



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 28, 2025

Administrator
The Emeralds at St Paul LLC
420 MARSHALL AVENUE
SAINT PAUL, MN 55102

RE: CCN: 245295

Cycle Start Date: June 25, 2025

Dear Administrator:

On July 17, 2025, we notified you a remedy was imposed. On August 22, 2025, the Minnesota Departments of Health and Public Safety 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 21, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 12, 2025 will be discontinued as of August 21, 2025. (42 CFR 488.417 (b))

In our letter of July 17, 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 June 25, 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,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

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 17, 2025

Administrator

The Emeralds at St. Paul

420 MARSHALL AVENUE

SAINT PAUL, MN 55102

RE: CCN: 245295

Cycle Start Date: June 25, 2025

Dear Administrator:

On June 25, 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 immediate jeopardy (Level J), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other 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), whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On June 14, 2025, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

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 Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 25, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 25, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 25, 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.

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

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 St. Paul LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 25, 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.

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

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.

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

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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 25, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

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. 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.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER The Emeralds at St Paul LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F0000	<p>INITIAL COMMENTS</p> <p>On 6/23/25 to 6/25/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed H52957567C (MN00113912) and H52957807C (MN00114045).and a deficiency was issued at F689 at PAST NON-COMPLIANCE.</p> <p>In addition, the follow deficiencies were issued at F609 and F610</p> <p>Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance. However, a plan of correction for the other citations issued is required and will serve as your allegation of compliance.</p> <p>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.</p>	F0000		
F0609 SS = D	<p>Reporting of Alleged Violations</p> <p>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§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</p>	F0609	<p>F609 – Timely Reporting</p> <p>R1 remains the facility.</p> <p>Nurse was suspended pending investigation and brought back to duty once completed education and having received final written warning. Receptionist received education related to timely reporting and was provided with a final written warning.</p> <p>The facility's Abuse and Elopement Policies were reviewed and remain current.</p>	07/28/2025

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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F0609 SS = D	<p>Continued from page 1 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.</p> <p>§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.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, and document review, the facility failed to report lack of supervision incident (6/7/25) and elopement (6/13/25) was reported timely to the State Agency (SA) for 1 of 1 resident (R1) reviewed for elopement.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) dated 4/16/25, indicated R1 had intact cognition, no behaviors, used a walker and wheelchair, was independent with walking and wheeling, had no upper or lower extremity impairments, and used a wander/elopement alarm daily. Diagnoses included diabetes, dementia, malnutrition, anxiety disorder, depression, and post-traumatic stress disorder (PTSD).</p> <p>R1's most recent elopement assessment on 11/13/24, identified R1 had a habit/history of wandering or attempts to leave the unit/building and was able to ambulate or able to self-propel his wheelchair.</p> <p>R1's nurse progress note dated 6/7/25 at 9:34 a.m., identified R1 was found seated at the back of the building near the kitchen door. Reception staff reported R1 left the building around 5:30 a.m. and had his Wanderguard in his pocket. R1 returned at 7:20 a.m. and appeared to be fine. R1 did not recall how he exited the building. The Wanderguard had been secured on his ankle. Would do 15-minute safety checks every shift. Director of Nursing (DON) and nurse manager were notified.</p>	F0609	<p>Continued from page 1</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>Staff were educated on timely reporting, 1:1 versus 15-minute safety checks, Elopement Policy, MN Abuse policy and Reporting, and Wanderguard transmitter placement process if resident has a pattern of removing.</p> <p>DON or designee will conduct audits to ensure timely reporting. Audits will be completed weekly x4 weeks. Audit results will be reviewed by QAPI Committee for further recommendations.</p> <p>Date Certain: 07/28/2025</p>	

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F0609 SS = D	<p>Continued from page 2</p> <p>R1's administrator progress notes on 6/7/25 at 9:34 a.m., R1 stated he was trying to go outside to smoke and mistakenly went to employee smoking area instead of resident smoking area. R1 stated he was not trying to leave the facility. Staff confirmed R1 was smoking and returned inside afterward. R1 was reoriented to resident smoking area.</p> <p>During an interview on 6/24/25 at 8:00 a.m., the administrator identified the video footage of R1's 6/7/25 incident was not reviewed and was no longer available to be viewed</p> <p>R1's smoking assessment dated 3/12/25, indicated R1 had cognitive loss, smoked two to five cigarettes a day, smoked morning, afternoon, evenings, and nights, was found to be able to smoke safely and independently. However, the smoking assessment did not define the location where R1 was deemed safe to smoke and there was no indication the facility had thoroughly investigated the incident on how/why R1 was found in the employee smoking area.</p> <p>During an observation on 6/24/25 at approximately 1:00 p.m. the facility's outside secured resident smoking area noted an area of grass and concrete with locked gates surrounding the area. The back of the facility where R1 was found unsupervised in the staff smoking area was facing the alley where there was also delivery area and had ungated concrete steps to the lower level of the facility, dumpster's. There was a locked and coded door to re-enter the facility. There was no resident access areas accept from the front side of the building which would entail crossing a parking lot, public sidewalk, and public alley.</p> <p>During an interview on 6/25/25 at 2:13 p.m., receptionist (RCP)-C indicated she worked the night shift of 6/6/25 at 11:00 p.m. to 7:00 a.m. on 6/7/25. RCP-C was aware R1 went outside early that morning because she had to shut the door alarm off. RCP-C identified she thought it was about 6:50 a.m. or 6:55 a.m. RCP-C had historically been directed by "someone" (could not recall who" that if a resident were to go outside she was supposed to not "chase" after the resident but instead report it to the nurse. When RCP-C called the charge nurse (was not sure which nurse she talked to) she was told, "this is just what he [R1] does" with no further direction given. RCP-C further identified no one was ever available to relieve her when she took her breaks, so would leave the floor unsupervised during those times.</p> <p>During an interview on 6/24/25 at 11:18 a.m.,</p>	F0609		

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F0609 SS = D	<p>Continued from page 3</p> <p>registered nurse (RN)-A identified she was working day shift on 6/7/25 and a resident informed her at approximately 7:10 a.m. that R1 was sitting outside the back of the building by the kitchen door and employees smoking area and had been out there since 5:30 a.m. RN-A indicated R1 was not in a resident area or a safe area and should not have been there. R1 was noted to have his Wanderguard in his pocket and it alarmed when he entered the building. RN-A stated R1 did not know how he had gotten out of the building or how he had gotten to the back of the building. RN-A indicated she would consider R1's leaving the building unsupervised an elopement and notified the DON and the nurse manager; implemented 15-minute checks; and reapplied R1's Wanderguard.</p> <p>The Minnesota Adult Abuse Reporting Center did not contain any facility reported incidents or investigations related to R1's reported elopement on 6/7/25.</p> <p>A facility reported Vulnerable Adult Maltreatment Report submitted to the State Agency on 6/14/25 at 3:10 p.m., identified on 6/13/25 at approximately 6:00 p.m., R1 was able to elope through the front doors of the facility and make it down to the corner of Western and Marshall Avenue in his wheelchair.</p> <p>R1's behavior progress noted on 6/14/25 at 1:13 p.m., indicated social service designee (SSD) was informed by another resident (later identified as R4) that R1 had eloped from the facility the evening prior [6/13/25]. R4 found R1 on the corner of [intersection of two streets] between 6:30 p.m. - 7:00 p.m. R1 was noted to be in his wheelchair and R4 guided R1 back to the facility.</p> <p>During an interview on 6/23/25 at 4:38 p.m., receptionist (RCP)-A acknowledged working the evening of 6/13/25. RCP-A indicated she did not see R1 because she was on break, and he did not have a Wanderguard on so the Wanderguard system did not alarm when he left the building. No one had told her he left. RCP-A indicated she took her break between 8:00 p.m. and 8:30 p.m., and when she returned, she noted R1 coming in the front door, but the door did not alarm. RCP-A stated she did not report R1 being outside the building unsupervised the evening of 6/13/25. RCP-A stated she was not aware of R1 leaving the facility unsupervised on 6/7/25.</p> <p>During an interview on 6/24/25 at 9:51 a.m., nurse manager (NM)-A, indicated R1 had attempted to elope before so required a Wanderguard but also has a history</p>	F0609		

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F0609 SS = D	<p>Continued from page 4 of removing it or cutting it off. NM-A indicated knowledge R1's 6/7/25 incident and initiated 15-minute checks but did not know if it was reported to the State Agency. NM-A identified R1's elopement on 6/13/25 was not reported to nursing until the next day and should have been reported immediately.</p> <p>During an interview on 6/24/25 at 2:37 p.m., the social service director (SSD) indicated she was informed of R1's 6/7/25 incident of the leaving the building on 6/9/25 during an interdisciplinary team (IDT) meeting. and would consider that incident an elopement but when discussed, the IDT did not all agree, and the administrator had the final say and determined it was not an elopement because he was still on the property and did not have any injuries. The SSD reported R1 being outside in that area was not a safe area as there have been drug addicts in that area digging through the facility trash, R1 could have fallen and hit his head, and it was fortunate he ended up where he did instead of wandering further off the campus. SSD stated, "if we would have taken the necessary steps on the seventh [6/7/25], he would not have gotten out the second time [6/13/25].</p> <p>During an interview on 6/24/25 at 3:58 p.m., the DON indicated on 6/13/25 when R1 eloped, the receptionist did not report R1 leaving the facility unsupervised to anyone. The DON was aware of R1's 6/7/25 incident but did not think he was aware of the details. The DON understood R1 left the facility out the front door early morning to smoke and staff found him and brought him back in. The DON indicated if a resident is found outside of where they should not be and had breached the facility security, it would be considered an elopement. The DON further identified R1 is not safe to be outside unsupervised due to R1's fluctuating cognitive status and R1's elopements are a "serious concern". The DON indicated his expectation would be to immediately report any elopement to the State Agency immediately but was not submitted timely.</p> <p>During an interview on 6/24/25 at 3:24 p.m., the administrator indicated the social services director (SSD) notified her of R1's 6/13/25 elopement on 6/14/25 early afternoon but should have been notified immediately. Further noted about a week prior (6/7/25), R1 "attempted to go out and smoke and was redirected back in" but was not aware he was outside for approximately two hours and did not feel the area was unsafe as it was on campus. The administrator verified the area that R1 was found in was in the back of the facility with concrete stairs close, a delivery area, next to an alley, and near the employee smoking area</p>	F0609		

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F0609 SS = D	Continued from page 5 but did not report the incident to the State Agency. The facility policy titled Elopement Policy last reviewed 6/2023, included Post elopement assessment: after the resident is located and returned to the unity, assess for changes identifying the following items: observed behaviors or resident statements; objective data, underlying illnesses, or diagnoses; physical assessment; general appearance. Document findings in an interdisciplinary team progress note (IPN) The administrator, or designee, shall notify State Agency, as necessary by state requirement, family/family representative, and physician. The facility policy Abuse, Prohibition/Vulnerable Adult Policy last reviewed 4/2025, included All staff are responsible for reporting any situation that is considered abuse or neglect; a supervisor will be notified immediate and will assess the situation to determine if any emergency treatment or action is required; notification of the facility administrator will occur immediately for any incidents of resident neglect; if the administrator is absent or unavailable, staff will follow the chain of command for notification. Incidents to be reported: neglect - is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress; elopement [no definition provided]. When to report to the State Agency includes suspicion of neglect, exploitation, or misappropriation of proper must be reported to OHFC online reporting process not later than 2 hours if the incident resulted in serious bodily injury or if the incident did not cause serious bodily injury, reports must be made within 24 hours. Investigation will begin immediately in accordance with Federal law.	F0609		
F0610 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,	F0610	F610 – Investing Alleged Abuse R1 remains at facility. Nurse was suspended pending investigation and brought back to duty once completed education and having received final written warning. Receptionist received education related to timely reporting and was provided with a final written warning. The facility's Abuse and Elopement Policies were	07/28/2025

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F0610 SS = D	<p>Continued from page 6 exploitation, or mistreatment while the investigation is in progress.</p> <p>§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.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review the facility failed to ensure a thorough investigation for an incident that involved the lack of required supervision for 1 of 3 residents (R1) reviewed who required supervision. R1 was found outside the facility on 6/7/25 in an unsafe unauthorized area.</p> <p>Findings include</p> <p>R1's quarterly Minimum Data Set (MDS) dated 4/16/25, indicated R1 had intact cognition, no behaviors, used a walker and wheelchair, was independent with walking and wheeling, had no upper or lower extremity impairments, and used a wander/elopement alarm daily. Diagnoses included diabetes, dementia, malnutrition, anxiety disorder, depression, and post-traumatic stress disorder (PTSD).</p> <p>R1's nurse progress note dated 6/7/25 at 9:34 a.m., identified R1 was found seated at the back of the building near the kitchen door. Reception staff reported R1 left the building around 5:30 a.m. and had his Wanderguard in his pocket. R1 returned at 7:20 a.m. and appeared to be fine. R1 did not recall how he exited the building. The Wanderguard had been secured on his ankle. Would do 15-minute safety checks every shift. Director of Nursing (DON) and nurse manager were notified.</p> <p>R1's administrator progress notes on 6/7/25 at 9:34 a.m., R1 stated he was trying to go outside to smoke and mistakenly went to employee smoking area instead of resident smoking area. R1 stated he was not trying to leave the facility. Staff confirmed R1 was smoking and returned inside afterward. R1 was reoriented to resident smoking area.</p> <p>During an interview on 6/24/25 at 8:00 a.m., the administrator identified the video footage of R1's 6/7/25 incident was not reviewed and was no longer</p>	F0610	<p>Continued from page 6 reviewed and remain current.</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>Staff were educated on thorough investigation of alleged lack of supervision, 1:1 versus 15-minute safety checks, Elopement Policy, MN Abuse policy and Reporting, and Wanderguard transmitter placement process if resident has a pattern of removing.</p> <p>DON or designee will conduct random audits to ensure proper assessment, monitoring, and implementation of interventions for residents with wanderguards and/or at risk for elopement or lack of supervision. Audits will be completed weekly x4 weeks. Audit results will be reviewed by QAPI Committee for further recommendations.</p> <p>Date Certain: 07/28/2025</p>	

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F0610 SS = D	<p>Continued from page 7 available to be viewed</p> <p>R1's smoking assessment dated 3/12/25, indicated R1 had cognitive loss, smoked two to five cigarettes a day, smoked morning, afternoon, evenings, and nights, was found to be able to smoke safely and independently. However, the smoking assessment did not define the location where R1 was deemed safe to smoke and there was no indication the facility had thoroughly investigated the incident on how/why R1 was found in the employee smoking area.</p> <p>During an observation on 6/24/25 at approximately 1:00 p.m. the facility's secured resident smoking area noted an area of grass and concrete with locked gates surrounding the area. The back of the facility where R1 was found unsupervised in the staff smoking area was facing the alley where there was also delivery area and had ungated concrete steps to the lower level of the facility, dumpster's. There was a locked and coded door to re-enter the facility. There was no resident access areas accept from the front side of the building which would entail crossing a parking lot, public sidewalk, and public alley.</p> <p>During an interview on 6/25/25 at 2:13 p.m., receptionist (RCP)-C indicated she worked the night shift of 6/6/25 at 11:00 p.m. to 7:00 a.m. on 6/7/25. RCP-C was aware R1 went outside early that morning because she had to shut the door alarm off. RCP-C identified she thought it was about 6:50 a.m. or 6:55 a.m. RCP-C had historically been directed by "someone" (could not recall who) that if a resident were to go outside she was not supposed to "chase" after the resident but instead report it to the nurse. When RCP-C called the charge nurse (not sure which nurse she talked to) she was told, "this is just what he [R1] does" with no further direction given. RCP-C further identified no one was ever available to relieve her when she took her breaks.</p> <p>During an interview on 6/25/25 at 2:03 p.m., RCP-B indicated when she arrived for her shift on 6/7/25 at 7:00 a.m., the night receptionist was not at the front desk, she was not aware of where she was, and the alarm was not sounding. The overnight nurse left but did not report R1 was outside. A resident told RCP-B (but could not recall which resident) that R1 had left the building and was sitting outside in the back of the facility by the alley. RCP-B stated she told R1 that he was not supposed to be out there, it was not safe, and tried to get R1 to come in but he refused to come in. She reported it to the charge nurse. The charge nurse and a nursing assistant (NA) came down and got him back</p>	F0610		

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F0610 SS = D	<p>Continued from page 8 in the building. RCP-B indicated the only way R1 could have gotten out was the front entrance door, down the sidewalk, over a curb, and around to the back-alley way. RCP-B further stated she found an unsigned note on the receptionist desk that said R1 had left the building about 5:00 a.m. but was not sure who wrote the note and threw the note away.</p> <p>During an interview on 6/24/25 at 11:18 a.m., registered nurse (RN)-A identified the receptionist on first floor was responsible for monitoring the Wanderguard system and the doors 24/7. The Wanderguard alarms did not alert to the 2nd, 3rd, or 4th floors so staff would not be aware if a resident tried to get out of the facility through the main entrance on the first floor. RN-A indicated she was working day shift on 6/7/25. At approximately 7:10 a.m. a resident (she could not recall which resident) had informed her that since 5:30 a.m., R1 was sitting outside the back of the building by the kitchen door and employees smoking area. R1 was not in a resident area or a safe area and should not have been there. R1 had his Wanderguard in his pocket and it alarmed when he entered back into the building. R1 did not know how he had gotten out of the building or how he had gotten to the back of the building. RN-A indicated there was not a receptionist at the desk when she arrived for work at approximately 6:50 a.m. and the only way R1 could have gotten out was the front door was someone had to silence the Wanderguard alarm but was not sure who would have done that.</p> <p>During an interview on 6/24/25 at 2:37 p.m., the social service director (SSD) indicated she was informed of R1's 6/7/25 incident of the leaving the building on 6/9/25 during an interdisciplinary team (IDT) meeting. and would consider that incident an elopement but when discussed, the IDT did not all agree, and the administrator had the final say and determined it was not an elopement because he was still on the property and did not have any injuries.</p> <p>During an interview on 6/24/25 at 3:58 p.m., the DON indicated awareness of R1's 6/7/25 incident but did not think he was aware of all of the details. The DON understood R1 left the facility out the front door early morning to smoke and staff found him and brought him back in. The DON indicated if a resident is found outside of where they should not be and had breached the facility security, it would be considered an elopement. The DON further identified R1 is not safe to be outside unsupervised due to R1's fluctuating cognitive status and R1's elopements are a "serious concern". The DON verified an internal investigation</p>	F0610		

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F0610 SS = D	<p>Continued from page 9 was not completed.</p> <p>During an interview on 6/24/25 at 3:24 p.m., the administrator indicated about a week prior (6/7/25), R1 "attempted to go out and smoke and was redirected back in" but was not aware he was outside for approximately two hours and did not feel the area was unsafe as it was on campus. The administrator verified the area that R1 was found at the back of the facility that was not an area for residents and an investigation into the incident was not completed. The administrator also stated she did not view the camera footage to determine how long R1 had been outside behind the facility. The administrator defined an elopement as a resident" gets out of the facility and off the premises" [facility campus].</p> <p>Policies related to risk management, incident reporting, investigation, or resident safety policies were requested but were not received.</p> <p>The facility policy titled Elopement Policy last reviewed 6/2023, included Post elopement assessment: after the resident is located and returned to the unity, assess for changes identifying the following items: observed behaviors or resident statements; objective data, underlying illnesses, or diagnoses; physical assessment; general appearance. Document findings in an interdisciplinary team progress note (IPN) The administrator, or designee, shall notify State Agency, as necessary by state requirement, family/family representative, and physician. The facility policy did not contain the definition of elopement.</p> <p>The facility policy Abuse, Prohibition/Vulnerable Adult Policy last reviewed 4/2025, included All staff are responsible for reporting any situation that is considered abuse or neglect; a supervisor will be notified immediate and will assess the situation to determine if any emergency treatment or action is required; notification of the facility administrator will occur immediately for any incidents of resident neglect; if the administrator is absent or unavailable, staff will follow the chain of command for notification. Investigation will begin immediately in accordance with Federal law.</p>	F0610		
F0689 SS = SQC-J	<p>Free of Accident Hazards/Supervision/Devices</p> <p>CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents.</p>	F0689	"Past Noncompliance - no plan of correction required"	07/22/2025

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F0689 SS = SQC-J	<p>Continued from page 10 The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review, the facility failed to provide adequate supervision and identify a foreseeable hazard for 1 of 3 residents (R1) reviewed who required supervision. R1's was found unsupervised on two occasions; On 6/7/27 while outside in the staff smoking area and on 6/13/25 as a result of nonfunctional wanderguard and the facility not performing physician ordered 15-minute checks was found at a busy intersection. This resulted in an immediate jeopardy for R1 health and safety.</p> <p>The Immediate Jeopardy (IJ) began on 6/7/25, was corrected on 6/14/25 when the facility implemented interventions to prevent recurrence. The Administrator, Director of Nursing (DON), Regional Director of Operations, and Regional Nurse Consultant were notified of the IJ on 6/24/25 at 5:50 p.m. The facility implemented immediate corrective action on 6/14/25 to prevent recurrence, so the IJ was issued at past none compliance.</p> <p>Findings include:</p> <p>R1's Saint Louis University Mental Status Exam dated 7/19/24 (SLUMS- is a screening tool used to detect mild cognitive impairment and dementia in older adults) identified R1's score was indicative of dementia.</p> <p>R1's quarterly Minimum Data Set (MDS) dated 4/16/25, indicated R1 had intact cognition, no behaviors, used a walker and wheelchair, was independent with walking and wheeling, had no upper or lower extremity impairments, and used a wander/elopement alarm daily. The MDS also identified R1 required care and monitoring for diagnoses of diabetes, dementia, malnutrition, anxiety disorder, depression, and post-traumatic stress disorder (PTSD).</p> <p>R1's Care Plan Report focus initiated 7/23/24, identified R1 was at risk for elopement related to diagnoses of bipolar affective disorder (disorder with episodes of mood swings), alcohol abuse, dementia with</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 11 behavioral disturbances, and history of elopement attempt. R1 had a history of cutting off the Wanderguard device (off his person). The goals identified R1 would not leave the building alone and would follow the facility leave of absence (LOA) policy. The interventions initiated on 7/23/24, directed staff to invite R1 to all activities of choice; answer door alarms promptly; monitor Wanderguard per manufacturer's guidelines; new wander guards were kept at the receptionist desk or/and the director of nursing (DON) office; and Wanderguard was to be monitored for proper functioning, placement, and expiration date per orders.</p> <p>R1's most recent elopement assessment on 11/13/24, identified R1 had a habit/history of wandering or attempts to leave the unit/building and was able to ambulate or able to self-propel his wheelchair. The assessment resulted in a score of three which did not meet the facility's guideline of four or greater to indicate at risk for elopement. Despite the score of three, an elopement risk care plan was indicated with the goals and interventions listed in R1's care plan. R1's medical record did not include quarterly elopement assessments for February 2025, May 2025.</p> <p>R1's nurse progress note dated 6/7/25 at 9:34 a.m., written by registered nurse (RN)-A, identified R1 was found seated at the back of the building near the kitchen door. Reception staff reported R1 left the building around 5:30 a.m. and had his Wanderguard in his pocket. R1 returned at 7:20 a.m. and appeared to be fine. R1 did not recall how he exited the building. The Wanderguard had been secured on his ankle. Would do 15-minute safety checks every shift. Director of Nursing (DON) and nurse manager were notified.</p> <p>R1's Medication Administration Record (MAR) dated June 2025, identified an order entered on 6/7/25 directed staff to do hourly safety checks due to increased risk for elopement. Document any exit seeking behaviors or comments in the progress notes and update provider, as needed. Another order entered on 6/7/25 directed staff to do 15-minute checks every shift for confusion and were signed by staff as completed.</p> <p>R1's administrator progress notes on 6/7/25 at 9:34 a.m., R1 stated he was trying to go outside to smoke and mistakenly went to employee smoking area instead of resident smoking area. R1 stated he was not trying to leave the facility. Staff confirmed R1 was smoking and returned inside afterward. R1 was reoriented to resident smoking area.</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 12</p> <p>During an interview on 6/24/25 at 8:00 a.m., the administrator identified the video footage of R1's 6/7/25 incident was not reviewed and was no longer available to be viewed</p> <p>R1's smoking assessment dated 3/12/25, indicated R1 had cognitive loss, smoked two to five cigarettes a day, smoked morning, afternoon, evenings, and nights, was found to be able to smoke safely and independently. However, the smoking assessment did not define the location where R1 was deemed safe to smoke and there was no indication the facility had thoroughly investigated the incident on how/why R1 was found in the employee smoking area. Further, despite R1 going to the wrong smoking area on 6/7/25, R1's record did not include a follow-up assessment that identified if R1 continued to be safe to leave the building to smoke independently after 6/7/25. Additionally even though 15-minute checks were implemented it was not evident R1's care plan was updated with safety interventions to prevent R1 from going to the wrong smoking area.</p> <p>During an observation on 6/24/25 at approximately 1:00 p.m. the facility's secured resident smoking area noted an area of grass and concrete with locked gates surrounding the area. The back of the facility where R1 was found unsupervised in the staff smoking area was facing the alley where there was also delivery area and had ungated concrete steps to the lower level of the facility, dumpster's. There was a locked and coded door to re-enter the facility. There was no resident access areas accept from the front side of the building which would entail crossing a parking lot, public sidewalk, and public alley.</p> <p>During an interview on 6/25/25 at 2:13 p.m., receptionist (RCP)-C indicated she worked the night shift of 6/6/25 at 11:00 p.m. to 7:00 a.m. on 6/7/25. RCP-C was aware R1 went outside early that morning because she had to shut the door alarm off. RCP-C identified she thought it was about 6:50 a.m. or 6:55 a.m. RCP-C had historically been directed by "someone" (could not recall who) that if a resident were to go outside she was not supposed to "chase" after the resident but instead report it to the nurse. When RCP-C called the charge nurse (not sure which nurse she talked to) she was told, "this is just what he [R1] does" with no further direction given. RCP-C further identified no one was ever available to relieve her when she took her breaks, so would leave the floor unsupervised during those times,</p> <p>During an interview on 6/25/25 at 2:03 p.m., RCP-B indicated when she arrived for her shift on 6/7/25 at</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 13</p> <p>7:00 a.m., the night receptionist was not at the front desk, she was not aware of where she was, and the alarm was not sounding. The overnight nurse left but did not report R1 was outside. A resident told RCP-B (but could not recall which resident) that R1 had left the building and was sitting outside in the back of the facility by the alley. RCP-B stated she told R1 that he was not supposed to be out there, it was not safe, and tried to get R1 to come in but he refused to come in. She reported it to the charge nurse. The charge nurse and a nursing assistant (NA) came down and got him back in the building. RCP-B indicated the only way R1 could have gotten out was the front entrance door, down the sidewalk, over a curb, and around to the back-alley way. RCP-B further stated she found an unsigned note on the receptionist desk that said R1 had left the building about 5:00 a.m. but was not sure who wrote the note and threw the note away.</p> <p>During an interview on 6/24/25 at 11:18 a.m., registered nurse (RN)-A identified the receptionist on first floor was responsible for monitoring the Wanderguard system and the doors 24/7. The Wanderguard alarms did not alert to the 2nd, 3rd, or 4th floors so staff would not be aware if a resident tried to get out of the facility through the main entrance on the first floor. RN-A indicated she was working day shift on 6/7/25. At approximately 7:10 a.m. a resident (she could not recall which resident) had informed her that since 5:30 a.m., R1 was sitting outside the back of the building by the kitchen door and employees smoking area. R1 was not in a resident area or a safe area and should not have been there. R1 had his Wanderguard in his pocket and it alarmed when he entered back into the building. R1 did not know how he had gotten out of the building or how he had gotten to the back of the building. RN-A indicated there was not a receptionist at the desk when she arrived for work at approximately 6:50 a.m. and the only way R1 could have gotten out was the front door was someone had to silence the Wanderguard alarm but was not sure who would have done that. RN-A indicated 15-minute checks were implemented and R1's Wanderguard was reapplied.</p> <p>R1's Late Entry behavior progress note for 6/12/25, recorded on 6/14/25 at 7:08 p.m., identified nurse manager was notified that R1 had removed/cut off Wanderguard to right ankle and Wanderguard was reapplied to right ankle. On 6/13/25, at 4:00 p.m., the nurse manager noted R1's Wanderguard was on his bed and R1 was not in his room. R1 was located and the attempt to re-apply the Wanderguard was unsuccessful due to R1 using threats and throwing punches at the nurse manager. R1 was not redirectable and left the room to</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 14 go smoke. Nurse manager updated evening staff to reinforce application of Wanderguard.</p> <p>R1's nurse progress note on 6/13/25 at 10:05 p.m., identified the nurse attempted to place the Wanderguard on R1 but he refused. The nurse tried again after a short while but R1 refused again. R1's record did not identify immediate interventions were implemented as a result of R1 refusing to wear Wanderguard.</p> <p>Observation of facility's video footage of R1's elopement on 6/13/25, identified the following timeline: 8:00 p.m. R4 and visitor leave the facility through the main entrance; 50 seconds later R1 exits through the main entrance and wheels to the right out of sight; at 8:52 p.m. R4 enters the facility through the main entrance; 9:07 p.m. a staff person enters through the main entrance; 9:08 p.m., 1 hour and 16 minute later R1 enters through the main entrance and appears to be talking to someone at the front desk. R1's progress notes did not address R1 exiting the facility on 6/13/25 but identified a note on 6/14/25.</p> <p>R1's behavior progress noted on 6/14/25 at 1:13 p.m., indicated social service designee (SSD) was informed by another resident (later identified as R4) that R1 had eloped from the facility the evening prior (6/13/25). R4 found R1 on the corner of (intersection of two streets) between 6:30 p.m. - 7:00 p.m. R1 was noted to be in his wheelchair and R4 guided R1 back to the facility. R4 reported there was not a receptionist at the desk when they returned. The SSD instructed nurse to apply a Wanderguard on R1 but R1 became combative so the Wanderguard was applied to the wheelchair. A follow up note at 1:29 p.m., identified staff applied a Wanderguard on R1's wheelchair and on R1's left ankle and directed staff to continue the 15-minute checks. A behavior note on 6/14/25 at 3:54 p.m., identified nursing staff informed that R1 was to have 1:1 staff supervision.</p> <p>R1's SLUMS examination completed by a psychology provider on 6/16/25, identified R1 had dementia.</p> <p>During an interview on 6/24/25 at 2:37 p.m., the social service director (SSD) indicated she was informed of R1's 6/7/25 incident of the leaving the building on 6/9/25 during an interdisciplinary team (IDT) meeting. R1 could only have exited through the front door as the back two doors have codes to exit and R1 would not have known the codes. The SSD indicated R1 would have had to go over a curb with his wheelchair and around to the back alley to get to that location. SSD reported R1 being outside in that area was not a safe area as there</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 15</p> <p>have been drug addicts in that area digging through the trash, R1 could have fallen and hit his head, and it was fortunate he ended up where he did instead of wandering further off the campus. SSD stated, "if we would have taken the necessary steps on the seventh [6/7/25], he would not have gotten out the second time [6/13/25]." SSD further described the area R1 was found on 6/13/24 as a "very busy intersection with a college close by." On 6/14/25, the SSD was the manager on duty and was at the facility when R4 informed her that he had to bring R1 back to the facility the evening before (6/13/25). SSD immediately notified the charge nurse, administrator, DON, and the State Agency. SSD noted R1 was not wearing a Wanderguard. SSD and charge nurse applied a Wanderguard to R1's wheelchair until he would cooperate to place a Wanderguard on his ankle.</p> <p>The facility's internal investigation dated 6/14/25, identified potential contributing factors leading to R1's elopement included: receptionist was on break; no one monitoring the front entrance; alarm not sounding and door not locking due to R1 removing his Wanderguard; staff not following the order for 15-minute safety checks on R1; nurse failed to follow direction from manager and place Wanderguard on resident.</p> <p>During observation and interview on 6/23/25 12:40 p.m., R1 was noted to be lying in his bed, unshaven, with a pack of cigarettes and lighter lying next to him. R1 yelled and used foul language when discussing the facility and the care he received but refused interview. R1 was noted to have a nursing assistant (NA) outside his door. During follow up interview attempt on 6/24/25 at 9:28 a.m., R1 was lying in bed and noted to be wearing a Wanderguard on his right ankle and had a second Wanderguard on the back of his wheelchair. NA outside of his door. R1 indicated he was angry and not in the mood to visit.</p> <p>During an interview on 6/23/25 at 12:55 p.m., R4 who had no cognitive impairment according to BIMS (Brief Interview for Mental Status) dated 5/19/25 stated R1 had "eloped" from the facility the week prior and found him near the corner of an intersection about a block away from the facility. R4 further indicated on 6/13/25 at approximately 7:00 p.m. to 8:00 p.m., he and a friend (not a fellow resident) left the facility by electric wheelchair to go out for supper at a restaurant about a mile away and R1 must have followed them out the door. R4 indicated there was usually a receptionist at the front desk that the residents check in and out with when they leave but the desk was unoccupied when he left. When they were returning from</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 16 the restaurant, they saw R1 in his wheelchair wheeling toward the intersection and was approximately ten feet away from the corner. R4 further indicated, when R4 approached R1, R1 asked what intersection he was at and told him he was on a weeklong leave of absence from the facility and was not going back. R4 knew R1 was confused and usually wore a Wanderguard. R4 stated he was able to "convince" R1 to return to the facility and escorted him back. R4 indicated R1 had difficulty maneuvering the wheelchair over the uneven sidewalk but returned to the facility without incident. Once back at the facility, R1 wanted to stay out in front of the building to smoke so R4 entered the building and told the receptionist at the desk that R1 had "eloped" and was out front smoking. R4 stated the next day, he reported R1's elopement to social services.</p> <p>During an interview on 6/23/25 at 4:38 p.m., RCP-A acknowledged working the evening of 6/13/25. RCP-A indicated she did not see R1 leave because she was on break and he did not have a Wanderguard on so the Wanderguard system did not alarm when he left the building. No one had told her R1 left and stated R4 did not tell her R1 had left the facility until the next day which contradicts R4's interview statement. RCP-A indicated she took her break between 8:00 p.m. and 8:30 p.m., and when she returned, she noted R1 coming in the front door, but the door did not alarm. RCP-A was "just glad to see him coming in." RCP-A denied checking R1 to see if he was wearing a Wanderguard but stated she just "assumed" since he did not alarm, the nursing staff had removed his Wanderguard and he could go outside without supervision. RCP-A denied checking with the nursing staff about R1's Wanderguard status or reporting R1 had been outside the facility unsupervised the evening of 6/13/25. RCP-A stated she was not aware of R1 leaving the facility unsupervised on 6/7/25.</p> <p>During an interview on 6/24/25 at 7:03 p.m., RN-B indicated she was working on 6/13/25 and had attempted to re-apply R1's Wanderguard but he had refused and was aggressive. RN-B had RN-A try to reapply it but R1 refused again. RN-B indicated she checked on R1 "to the best of my ability, it was busy" but thought she had checked on him about every 30 to 60 minutes. RN-B stated she was informed on 6/14/25, that R1 had eloped from the facility and was informed at that time that R1 was supposed to be on 15-minute safety checks.</p> <p>During an interview on 6/24/25 at 9:51 a.m., nurse manager (NM)-A, indicated R1 had attempted to elope before so required a Wanderguard but also had a history of removing it or cutting it off. NM-A indicated the Wanderguard system only alarms on the first floor and</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 17</p> <p>there was always a receptionist at the front desk and was responsible to monitor the doors and respond to the alarms. The elevators were not locked or alarmed except the doors that open to the kitchen and back of the building which required a code. R1 spent most of his time on first floor because he went out to smoke. NM-A indicated knowledge R1's 6/7/25 incident and had initiated 15-minute checks. NM-A stated, "there was a systems breakdown" when R1 eloped on 6/13/25, further identifying the 15-minute checks were not being completed, the receptionist was not monitoring the front desk, and his elopement was not reported to nursing until the next day.</p> <p>During an interview on 6/24/25 at 3:58 p.m., the DON summarized R1's elopement events as the facility's multiple layers of security to prevent elopement failed and their "systems broke down". The DON further clarified the system of staff supervision broke down by not completing the ordered 15 minute checks; the nurses did not follow through when R1 refused to allow them to apply the wander guard; nurses did not report the refusal to their manager; the staff assumed R1 was in the facility if they did not hear an alarm, staff did not monitor R1 yet signed that they were monitoring R1; R1 was able to cut his Wanderguard off; the receptionist assumed staff removed R1's alarm; the receptionist did not look at the binder to confirm, and the receptionist did not report R1 leaving the facility unsupervised to anyone. The DON was aware of R1's 6/7/25 incident but did not think he was aware of the details. The DON understood R1 left the facility out the front door early morning to smoke and staff found him and brought him back in. The DON indicated if a resident was found outside of where they should not be and had breached the facility security, he considered it an elopement. The DON further identified R1 was not safe to be outside unsupervised due to R1's fluctuating cognitive status and R1's elopements are a "serious concern".</p> <p>During an interview on 6/24/25 at 3:24 p.m., the administrator indicated SSD notified her of R1's 6/13/25 elopement on 6/14/25 early afternoon and began 1:1 staffing with R1, immediate education with all staff, The administrator stated, "he [R1] knew where he was going and he got back after running into [R4] and following him back [to the facility]." The administrator indicated that although R1 safely navigated to the intersection, he required supervision when out of the facility. Further noted about a week prior (6/7/25), R1 "attempted to go out and smoke and was redirected back in" but was not aware he was outside for approximately two hours and did not feel</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 18 the area was unsafe as it was on campus. The administrator verified the area that R1 was found in was in the back of the facility with concrete stairs close, a delivery area, next to an alley, and near the employee smoking area. The administrator verified the facility failed to provide supervision and the ordered 15-minute checks leading to the elopement on 6/13/25.</p> <p>The facility policy titled Elopement Policy last reviewed 6/2023, included the facility is committed to provide a safe environment for all residents and will assure that each resident is assessed on an ongoing basis and has appropriate safety precautions in place. All residents will be reassess quarterly, annually, and as needed due to significant changes. The facility will identify such environmental hazards such as entrances, stairwells, or exits that pose a foreseeable danger to residents who wander or have an exit seeking behavior. The facility will implement interventions to minimize these risks and hazards as appropriate. Documentation should include: admission assessment, which may indicate potential to wander or exit facility; care plan that address potential to wander or exit facility and the measures taken to prevent wandering/elopement; all attempts to elope, efforts to locate, notification and results of efforts; full observation visualization after an elopement for any injuries or new symptoms or conditions which may have developed; entries that are time specific to reflect the responsiveness and "timeliness" of actions taken to locate and asses the resident; bracelet alarm/device is in place and functioning (per TAR or other form of documentation), if applicable. Post elopement assessment: after the resident is located and returned to the unity, assess for changes identifying the following items: observed behaviors or resident statements; objective data, underlying illnesses, or diagnoses; physical assessment; general appearance. Document findings in an interdisciplinary team progress note (IPN) The administrator, or designee, shall notify State Agency, as necessary by state requirement, family/family representative, and physician.</p> <p>The immediate jeopardy that began on 6/7/25, was removed on 6/14/25, prior to the survey when the facility implemented 1:1 supervision for R1, reviewed and updated R1's care plan; comprehensively reassessed all residents for risk of elopement and implemented interventions to protect all residents at risk for elopement; all residents checked for Wanderguard placement and functioning; reviewed elopement policy and procedures; reception desk supervised 24 hours a day, 7 days a week with required coverage for breaks; re-education on Wanderguard checks at all mag-locked</p>	F0689		

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F0689 SS = SQC-J	Continued from page 19 exits; re-education on elopement, 15-minute safety checks, abuse policy, reception area coverage, and elopement binder; and conducted elopement drills.	F0689		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 17, 2025

Administrator
The Emeralds at St. Paul
420 MARSHALL AVENUE
SAINT PAUL, MN 55102

Re: PS7N11

Dear Administrator:

The above facility survey was completed on 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,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

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

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20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS:</p> <p>On 6/23/25 to 6/25/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.</p> <p>The following complaints were reviewed: H52957567C (MN00113912) and H52957807C (MN00114045). NO licensing orders were issued.</p>	20000		

Office of Primary Care and Health Systems Management

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

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. 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		