# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** H52954945M
**Compliance #:** H52959048C

**Date Concluded:** February 4, 2026

**Name, Address, and County of Licensee Investigated:**
The Emeralds at St. Paul
420 Marshall Avenue
St. Paul, MN 55102
Ramsey County

**Facility Type:** Nursing Home

**Evaluator's Name:** Yolanda Dawson, RN
Special Investigator
Rhylee Gilb, RN
Special Investigator

**Finding:** Substantiated, facility responsibility

**Nature of Investigation:**
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

**Initial Investigation Allegation(s):**
The facility neglected a resident when they failed to address a change in the resident's skin condition leading to bilateral wounds on the resident's bridge of nose and left ear.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility unlicensed staff and nurses failed to properly monitor and assess the resident's skin condition. The resident required staff assistance to put on and take off her glasses and hearing headset. While the resident preferred to have her glasses and headset on at all times, staff did not take the glasses off often enough to relieve pressure and prevent skin breakdown. Nursing did not implement appropriate interventions regarding the glasses to prevent skin breakdown from occurring to the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of surveyor notes and documents to include, resident record, hospital records, facility internal investigation, and related facility policy and procedures.

The resident resided in a skilled nursing facility. The resident's diagnoses included stroke, acute and chronic respiratory failure, tracheostomy, ventilator dependent, anxiety, type 2 diabetes, and moderate protein-calorie malnutrition. The resident's care plan included assistance with all activities of daily living. The resident's assessment indicated the resident was non-verbal but mouthed and wrote words to communicate. The resident had anxiety that would heighten during staff interaction with cares.

The resident had a six week hospitalization for infections and returned to the facility. The hospital discharge orders included barrier cream twice daily and as needed for any soiling. There were no facial wounds.

The resident's readmission assessment indicated the resident used glasses daily. The assessment indicated the resident was at risk for skin breakdown due to immobility and incontinence. The assessment did not indicate evidence of any facial pressure injury.

The resident's care plan indicated the resident used glasses for vision impairment and was severely hard of hearing. The resident used a pocket talker to help with hearing and had a history of refusing to remove the pocket talker.

The resident's progress notes indicated the resident was at the facility approximately four weeks before another hospitalization. Review of progress notes failed to indicate any skin concerns, aside from the sacrum pressure injury, until one week after readmission.

A wound meeting note one week after readmission indicated the resident readmitted to the facility from the hospital with a blister to her right forearm and was being treated. The same date as the wound note, nursing updated the resident's care plan to include a history of refusing to remove her glasses. The care plan lacked any intervention to manage her behavior or monitor her skin condition due to her non-compliance.

Occupational therapy (OT) notes indicated 10 days prior to hospitalization, the resident refused to allow removal of her glasses and pocket talker to wash her face. Four days later, another note indicated again the resident refused to allow OT to wash her face.

Nursing notes failed to indicate the resident had non-compliance with removing her glasses and failed to note any non-compliance was washing her face and hygiene. Additionally, nursing continued to document a weekly wound note, but only addressing the blister on her forearm. The notes lacked any indication of concern with the resident's glasses causing injury to her face.

The resident's hospital record indicated the resident admitted for gastrointestinal bleeding and septic shock (life-threatening total body infection). The emergency room note indicated the resident presented to the hospital with significant skin breakdown to the nasal bridge in the shape of her glasses nose pads with the bone visible. Hospital admission wound photos showed bloody deep impressions on both sides of the resident's nose located where glasses nose pads would rest. The left ear photo showed flaking

yellow crust on the inside of the ear with two dark impression marks behind the ear from the headphone set.

The resident's hospital record indicated the resident died five days later.

The facility made revisions to the resident's care plan after the resident's hospitalization to include an intervention of encouraging the resident to remove her glasses while resting and at bedtime.

Surveyor interviews indicated multiple nurses and staff members stated the resident wore her glasses and hearing headphone set 24 hours a day. It was well known among staff that she preferred to keep both glasses and headset on at all times, and she would get upset if they were removed. One nurse stated seven days before her hospital admission, redness without open skin was noted on the resident's bridge of her nose and lotion was applied. The nurse stated she did not measure the area and did not document her findings.

During an interview, the director of nursing (DON) stated there was no written report of redness or skin breakdown on the resident's face. The DON stated there was a time they talked about there being redness on the bridge of her nose, and they put a cream on it, and it started going away. The day the resident went to the hospital the nurse cleaned the resident's face, and she did not see an open area.

During investigative interviews, nurse-1, nurse-2, and an unlicensed staff member stated they had assisted the resident and had not seen redness or signs of skin breakdown on the resident's nose or ear during cares and assessments.

During an interview, nurse-2 stated he was assigned to do the resident's weekly assessment and stated he did not see any redness or skin breakdown on the resident's nose. Nurse-2 stated staff did take the resident's glasses off to clean them, otherwise the resident was allowed to wear her glasses whenever she wanted to wear them.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

**Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.**
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

**Neglect: Minnesota Statutes, section 626.5572, subdivision 17**
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

**Vulnerable Adult interviewed**: No, deceased.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: Not applicable.he

**Action taken by facility:**
Everyone received education on the importance of weekly skin assessment.

**Action taken by the Minnesota Department of Health:**
MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, and substantiated facility noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies. You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney
Saint Paul City Attorney
Saint Paul Police Department
Minnesota Board of Nursing

Minnesota State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**09/04/2025** |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **The Emeralds at St Paul LLC** | **420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| 20000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H52954945M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.<br><br>The following correction order is issued/orders are issued for #H52954945M, tag identification 21850. | 20000 | | |



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

Minnesota State Department of Health

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| 20000 | Continued from page 1<br><br>The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul .htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. 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. | 20000 | | |
| 21850 | Patients & Residents of HC Fac.Bill of Rights<br><br>CFR(s): MN St. Statute 144.651 Subd. 14<br><br>Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.<br><br>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. | 21850 | | |