions, and staff should have looked into it further. The ADON verified the alarm in the videos was the pulse oximeter alarm. The ADON stated probe may have needed readjustment, and staff should have gone in to check on her. On 4/23/25 at 10:14 a.m., the administrator was able to verify R1 was using Gentell Dermal Wound Cleanser on 4/3/25, (date of video footage). On 4/23/25 at 10:26 a.m., the director of nursing (DON) was interviewed. The DON stated he would advocate for more documentation. In response to the wound spray incident, the DON	F 684		

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F 684	Continued From page 15 stated there should have been follow up, the provider and poison control should have been notified to provide further direction. In response to the abuse allegation, the DON stated staff are in an environment with vulnerable adults, when they hear something, must investigate it and find the cause of the statement. The DON stated nurse should have asked more about it and she may have gotten an answer right away. For the pulse oximeter alarms, the DON stated it is always better to respond immediately, assess and fix the issue and find out if it is a pattern. RN-B was contacted for an interview but did not return the call. The Skin Assessment and Wound Management policy last revised 2/2025, directs when a significant alteration in skin integrity is noted such as large or multiple bruises, the following actions will be taken: notify provider, initiate skin and wound evaluation, notify nurse manager, update care plan. A policy or procedure pertaining to ingesting chemicals and pulse oximeter alarms was requested but not provided.	F 684		

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2 000	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 4/21/25-4/23/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H52953109C (MN00112504). No licensing order issued. H52953109C (MN00112355)/ H52953109C (MN00112345) with a licensing order issued at 0875. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 875	MN Rule 4658.0520 Subp. 2 I Adequate and Proper Nursing Care; Monitor TPR Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess and monitor a resident for bruises, pulse oximeter alarms and after ingesting wound spray for 1 of 3 residents (R1) reviewed for assessment and monitoring. Findings include: Gentell Dermal Wound Cleanser is a skin cleanser for all types of wounds. According to the gentell product information website, the ingredients include purified water, laurel glucoside, cocamidopropyl betaine, sorbitol, sodium laureth sulfate, polysorbate-80 lactic acid,	2 875	Corrected.	4/25/25

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT ST PAUL LLC	420 MARSHALL AVENUE SAINT PAUL, MN 55102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 875	Continued From page 3 triethanolamine, imidazolindinyl urea, disodium EDTA and methylparaben. The bottle indicates to seek medical attention or contact the poison control center if swallowed. R1's quarterly Minimum Data Set (MDS) assessment dated 3/12/25, indicated R1 was severely cognitively impaired and was independent in activities of daily living besides toileting. R1's face sheet dated 4/21/25, indicated R1 had diagnoses of chronic respiratory failure, paranoid schizophrenia, tracheostomy (procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck) status and dependence on ventilatora (medical device used to help a person breathe when they are unable to do so on their own or when their breathing is inadequate) status. R1's care plan dated 4/21/25, indicated R1 "would benefit from having all cares done by a female staff to include bathing, showering, grooming and dressing due to past trauma history of sexual assault from a male." R1's progress notes lacked any documentation about a bruise on R1's right upper arm. The progress notes lacked documentation about staff-to-resident abuse allegations or investigation. There were no notes documenting R1 sprayed wound cleanser into her mouth, if the physician was notified of the event or if poison control was contacted for further instruction. R1's weekly skin assessments dated 3/28/25 and 4/4/25, lacked documentation about a bruise on R1's right upper arm.	2 875		

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2 875	Continued From page 4 R1's respiratory therapy order dated 11/22/24, indicated R1's ventilator settings and to have the continuous oximeter on while using the ventilator to keep oxygen saturations at 92% or higher. R1's physician order dated 3/27/25, indicated to cleanse the wound on the top of the left foot with wound cleanser. Video footage from the camera in R1's room, dated 3/29/25 at 8:53 p.m., showed R1 in bed, family member (FM)-A, sitting in the room and registered nurse (RN)-A standing by the door and looking towards R1. R1 raised her right arm, FM-A pointed to R1's arm and said "What happened there? Ouch look at the back of your arm. There is a good size bruise. Is that from a fall?" RN-A asked, "Did you bump your arm somewhere?" RN-A walked to R1 and looked closely at the bruise and touched R1's arm. R1 stated "If men just leave me alone at night." FM-A asked, "who is bothering you at night?" R1 states "some guy." RN-A did not say anything, began walking away from R1, exited the room and closed the door. A photo from FM-A dated 3/29/25 at 8:55 p.m., showed R1's right upper arm. The dark purple bruise was circular and measured at least one inch by one inch. Video footage from the camera in R1's room, dated 4/3/25 at unknown time, showed R1 in bed with a psychologist sitting in a chair next to her. There was a bedside table in between R1 and the psychologist. There was a spray bottle and a water bottle on the bedside table. R1 pointed to the spray bottle and the psychologist handed the bottle to her. R1 proceeded to put her mouth around the nozzle and spray it into her mouth. R1	2 875		

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2 875	Continued From page 5 grimaces and says "ick." The psychologist gave R1 the water bottle. Video footage from the camera in R1's room, dated 4/3/25 at 9:54 p.m., showed R1 lying in bed, FM-A and FM-B standing by the bed and RN-B standing by the door. FM-A stated "I've seen her take a drink of this [wound cleanser spray] and we have that on camera. I was reading it, and it says if swallowed seek medical attention and call the poison control center. Did anyone report today that she sprayed some in her mouth?" RN-B said, "I was not aware that she drank that, do you still have that on camera?" RN-B asked to see the camera footage. FM-A says she wants to get her mother's consent before sharing the video and she would rather report the concern to the nurse manager first. Video footage from the camera in R1's room, dated 3/30/25 at 12:28 a.m., showed R1 lying in bed and sleeping. The pulse oximeter alarmed 32 times in the 5 minute and 22 second video. No staff responded to the alarm. The vitals on the pulse oximeter were unable to be read due to the glare of the camera. Video footage from the camera in R1's room, dated 3/30/25 at 12:58 a.m., showed R1 lying in bed and sleeping. The pulse oximeter alarmed 36 times in the 6 minutes and 3 second video. No staff responded to the alarm. The vitals on the pulse oximeter were unable to be read due to the glare of the camera. On 4/22/25 at 3:04 p.m., the nurse practitioner was interviewed. She could not remember if the facility updated her about the wound spray ingestion and she was not able to look in her (R1's) electronic health record for any related	2 875		

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2 875	Continued From page 6 notes. The nurse practitioner stated she would potentially call poison control if a resident swallowed wound spray. On 4/22/25 at 3:16 p.m., the psychologist was interviewed. She could not remember if she reported the wound spray ingestion incident to facility staff or not. On 4/23/25 at 8:35 a.m., RN-A was interviewed. She stated she was not aware that R1 sprayed wound cleanser in her mouth. RN-A stated R1 may have had a bruise that could have been from a fall or her insulin injections, but she was unsure of the cause. She stated the bruise was not new and she notified the nurse manager of the bruise. The nurse manager would decide if the bruise needed to be monitored or documented. RN-A stated she was not aware that R1 claimed a man gave her the bruise. On 4/23/25 at 10:00 a.m., the assistant director of nursing (ADON) was interviewed. The ADON stated there was no documentation for the bruise. The ADON stated since R1 has a history of bruises, she prefers to have her insulin injections on her arms and the bruise went away. The ADON said he was not aware of R1 ingesting wound spray but he would expect staff to call the provider and monitor vital signs. The ADON did not know if poison control was called. The ADON stated R1 does have a history of delusions, but the nurse should not have made any assumptions, and staff should have looked into it further. The ADON verified the alarm in the videos was the pulse oximeter alarm. The ADON stated probe may have needed readjustment, and staff should have gone in to check on her. On 4/23/25 at 10:14 a.m., the administrator was	2 875		

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2 875	Continued From page 7 able to verify R1 was using Gentell Dermal Wound Cleanser on 4/3/25, (date of video footage). On 4/23/25 at 10:26 a.m., the director of nursing (DON) was interviewed. The DON stated he would advocate for more documentation. In response to the wound spray incident, the DON stated there should have been follow up, the provider and poison control should have been notified to provide further direction. In response to the abuse allegation, the DON stated staff are in an environment with vulnerable adults, when they hear something, must investigate it and find the cause of the statement. The DON stated nurse should have asked more about it and she may have gotten an answer right away. For the pulse oximeter alarms, the DON stated it is always better to respond immediately, assess and fix the issue and find out if it is a pattern. RN-B was contacted for an interview but did not return the call. The Skin Assessment and Wound Management policy last revised 2/2025, directs when a significant alteration in skin integrity is noted such as large or multiple bruises, the following actions will be taken: notify provider, initiate skin and wound evaluation, notify nurse manager, update care plan. A policy or procedure pertaining to ingesting chemicals and pulse oximeter alarms was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could provide education to all staff regarding answering equipment alarms, assessment and monitoring of	2 875		

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2 875	Continued From page 8 bruises, and consumption of chemicals The DON or designee could monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 875		