



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 'M. 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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August 28, 2025

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

Re: Reinspection Results
Event IDs: PS7N-H2 and G589-H2

Dear Administrator:

On August 6, 2025 and August 12, 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 June 25, 2025 and July 22, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

An equal opportunity employer.



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July 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 informed you of imposed enforcement remedies.

On July 22, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey/revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 12, 2025.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 12, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 12, 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.

As we notified you in our letter of July 17, 2025, accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 25, 2025.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

- Optional denial of payment for new Medicare and Medicaid admissions
(42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

**Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728**

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division

staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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.

Feel free to contact me if you have 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 CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/14/2025	
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	INITIAL COMMENTS On 7/9/25, 7/10/25 and 7/14/25, 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 complaint was reviewed H52959048C (MN114440) with a deficiency issued at F656, F686 and F842. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.		F0000				
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and		F0656	R1 discharged from the facility. All like residents who have been identified for pressure ulcers or at risk for pressure ulcers plan of care have been reviewed and updated to reflect pressure ulcer care plan focus and interventions. The Care Planning Policy has been reviewed with no changes. All residents have the potential to be affected by this deficient practice. The DON or designee will provide re-education to all appropriate staff on comprehensive care plans and pressure ulcer interventions to reduce risk of skin		08/08/2025	

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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F0656 SS = D	Continued from page 1 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure a comprehensive care plan was developed for 1 of 1 resident (R1) reviewed for pressure ulcers Findings include: R1's admission Minimum Data Set (MDS) dated 6/17/25, identified R1 had highly impaired hearing that required a hearing device. R1 had severe cognitive impairment, no speech, and was completely dependent on staff for all activities of daily living (ADL's). R1's diagnoses included acute and chronic respiratory failure (when the lungs can't adequately provide oxygen to the blood or remove carbon dioxide from it) with hypoxia (when the body doesn't receive enough oxygen), encounter for		F0656	Continued from page 1 breakdown. The DON or designee will complete audits on comprehensive care plans for residents with or at risk for pressure ulcers to ensure proper pressure ulcer care plan focus and interventions are in place. Audits will be conducted weekly X 4, and then monthly X 2. Audit results will be reviewed by QAPI Committee for further recommendation.			

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F0656 SS = D	Continued from page 2 tracheostomy (a surgical procedure creating an opening in the trachea (windpipe) to facilitate breathing) and anxiety disorder. Further identified R1 was at risk for pressure ulcers. R1’s care area assessment (CAA) dated 6/17/25, identified Section 3; Visual function: identifying triggers indicated an ability to see in adequate light (with glasses or other visual appliances) was impaired. Analysis of findings identified R1 had impaired vision related to multiple comorbidities, used glasses on a daily basis. Overall objective for care planning was to minimize risks. Section 4 Communication triggering conditions identified R1’s ability to hear was highly impaired. Analysis of findings identified R1 was at risk for communication difficulty related to multiple comorbidities. R1 had no speech, sometimes understands and sometimes make self-understood. R1 had impaired vision, impaired hearing, does not use hearing aide/device. Will proceed to care plan. Staff will repeat messages as necessary to assure communication has been successful. R1’s Nurse Practitioner (NP) visit dated 6/27/25, identified R1 was severely hard of hearing with hearing device responds appropriately. R1's Care Plan Audit Report for R1 Printed: 7/14/25 Revision Date: 7/5/25 Focus: Communication R1 experienced altered communication due to a tracheostomy (chronic respiratory failure), hearing impairment, and lack of speech. R1 often refuses to remove her pocket talker device (an amplified hearing tool). Interventions: · 4/9/25: Staff to apply hearing box when communicating with R1; speak clearly, face R1, use writing tools; minimize background noise (e.g., TV, suctioning machine). · 7/7/25: Ensure R1 wears headphones when communicating or watching TV, per her preference. · 7/9/25: Ensure R1 has box talker device at all times and within reach. Focus: Vision R1 has altered vision and wears glasses consistently, often refusing to remove them even during sleep with a revision date of 7/5/25. Interventions:			F0656			

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F0656 SS = D	Continued from page 3 ·7/5/25: Assist with daily wear of glasses; monitor/document vision changes or eye pain; ensure call light is accessible; monitor for eye infection; staff responsible for care and maintenance of glasses; schedule ophthalmology appointments as needed/requested. ·7/7/25: Encourage R1 to remove glasses while resting and at HS. Care plan was reviewed and did not identify interventions for skin breakdown for eyeglasses or headphones for pocket talker even though according to the care plan R1 had a history of refusing to remove and R1 was at risk for pressure ulcers according to the assessment dated 6/17/25. During an interview on 7/10/25 at 12:28 p.m., registered nurse (RN)-B stated he was the nurse manager for R1and indicated R1 kept her eyeglasses and headphones for her pocket talker on 24 hours a day seven days a week. RN-B reviewed R1's care plan, then stated the care plan did not identify this and there were no prevention interventions implemented to prevent pressure ulcers to her nose or her ears and there should have been. During an interview on 7/10/25 at 2:17 p.m., the director of nursing (DON) stated staff shared with him that R1 was resistive to having her glasses and headphones removed. R1 was a mechanical ventilator resident who was fully dependent with ADL's putting her at high risk for pressure ulcer development. DON further stated R1's care plan should have identified R1 was at risk for pressure ulcer development if R1's glasses and headphones were not removed, and prevention interventions should have been developed to prevent pressure ulcers to these areas. Facility Care Planning policy revised 11/2024, identified...comprehensive care plan: the interdisciplinary team (IDT), in conjunction with the resident and the resident representative, will develop and implement a comprehensive individualized care plan no later than the 21st day of admission of the resident. The care plan interventions are derived form a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive person-centered care plan will be consistent with the resident's rights to identify problem areas and their causes and develop interventions that are targeted and meaningful to the resident. The plan of care will be utilized to provide care to the resident. The care plan			F0656			

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F0656 SS = D	Continued from page 4 is to be modified and updated as the condition and care needs of the resident changes.		F0656				
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure that 1 of 3 residents (R1) reviewed for pressure ulcers received care and services to prevent occurrence of newly developed pressure ulcers. The facility's failure resulted in actual harm to R1 when R1's skin was not comprehensively assessed and failed to develop a care plan for pressure ulcer prevention that resulted in six (6) pressure ulcers including Stage 4 pressure ulcer to R1's nose and deep tissue injuries to R1's ear. Findings include Findings include: According to the State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, revised 08-08-2024, included the following definitions: -"Pressure Ulcer/Injury (PU/PI)" refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. The		F0686	R1 discharged from the facility. All like residents who have been identified for pressure ulcers or at risk for pressure ulcers, their assessments, interventions and plan of care have been reviewed and updated to reflect pressure ulcer interventions. The Skin and Wound Policy has been reviewed with no changes. All residents have the potential to be affected by this deficient practice. The DON or designee will provide re-education to all appropriate staff on initial skin assessments, weekly skin assessments, and pressure ulcer interventions to reduce risk of skin breakdown. Wound Care Procedure has been reviewed with the appropriate staff. The DON or designee will complete audits on residents with or at risk for pressure ulcers to ensure proper pressure ulcer interventions are in place. Audits will be conducted weekly X 4, and then monthly X 2. Audit results will be reviewed by QAPI Committee for further recommendation.		08/08/2025	

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F0686 SS = G	Continued from page 5 injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. - "Stage 4 pressure ulcer" refers to full thickness skin and tissue loss with exposed or directly palpable fascia, muscle tendon, ligament, cartilage, or bone in the ulcer. Slough and /or eschar may be visible on some parts of the wound bed. - "Eschar" refers to dead or revitalized tissue that is hard or soft in texture; usually black, brown or tan in color, and may appear scab like, Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides and edges of the wound. - "Unstageable pressure ulcer" refers to a full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If the slough or eschar is removed, a stage 3 or 4 pressure ulcer will be revealed. - "Deep tissue pressure injury (DTPI)" refers to intact skin with localized area of non-blanchable deep red, maroon or dark purple discoloration due to the damage of underlying soft tissue. - "Avoidable" means that the resident developed a pressure ulcer/injury, and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. R1's Braden Scale for Predicting Pressure Sore Risk dated 6/11/25, identified a score of 13 indicating R1 was at moderate risk due to the following factors: 1. Sensory perception-very limited, responds to only painful stimuli...2. Moisture-occasionally moist requiring an extra linen change once a day, 3. Activity-chairfast ability to walk severely limited or non-existent, cannot bear own weight and must be assisted into a chair or wheelchair. 4. Mobility-very limited makes occasional slight changed in body or extremity position but unable to make frequent or significant changes daily. 5. Nutrition was adequate...6. Friction and Sheer-a problem required moderate to maximum assistance in moving. Complete lifting without sliding against sheets was impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity,		F0686				

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F0686 SS = G	Continued from page 6 contractures or agitation leads to almost constant friction. R1's admission Minimum Data Set (MDS) dated 6/17/25, identified R1 had highly impaired hearing that required a hearing device and had impaired vision with corrective lenses. R1 had severe cognitive impairment, no speech and was completely dependent on staff for all activities of daily living (ADL's). R1's diagnoses included acute and chronic respiratory failure (when the lungs can't adequately provide oxygen to the blood or remove carbon dioxide from it) with hypoxia (when the body doesn't receive enough oxygen), encounter for tracheostomy (a surgical procedure creating an opening in the trachea (windpipe) to facilitate breathing) and anxiety disorder. R1 was at risk for pressure ulcers and had no identified skin concerns. R1's MDS triggered Care Area Assessments (CAA) for pressure ulcers, vision, and communication. R1's Pressure ulcer CAA dated 6/17/25 identified R1 at risk for skin breakdown related to decreased mobility, incontinence. R1 requires assistance from staff with mobility, transfers, and toileting needs R/T physical limitations but R1 can make some position changes on her own however, staff assist with repositioning and offloading as needed. Staff will monitor skin and report changes for evaluation/intervention/treatment as appropriate. R1's vision CAA identified R1 had impaired vision related to multiple comorbidities and used glasses on a daily basis. R1's Communication CAA identified R1's ability to hear was highly impaired related to multiple comorbidities. R1 did not use hearing aide/device. Will proceed to care plan. According to R1's care plan audit report (printed on 7/14/25) did not specifically include a pressure ulcer focus nor identify R1 was at risk for pressure ulcers. However, the care plan did include a Skin care plan focus that was created and initiated on 4/9/25, which identified R1 was at risk for impaired skin integrity and advised R1 had a fluid filled blister on her arm with no other skin issues identified. The intervention also dated 4/9/25 directed staff to monitor skin integrity daily during cares and weekly skin inspection by nurse. R1's communication focus created on 4/9/25 included the intervention "Staff to apply hearing box on resident when communicating with her" which also had a created date of 4/9/25. In review of CAA's and R1's care plan dated 6/11/25 through 7/4/25, there was no indication R1's external devices (glasses and hearing box) used over bony prominences (nose and ears) were comprehensively		F0686				

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F0686 SS = G	Continued from page 7 assessed nor identified as risk for factors for pressure ulcer development. Additionally, or alternatively, there was no indication individualized pressure relieving/reducing interventions associated with devices were developed and implemented except for turn and reposition every 2 to 3 hours dated 4/9/25. R1's order summary dated 6/11/25, identified to perform weekly skin inspection by licensed nurse. Complete weekly skin Inspection in Point Click Care (PCC-an electronic health record) every Wednesday and Sunday evening shift. Review of R1's record between 6/11/25 through 7/4/25 identified Weekly Skin Inspections assessments were completed on 6/11/25, 6/15/25, and 6/25/25. These assessments identified R1 did not have any skin issues. R1's Treatment Administration Record (TAR), dated July 2025, identified weekly skin inspection by licensed nurse. Complete weekly skin inspection in PCC every Wednesday and Sunday evening shift. The box on 7/2/25, identified a nurse had put their initials in box indicating the skin assessment was completed. However, in review of R1's record no comprehensive weekly skin inspection assessment completed for R1 on 7/2/25. R1's progress note dated 7/4/25 at 10:21 a.m., identified R1 was transferred to the hospital related to a large amount of blood in R1's colostomy bag. R1's Emergency Department (ED) to hospital admission record dated 7/4/25, identified R1 was admitted to ED at 10:33 a.m. for gastrointestinal (GI) bleed. Conditions present on admission identified R1 had severe skin breakdown on nasal bridge, visible bone (photo in chart) with significant concerns for elder abuse/neglect. This was escalated to charge nursing... R1's glasses were removed, and bilateral wounds present on bridge of nose where glasses rest. Headphones (for pocket talker) were removed, and wounds noted to left ear. Upon speaking with R1's family member (FM)-A. FM-A stated she had asked facility staff about routinely removing R1's eyeglasses and headphones at night and was told by staff that they are not allowed to remove these items if R1 refused. R1 had significant skin breakdown on nasal bridge in shape of R1's glasses nose pads. Bone was visible beneath. R1 was noted to have a suspected pressure ulcer to the left side of her nose, suspected pressure ulcer to the right side of the nose and wounds to R1's left ear. Picture description of left nasal bridge: one rectangular shaped ulcer located to her left lateral		F0686				

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F0686 SS = G	Continued from page 8 side of her nasal bridge with clear slough over exposed bone, scabs surrounding the open area. (consistent with stage 4 pressure ulcer). Picture description of right nasal bridge: one rectangular shaped ulcer noted to right lateral side of nasal bridge with exposed bone, surrounded by bloody drainage. (consistent with stage 4 pressure ulcer). Picture description of left ear: one wound on the end of the tragus (small, cartilaginous flap of tissue located on the outer ear, situated in front of and partially covering the opening of the ear canal) with eschar formation, one wound on the edge of the antitragus (It's situated above the earlobe and points anteriorly, meaning towards the front of the head) with eschar formation. R1's pinna (The visible, fleshy part of the ear on the side of the head. It is made up of cartilage covered in skin) of the ear was pulled forward to identify two darkened areas of skin on the mastoid process (area just below and behind your ear) where the stems of the glasses would lie. (coincides with medical device related pressure injury). Tragus and antitragus wound coincide with an unstageable pressure ulcer. According to R1's care plan audit report (printed on 7/14/25) there were no identification of pressure ulcer risk associated with external devices (glasses and pocket talker) and no corresponding interventions were developed to reduce pressure and/or mitigate the risk for pressure ulcers associated with devices until after R1 was hospitalized. R1's vision focus identified R1 had alteration in vision as evidenced by: "Resident wearing glasses" and "Resident has history of refusing glasses and will often sleep with them on"; this focus was created on 7/5/25 (after R1 was transferred to the hospital) but had an initiated date of 6/19/25 (prior to R1's hospitalization). A corresponding intervention that directed staff to "Encourage resident to remove glasses while resting and at HS [at night]" was created on 7/7/25 (three days after R1's transfer to the hospital) but had an initiated date of 7/3/25 (one day prior to R1's hospitalization). R1's communication focus was revised 7/5/25 to include "Resident often refuses to remove pocket talker. An additional intervention was created on 7/7/25 that directed staff to Encourage resident to remove pocket talker while resting and at HS, however identified 7/3/25 as the date the intervention was initiated. During a phone interview on 7/9/25 at 9:31 a.m., hospital social worker (HSW)-A stated R1 was hospitalized on 7/4/25 and when R1 first admitted the		F0686				

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F0686 SS = G	Continued from page 9 nurse “had to peel the glasses off R1’s face.” and “it was like R1 never had her glasses removed off her face” while she resided at the facility. HSW-A explained there were good pictures of her wounds in her hospital record; HSW-A remarked R1’s wounds to her nose were definitely from pressure from her glasses and could have been prevented. During an interview on 7/10/25 at 11:54 a.m., hospital RN (HRN)-A stated she was working on 7/4/25, the day R1 was admitted around 5:00 p.m., she did a full body skin assessment on R1 and noticed redness around her glasses. HRN-A used R1’s pocket talker to explain what she was going to do and removed R1’s glasses without refusal. HRN-A stated she had trouble removing R1’s eyeglasses because “like they were stuck to her face” HRN-A noted R1 to have full thickness pressure ulcers that were rectangular shaped on either side of R1’s nose directly from the rectangular nose pieces of her glasses. HRN-A had never seen anything like it before and she believed R1 to have pain because during the removal of the glasses, R1 had facial wincing and grimacing. HRN-A stated when she removed R1’s headphones she noted two unstageable pressure ulcers to the tragus and antitragus portion of the left ear with eschar formation and two deep tissue pressure injuries behind the left ear from the stems of the glasses where they wrapped around the ear. R1’s pressure ulcers were from pressure from her eyeglasses and headphones and were completely preventable. HRN-A indicated it looked like they had never been removed from the facility she resided at. During an interview on 7/10/25 at 10:33 a.m., family member (FM)-A stated she visited R1 at the facility twice a day. FM-A would see the aides come in to do skin assessments, but they would just usually look at her bottom. FM-A never witnessed the staff “ever remove R1’s glasses or headphones from her ears.” FM-A stated when she came to visit in the morning R1’s headphones and glasses were always on even though she was sleeping and indicated she would come back at night and stay until R1 fell asleep. FM-A reiterated that no staff ever came in to remove R1’s glasses or headphones. FM-A was at the hospital on 7/4/25, when the nurse at the hospital took R1’s glasses off and stated, “she had deep wounds on either side of her nose that were rectangular shaped from her nose piece of her glasses. FM-A described the wounds as, "bloody gashes in the sides of R1’s nose.” FM-A stated she had wounds in and behind her left ear where her headphone being on her ears at all times and her glasses “digging in.” During an interview on 7/10/25 at 11:40 a.m., nursing		F0686				

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F0686 SS = G	Continued from page 10 assistant (NA)-A indicated she was familiar with R1's morning cares. NA-A stated R1 would never allow me to remove her headphones, R1 would push her hands out at me, so I would just move them a little bit forward to clean her face and had never noticed any sores on R1's ears. NA-A stated R1 never allowed anyone to remove her eyeglasses, she would kick and flail when staff tried. NA-A did notice R1 had red marks on her face from the eyeglasses but didn't think they were open sores and thought the nurses were aware. During an interview on 7/10/25 at 12:22 p.m., NA-B stated R1 always wore her glasses and headphones for her pocket talker. NA-B never noticed any redness under R1's glasses and never noticed skin concerns under her headphones but admitted she never removed R1's headphones or eyeglasses due to refusals. During an interview on 7/10/25 at 11:21 a.m., licensed practical nurse (LPN)-A indicated he worked with R1 on the day shift of 7/2/25 and had noticed R1 had redness on the bridge of her nose under her eyeglasses when they were repositioning her and stated he put a cream on it but was not sure what cream he put on it. LPN-A reported this skin concern to registered nurse (RN)-B who was the nurse manager. LPN-A never took R1's glasses off to fully assess R1's skin and stated he did not document the redness he had seen. LPN-A further stated R1 always kept her glasses and her headphones on her ears 24 hours a day. R1 would refuse to take her glasses or her headphones off. When R1 would refuse to take them off, LPN-A never explained to R1 the risks of pressure ulcer development from not removing the devices. During an interview on 7/10/25 at 12:28 p.m., RN-B stated he was the nurse manager for R1 and indicated R1 kept her eyeglasses and headphones for her pocket talker on 24 hours a day seven days a week. R1 refused to have her glasses, or her headphones removed. RN-B indicated that the care plan did not identify this and there were no prevention interventions implemented to prevent pressure ulcers to her nose or her ears and there should have been. R1's last comprehensive skin assessment was completed on 6/25/25, and it was missed on 7/2/25. RN-B explained LPN-A had notified him on 7/2/25 that R1 had redness under her eyeglasses, but admittedly he did not complete a comprehensive skin assessment. R1 was sent to the hospital on 7/4/25, and the hospital had reached out to the facility stating R1 admitted with pressure ulcers to R1's nose and left ear that he had not been aware of. During an interview on 7/10/25 at 11:08 a.m.,			F0686			

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F0686 SS = G	Continued from page 11 registered nurse (RN)-A stated she was a regular floor nurse that worked on R1's unit. RN-A never saw R1 with her glasses and her headphones from her pocket talker off of her ears. R1 had never refused cares for her, "as long as you used R1's pocket talker to explain what you were doing [R1] did not refuse cares." RN-A explained the risk of never taking R1's eyeglasses and headphones off her ears would be a high risk for pressure ulcer development. During an interview on 7/10/25 at 2:17 p.m., the director of nursing (DON) stated staff shared with him that R1 was resistive to having her glasses and headphones removed after hearing from the hospital about R1's pressure ulcers. DON indicated R1 was a mechanical ventilator resident who was fully dependent with adl's putting her at high risk for pressure ulcer development. R1's care plan should have identified she would be at risk for pressure ulcer development if R1's glasses and headphones were not removed, and prevention interventions should have been developed to prevent pressure ulcers to these areas. DON indicated R1's 7/2/25, skin assessment was missed and the staff at the hospital did notify the facility that R1 admitted to the hospital with pressure ulcers to her nose and left ear. DON stated comprehensive skin assessments must be performed weekly. DON indicated R1's pressure ulcers were preventable. A facility policy, "Skin Assessment and Wound Management," revised 2/2025 indicated Provide guidelines for assessing and managing wounds were: A pressure ulcer risk assessment (Braden Scale) will be completed per Monarch's Assessment Schedule/Grid. Implement appropriate preventative skin measures. Examples include, but are not limited to-nutritional interventions, mobility and repositioning plan, pressure redistribution plan. Skin Evaluation and Skin Risk Factors Form is completed before initial MDS, annually, and upon significant change. Staff will perform routine skin inspections (with daily care). Nurses are to be notified if skin changes are identified. Licensed staff will complete a weekly skin inspection.		F0686				
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.		F0842	R1 has discharged from the facility. All like residents who have been identified for pressure ulcers or at risk for pressure ulcers Medical Records have been reviewed and updated to reflect that they are complete, accurately documented, readily accessible, and systematically organized.		08/08/2025	

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F0842 SS = D	Continued from page 12 (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for-			F0842	Continued from page 12 All residents have the potential to be affected by this deficient practice. The DON or designee will provide re-education to all appropriate staff on medical records accuracy. The DON or designee will complete audits on medical records to ensure they are complete, accurately documented, readily accessible, and systematically organized. Audits will be conducted weekly X 4, and then monthly X 2. Audit results will be reviewed by QAPI Committee for further recommendation.		

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F0842 SS = D	Continued from page 13 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure medical records were accurate and readily accessible for 1 of 1 resident (R1) reviewed for pressure ulcers. Findings include: On 7/14/25 the facility had provided electronic health record (EHR) access to review resident records. The viewable access to R1's record included care plan history dates, however, when printed the dates were inconsistent with what was displayed that was readily accessible. The facility provided R1's care plan on 7/14/25 at 7:51 a.m. This care plan included a communication focus that identified an initiated date of 4/9/25, "Resident has Alteration in communication R/T [related to] Placement of Tracheostomy D/T [do to] chronic respiratory failure, HOH [hard of hearing], No speech." and "Resident often refuses to remove pocket talker device." The corresponding goals were initiated on 4/9/25 with revision dates of 7/9/25 (did not identify what the revisions were); the goals included resident		F0842				

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F0842 SS = D	Continued from page 14 will have adequate communication as evidenced by: ability to communicate basic needs and Residents needs will be anticipated and met by staff. There were no other dates that were included in the focus area column and the interventions did not include any dates including when they were initiated. R1's care plan that was provided on 7/14/25 at 7:51 a.m. also included a focus area for vision that was initiated on 6/19/25; Resident has Alteration in vision AEB (as evidenced by): related to: Resident wearing glasses. Resident has history of refusing to remove glasses and will often sleep with them on. The corresponding goals had an initiated date of 7/5/25 with a revision date of 7/9/25 which was not consistent with when the vision care plan focus was initiated. The interventions did not include any dates of initiation or revision. The facility then provided another copy of R1's care plan on 7/14/25 at 8:46 a.m. via email from the administrator in which the administrator wrote, "See attached. I had to have Corporate change the configuration for CP [care plan]" The attachment was labeled "cp with revisions". This care plan included the focus area of communication with the initiated date of 4/9/25, the goals remained the same and included dates the interventions were initiated. The interventions were all initiated on 4/9/25, with the exception of "staff to ensure resident has her headphone one [sic] when communicating..." which was 6/19/25, and "Staff to ensure resident has his [sic] box talker..." which was dated 7/5/25. This version of the care plan included an intervention that was not reflected on the first version provided at 7:51 a.m. which was "Encourage resident to remove pocket talker while resident and at HS [at night]" with initiated date of 7/3/25. -In the same copy of the care plan provided at 8:46 a.m. was the vision focus that was initiated on 6/19/25. The goals were unchanged between this copy and the previous copy that was provided at 7:51 a.m. The interventions that were listed all identified they were initiated on 7/5/25 with the exception of "Encourage resident to remove glasses while resident and at HS" which identified an initiated of 7/3/2025. There was no revision dates identified for any interventions listed. The facility then provided "Care Plan Audit [resident initials]" via email on 7/14/25 at 10:50 a.m. The audit report identified the focus of communication was created and initiated on 4/9/25 and had a revision date of 7/5/25. The corresponding goals identified they were		F0842				

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F0842 SS = D	Continued from page 15 created and initiated on 4/9/25 and had a revision date of 7/9/25. The audit report identified most of the interventions had been created on and initiated on 4/9/25, except for one intervention that was created by the administrator and one intervention was created by registered nurse (RN)-B in which those interventions had a created-on date after the initiation date. The intervention "Encourage resident to remove pocket talker while resting and at HS Date" was created on 7/7/25 by the administrator, however the initiated date of the intervention was 07/03/2025. The intervention "Staff to ensure resident has her headphone one [sic] when communicating and watching TV per her choice" was created on 7/9/2025 by registered nurse (RN)-B however the initiated date of the intervention was 6/19/25. -In the same copy of the Care plan Audit report that was provided at 10:50 a.m. included the vision focus which identified RN-B created the focus on 7/5/25 and the administrator revised the focus on 7/5/25, but the initiated date was 6/19/25. The corresponding goals were created on 7/5/2025 and revised on 7/9/25 by RN-B. The intervention "Encourage resident to remove glasses while resting and at HS" was created on 7/7/25 by the administrator however the care plan identified the initiated date was 7/3/25. All of the interventions were created and initiated on 7/5/25 by RN-B. The care plan did not identify any revision dates. During an interview on 7/14/25 at 10:17 a.m., administrator stated she was unsure why the care plans when printed showed the wrong dates. Administrator stated she initiated the focus of R1's refusal of removing pocket talker on 7/5/25 after her hospitalization on 7/4/25. Administrator further stated R1 focus of vision with history of refusing to remove her glasses was not implemented until 7/5/25. Administrator was unsure why the care plan was printing out with inaccurate dates. During an interview on 7/14/25 at 10:33 a.m. regional nurse consultant (RNC)-A stated R1's care planned dates for the focus of vision and communication were not accurate or readily accessible and should be. RNC-A stated R1's care plan audit report would be most accurate and was not sure why the dates on R1's care plan revision was inaccurate. During an interview on 7/14/25 at 11:12 a.m., registered nurse (RN)-B stated he was the nurse manager for R1's unit and indicated the dates were not accurate when printed for the focus of vision and communication. R1's refusals were not initiated until after her		F0842				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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 07/14/2025	
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
F0842 SS = D	Continued from page 16 hospitalization on 7/4/25. RN-B stated the care plan should be printing out accurate dates. Policy regarding resident medical record was requested and was not received.			F0842			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 28, 2025

Administrator

The Emeralds at St Paul LLC

420 MARSHALL AVENUE

SAINT PAUL, MN 55102

Re: State Nursing Home Licensing Orders

Event ID: G58911

Dear Administrator:

The above facility was surveyed on July 22, 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:

**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**

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

Minnesota State Department of Health

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/9/25, 7/10/25 and 7/14/25, 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 and identify the date when they will be completed.		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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20000	Continued from page 1 The following complaints were reviewed, H52959048C (MN114440) with licensing orders issued at 20565, 20625, and 20900. 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 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.		20000				
20565	Comprehensive Plan of Care; Use CFR(s): MN Rule 4658.0405 Subp. 3 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility		20565			08/08/2025	

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20565	Continued from page 2 failed to ensure a comprehensive care plan was developed for 1 of 1 resident (R1) reviewed for pressure ulcers Findings include R1’s admission Minimum Data Set (MDS) dated 6/17/25, identified R1 had highly impaired hearing that required a hearing device. R1 had severe cognitive impairment, no speech, and was completely dependent on staff for all activities of daily living (ADL’s). R1’s diagnoses included acute and chronic respiratory failure (when the lungs can’t adequately provide oxygen to the blood or remove carbon dioxide from it) with hypoxia (when the body doesn’t receive enough oxygen), encounter for tracheostomy (a surgical procedure creating an opening in the trachea (windpipe) to facilitate breathing) and anxiety disorder. Further identified R1 was at risk for pressure ulcers. R1’s care area assessment (CAA) dated 6/17/25, identified Section 3; Visual function: identifying triggers indicated an ability to see in adequate light (with glasses or other visual appliances) was impaired. Analysis of findings identified R1 had impaired vision related to multiple comorbidities, used glasses on a daily basis. Overall objective for care planning was to minimize risks. Section 4 Communication triggering conditions identified R1’s ability to hear was highly impaired. Analysis of findings identified R1 was at risk for communication difficulty related to multiple comorbidities. R1 had no speech, sometimes understands and sometimes make self-understood. R1 had impaired vision, impaired hearing, does not use hearing aide/device. Will proceed to care plan. Staff will repeat messages as necessary to assure communication has been successful. R1’s Nurse Practitioner (NP) visit dated 6/27/25, identified R1 was severely hard of hearing with hearing device responds appropriately. R1's Care Plan Audit Report for R1 Printed: 7/14/25 Revision Date: 7/5/25 Focus: Communication R1 experienced altered communication due to a tracheostomy (chronic respiratory failure), hearing impairment, and lack of speech. R1 often refuses to remove her pocket talker device (an amplified hearing tool). Interventions:		20565				

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20565	Continued from page 3 · 4/9/25: Staff to apply hearing box when communicating with R1 ; speak clearly, face R1 , use writing tools; minimize background noise (e.g., TV, suctioning machine). · 7/7/25: Ensure R1 wears headphones when communicating or watching TV, per her preference. · 7/9/25: Ensure R1 has box talker device at all times and within reach. Focus: Vision R1 has altered vision and wears glasses consistently, often refusing to remove them even during sleep with a revision date of 7/5/25. Interventions: ·7/5/25: Assist with daily wear of glasses; monitor/document vision changes or eye pain; ensure call light is accessible; monitor for eye infection; staff responsible for care and maintenance of glasses; schedule ophthalmology appointments as needed/requested. ·7/7/25: Encourage R1 to remove glasses while resting and at HS. Care plan was reviewed and did not identify interventions for skin breakdown for eyeglasses or headphones for pocket talker even though according to the care plan R1 had a history of refusing to remove and R1 was at risk for pressure ulcers according to the assessment dated 6/17/25. During an interview on 7/10/25 at 12:28 p.m., registered nurse (RN)-B stated he was the nurse manager for R1and indicated R1 kept her eyeglasses and headphones for her pocket talker on 24 hours a day seven days a week. RN-B reviewed R1's care plan, then stated the care plan did not identify this and there were no prevention interventions implemented to prevent pressure ulcers to her nose or her ears and there should have been. During an interview on 7/10/25 at 2:17 p.m., the director of nursing (DON) stated staff shared with him that R1 was resistive to having her glasses and headphones removed. R1 was a mechanical ventilator resident who was fully dependent with ADL's putting her at high risk for pressure ulcer development. DON further stated R1's care plan should have identified R1 was at risk for pressure ulcer development if R1's glasses and headphones were not removed, and prevention interventions should have been developed to prevent		20565				

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20565	Continued from page 4 pressure ulcers to these areas. Facility Care Planning policy revised 11/2024, identified...comprehensive care plan: the interdisciplinary team (IDT), in conjunction with the resident and the resident representative, will develop and implement a comprehensive individualized care plan no later than the 21st day of admission of the resident. The care plan interventions are derived form a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive person-centered care plan will be consistent with the resident's rights to identify problem areas and their causes and develop interventions that are targeted and meaningful to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should create and/or review or revise policies and procedures to ensure care plans are developed and implemented in order to meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure personalized individual care plans are used and followed. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20565				
20625	Clinical Record Contents; In General CFR(s): MN Rule 4658.0450 Subp. 1 A-P Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J;		20625			08/08/2025	

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20625	Continued from page 5 D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility			20625			

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20625	Continued from page 6 failed to ensure medical records were accurate and readily accessible for 1 of 1 resident (R1) reviewed for pressure ulcers. Findings include Findings include: On 7/14/25 the facility had provided electronic health record (EHR) access to review resident records. The viewable access to R1's record included care plan history dates, however, when printed the dates were inconsistent with what was displayed that was readily accessible. The facility provided R1's care plan on 7/14/25 at 7:51 a.m. This care plan included a communication focus that identified an initiated date of 4/9/25, "Resident has Alteration in communication R/T [related to] Placement of Tracheostomy D/T [do to] chronic respiratory failure, HOH [hard of hearing], No speech." and "Resident often refuses to remove pocket talker device." The corresponding goals were initiated on 4/9/25 with revision dates of 7/9/25 (did not identify what the revisions were); the goals included resident will have adequate communication as evidenced by: ability to communicate basic needs and Residents needs will be anticipated and met by staff. There were no other dates that were included in the focus area column and the interventions did not include any dates including when they were initiated. R1's care plan that was provided on 7/14/25 at 7:51 a.m. also included a focus area for vision that was initiated on 6/19/25; Resident has Alteration in vision AEB (as evidenced by): related to: Resident wearing glasses. Resident has history of refusing to remove glasses and will often sleep with them on. The corresponding goals had an initiated date of 7/5/25 with a revision date of 7/9/25 which was not consistent with when the vision care plan focus was initiated. The interventions did not include any dates of initiation or revision. The facility then provided another copy of R1's care plan on 7/14/25 at 8:46 a.m. via email from the administrator in which the administrator wrote, "See attached. I had to have Corporate change the configuration for CP [care plan]" The attachment was labeled "cp with revisions". This care plan included the focus area of communication with the initiated date of 4/9/25, the goals remained the same and included dates the interventions were initiated. The interventions were all initiated on 4/9/25, with the		20625				

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20625	Continued from page 7 exception of "staff to ensure resident has her headphone one [sic] when communicating..." which was 6/19/25, and "Staff to ensure resident has his [sic] box talker..." which was dated 7/5/25. This version of the care plan included an intervention that was not reflected on the first version provided at 7:51 a.m. which was "Encourage resident to remove pocket talker while resident and at HS [at night]" with initiated date of 7/3/25. -In the same copy of the care plan provided at 8:46 a.m. was the vision focus that was initiated on 6/19/25. The goals were unchanged between this copy and the previous copy that was provided at 7:51 a.m. The interventions that were listed all identified they were initiated on 7/5/25 with the exception of "Encourage resident to remove glasses while resident and at HS" which identified an initiated of 7/3/2025. There was no revision dates identified for any interventions listed. The facility then provided "Care Plan Audit [resident initials]" via email on 7/14/25 at 10:50 a.m. The audit report identified the focus of communication was created and initiated on 4/9/25 and had a revision date of 7/5/25. The corresponding goals identified they were created and initiated on 4/9/25 and had a revision date of 7/9/25. The audit report identified most of the interventions had been created on and initiated on 4/9/25, except for one intervention that was created by the administrator and one intervention was created by registered nurse (RN)-B in which those interventions had a created-on date after the initiation date. The intervention "Encourage resident to remove pocket talker while resting and at HS Date" was created on 7/7/25 by the administrator, however the initiated date of the intervention was 07/03/2025. The intervention "Staff to ensure resident has her headphone one [sic] when communicating and watching TV per her choice" was created on 7/9/2025 by registered nurse (RN)-B however the initiated date of the intervention was 6/19/25. -In the same copy of the Care plan Audit report that was provided at 10:50 a.m. included the vision focus which identified RN-B created the focus on 7/5/25 and the administrator revised the focus on 7/5/25, but the initiated date was 6/19/25. The corresponding goals were created on 7/5/2025 and revised on 7/9/25 by RN-B. The intervention "Encourage resident to remove glasses while resting and at HS" was created on 7/7/25 by the administrator however the care plan identified the initiated date was 7/3/25. All of the interventions were created and initiated on 7/5/25 by RN-B. The care plan did not identify any revision dates.			20625			

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20625	Continued from page 8 During an interview on 7/14/25 at 10:17 a.m., administrator stated she was unsure why the care plans when printed showed the wrong dates. Administrator stated she initiated the focus of R1's refusal of removing pocket talker on 7/5/25 after her hospitalization on 7/4/25. Administrator further stated R1 focus of vision with history of refusing to remove her glasses was not implemented until 7/5/25. Administrator was unsure why the care plan was printing out with inaccurate dates. During an interview on 7/14/25 at 10:33 a.m. regional nurse consultant (RNC)-A stated R1's care planned dates for the focus of vision and communication were not accurate or readily accessible and should be. RNC-A stated R1's care plan audit report would be most accurate and was not sure why the dates on R1's care plan revision was inaccurate. During an interview on 7/14/25 at 11:12 a.m., registered nurse (RN)-B stated he was the nurse manager for R1's unit and indicated the dates were not accurate when printed for the focus of vision and communication. R1's refusals were not initiated until after her hospitalization on 7/4/25. RN-B stated the care plan should be printing out accurate dates. Policy regarding resident medical record was requested and was not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review, and revise policies and procedures related to accuracy of care plan created, initiation, and revision dates in the electronic medical record. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure resident records are true and accurate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days		20625				
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless		20900			08/08/2025	

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20900	Continued from page 9 the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure that 1 of 3 residents (R1) reviewed for pressure ulcers received care and services to prevent occurrence of newly developed pressure ulcers. The facility's failure resulted in actual harm to R1 when R1's skin was not comprehensively assessed and failed to develop a care plan for pressure ulcer prevention that resulted in six (6) pressure ulcers including Stage 4 pressure ulcer to R1's nose and deep tissue injuries to R1's ear. Findings include: According to the State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, revised 08-08-2024, included the following definitions: - "Pressure Ulcer/Injury (PU/PI)" refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. - "Stage 4 pressure ulcer" refers to full thickness skin and tissue loss with exposed or directly palpable fascia, muscle tendon, ligament, cartilage, or bone in the ulcer. Slough and /or eschar may be visible on some parts of the wound bed. - "Eschar" refers to dead or revitalized tissue that is hard or soft in texture; usually black, brown or tan in color, and may appear scab like, Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides and edges of the wound. - "Unstageable pressure ulcer" refers to a full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar.			20900			

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20900	Continued from page 10 If the slough or eschar is removed, a stage 3 or 4 pressure ulcer will be revealed. - “Deep tissue pressure injury (DTPI)” refers to intact skin with localized area of non-blanchable deep red, maroon or dark purple discoloration due to damage of underlying soft tissue. - "Avoidable" means that the resident developed a pressure ulcer/injury, and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. R1’s Braden Scale for Predicting Pressure Sore Risk dated 6/11/25, identified a score of 13 indicating R1 was at moderate risk due to the following factors: 1. Sensory perception-very limited, responds to only painful stimuli...2. Moisture-occasionally moist requiring an extra linen change once a day, 3. Activity-chairfast ability to walk severely limited or non-existent, cannot bear own weight and must be assisted into a chair or wheelchair. 4. Mobility-very limited makes occasional slight change in body or extremity position but unable to make frequent or significant changes daily. 5. Nutrition was adequate...6. Friction and Shear-a problem required moderate to maximum assistance in moving. Complete lifting without sliding against sheets was impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction. R1’s admission Minimum Data Set (MDS) dated 6/17/25, identified R1 had highly impaired hearing that required a hearing device and had impaired vision with corrective lenses. R1 had severe cognitive impairment, no speech and was completely dependent on staff for all activities of daily living (ADLs). R1’s diagnoses included acute and chronic respiratory failure (when the lungs can’t adequately provide oxygen to the blood or remove carbon dioxide from it) with hypoxia (when the body doesn’t receive enough oxygen), need for tracheostomy (a surgical procedure creating an opening in the trachea (windpipe) to facilitate breathing) and anxiety disorder. R1 was at risk for pressure ulcers and had no identified skin concerns. R1’s MDS triggered Care Area Assessments (CAA) for		20900				

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20900	Continued from page 11 pressure ulcers, vision, and communication. R1’s Pressure ulcer CAA dated 6/17/25 identified R1 at risk for skin breakdown related to decreased mobility, incontinence. R1 requires assistance from staff with mobility, transfers, and toileting needs R/T physical limitations but R1 can make some position changes on her own however, staff assist with repositioning and offloading as needed. Staff will monitor skin and report changes for evaluation/intervention/treatment as appropriate. R1’s vision CAA identified R1 had impaired vision related to multiple comorbidities and used glasses on a daily basis. R1’s Communication CAA identified R1’s ability to hear was highly impaired related to multiple comorbidities. R1 did not use hearing aide/device. Will proceed to care plan. According to R1’s care plan audit report (printed on 7/14/25) did not specifically include a pressure ulcer focus nor identify R1 was at risk for pressure ulcers. However, the care plan did include a Skin care plan focus that was created and initiated on 4/9/25, which identified R1 was at risk for impaired skin integrity and advised R1 had a fluid filled blister on her arm with no other skin issues identified. The intervention also dated 4/9/25 directed staff to monitor skin integrity daily during cares and weekly skin inspection by nurse. R1’s communication focus created on 4/9/25 included the intervention “Staff to apply hearing box on resident when communicating with her” which also had a created date of 4/9/25. In review of CAA’s and R1’s care plan dated 6/11/25 through 7/4/25, there was no indication R1’s external devices (glasses and hearing box) used over bony prominences (nose and ears) were comprehensively assessed nor identified as risk for factors for pressure ulcer development. Additionally, or alternatively, there was no indication individualized pressure relieving/reducing interventions associated with devices were developed and implemented except for turn and reposition every 2 to 3 hours dated 4/9/25. R1’s order summary dated 6/11/25, identified to perform weekly skin inspection by licensed nurse. Complete weekly skin Inspection in Point Click Care (PCC-an electronic health record) every Wednesday and Sunday evening shift. Review of R1’s record between 6/11/25 through 7/4/25 identified Weekly Skin Inspections assessments were completed on 6/11/25, 6/15/25, and 6/25/25. These assessments identified R1 did not have any skin issues. R1’s Treatment Administration Record (TAR), dated July			20900			

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20900	Continued from page 12 2025, identified weekly skin inspection by licensed nurse. Complete weekly skin inspection in PCC every Wednesday and Sunday evening shift. The box on 7/2/25, identified a nurse had put their initials in box indicating the skin assessment was completed. However, in review of R1's record no comprehensive weekly skin inspection assessment completed for R1 on 7/2/25. R1's progress note dated 7/4/25 at 10:21 a.m., identified R1 was transferred to the hospital related to a large amount of blood in R1's colostomy bag. R1's Emergency Department (ED) to hospital admission record dated 7/4/25, identified R1 was admitted to ED at 10:33 a.m. for gastrointestinal (GI) bleed. Conditions present on admission identified R1 had severe skin breakdown on nasal bridge, visible bone (photo in chart) with significant concerns for elder abuse/neglect. This was escalated to charge nursing... R1's glasses were removed, and bilateral wounds present on bridge of nose where glasses rest. Headphones (for pocket talker) were removed, and wounds noted to left ear. Upon speaking with R1's family member (FM)-A. FM-A stated she had asked facility staff about routinely removing R1's eyeglasses and headphones at night and was told by staff that they are not allowed to remove these items if R1 refused. R1 had significant skin breakdown on nasal bridge in shape of R1's glasses nose pads. Bone was visible beneath. R1 was noted to have a suspected pressure ulcer to the left side of her nose, suspected pressure ulcer to the right side of the nose and wounds to R1's left ear. Picture description of left nasal bridge: one rectangular shaped ulcer located to her left lateral side of her nasal bridge with clear slough over exposed bone, scabs surrounding the open area. (consistent with stage 4 pressure ulcer). Picture description of right nasal bridge: one rectangular shaped ulcer noted to right lateral side of nasal bridge with exposed bone, surrounded by bloody drainage. (consistent with stage 4 pressure ulcer). Picture description of left ear: one wound on the end of the tragus (small, cartilaginous flap of tissue located on the outer ear, situated in front of and partially covering the opening of the ear canal) with eschar formation, one wound on the edge of the antitragus (It's situated above the earlobe and points anteriorly, meaning towards the front of the head) with eschar formation. R1's pinna (The visible, fleshy part of the ear on the side of the head. It is made up of cartilage covered in skin) of the ear was pulled		20900				

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20900	Continued from page 13 forward to identify two darkened areas of skin on the mastoid process (area just below and behind your ear) where the stems of the glasses would lie. (coincides with medical device related pressure injury). Tragus and antitragus wound coincide with an unstageable pressure ulcer. According to R1's care plan audit report (printed on 7/14/25) there were no identification of pressure ulcer risk associated with external devices (glasses and pocket talker) and no corresponding interventions were developed to reduce pressure and/or mitigate the risk for pressure ulcers associated with devices until after R1 was hospitalized. R1's vision focus identified R1 had alteration in vision as evidenced by: "Resident wearing glasses" and "Resident has history of refusing glasses and will often sleep with them on"; this focus was created on 7/5/25 (after R1 was transferred to the hospital) but had an initiated date of 6/19/25 (prior to R1's hospitalization). A corresponding intervention that directed staff to "Encourage resident to remove glasses while resting and at HS [at night]" was created on 7/7/25 (three days after R1's transfer to the hospital) but had an initiated date of 7/3/25 (one day prior to R1's hospitalization). R1's communication focus was revised 7/5/25 to include "Resident often refuses to remove pocket talker. An additional intervention was created on 7/7/25 that directed staff to Encourage resident to remove pocket talker while resting and at HS, however identified 7/3/25 as the date the intervention was initiated. During a phone interview on 7/9/25 at 9:31 a.m., hospital social worker (HSW)-A stated R1 was hospitalized on 7/4/25 and when R1 first admitted the nurse "had to peel the glasses off R1's face." and "it was like R1 never had her glasses removed off her face" while she resided at the facility. HSW-A explained there were good pictures of her wounds in her hospital record; HSW-A remarked R1's wounds to her nose were definitely from pressure from her glasses and could have been prevented. During an interview on 7/10/25 at 11:54 a.m., hospital RN (HRN)-A stated she was working on 7/4/25, the day R1 was admitted around 5:00 p.m., she did a full body skin assessment on R1 and noticed redness around her glasses. HRN-A used R1's pocket talker to explain what she was going to do and removed R1's glasses without refusal. HRN-A stated she had trouble removing R1's eyeglasses because "like they were stuck to her face" HRN-A noted R1 to have full thickness pressure ulcers that were rectangular shaped on either side of R1's nose directly from the rectangular nose pieces of her		20900				

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20900	Continued from page 14 glasses. HRN-A had never seen anything like it before and she believed R1 to have pain because during the removal of the glasses, R1 had facial wincing and grimacing. HRN-A stated when she removed R1’s headphones she noted two unstageable pressure ulcers to the tragus and antitragus portion of the left ear with eschar formation and two deep tissue pressure injuries behind the left ear from the stems of the glasses where they wrapped around the ear. R1’s pressure ulcers were from pressure from her eyeglasses and headphones and were completely preventable. HRN-A indicated it looked like they had never been removed from the facility she resided at. During an interview on 7/10/25 at 10:33 a.m., family member (FM)-A stated she visited R1 at the facility twice a day. FM-A would see the aides come in to do skin assessments, but they would just usually look at her bottom. FM-A never witnessed the staff “ever remove R1’s glasses or headphones from her ears.” FM-A stated when she came to visit in the morning R1’s headphones and glasses were always on even though she was sleeping and indicated she would come back at night and stay until R1 fell asleep. FM-A reiterated that no staff ever came in to remove R1’s glasses or headphones. FM-A was at the hospital on 7/4/25, when the nurse at the hospital took R1’s glasses off and stated, “she had deep wounds on either side of her nose that were rectangular shaped from her nose piece of her glasses. FM-A described the wounds as, "bloody gashes in the sides of R1’s nose.” FM-A stated she had wounds in and behind her left ear where her headphone being on her ears at all times and her glasses “digging in.” During an interview on 7/10/25 at 11:40 a.m., nursing assistant (NA)-A indicated she was familiar with R1’s morning cares. NA-A stated R1 would never allow me to remove her headphones, R1 would push her hands out at me, so I would just move them a little bit forward to clean her face and had never noticed any sores on R1’s ears. NA-A stated R1 never allowed anyone to remove her eyeglasses, she would kick and flail when staff tried. NA-A did notice R1 had red marks on her face from the eyeglasses but didn’t think they were open sores and thought the nurses were aware. During an interview on 7/10/25 at 12:22 p.m., NA-B stated R1 always wore her glasses and headphones for her pocket talker. NA-B never noticed any redness under R1’s glasses and never noticed skin concerns under her headphones but admitted she never removed R1’s headphones or eyeglasses due to refusals. During an interview on 7/10/25 at 11:21 a.m., licensed		20900				

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20900	Continued from page 15 practical nurse (LPN)-A indicated he worked with R1 on the day shift of 7/2/25 and had noticed R1 had redness on the bridge of her nose under her eyeglasses when they were repositioning her and stated he put a cream on it but was not sure what cream he put on it. LPN-A reported this skin concern to registered nurse (RN)-B who was the nurse manager. LPN-A never took R1's glasses off to fully assess R1's skin and stated he did not document the redness he had seen. LPN-A further stated R1 always kept her glasses and her headphones on her ears 24 hours a day. R1 would refuse to take her glasses or her headphones off. When R1 would refuse to take them off, LPN-A never explained to R1 the risks of pressure ulcer development from not removing the devices. During an interview on 7/10/25 at 12:28 p.m., RN-B stated he was the nurse manager for R1 and indicated R1 kept her eyeglasses and headphones for her pocket talker on 24 hours a day seven days a week. R1 refused to have her glasses, or her headphones removed. RN-B indicated that the care plan did not identify this and there were no prevention interventions implemented to prevent pressure ulcers to her nose or her ears and there should have been. R1's last comprehensive skin assessment was completed on 6/25/25, and it was missed on 7/2/25. RN-B explained LPN-A had notified him on 7/2/25 that R1 had redness under her eyeglasses, but admittedly he did not complete a comprehensive skin assessment. R1 was sent to the hospital on 7/4/25, and the hospital had reached out to the facility stating R1 admitted with pressure ulcers to R1's nose and left ear that he had not been aware of. During an interview on 7/10/25 at 11:08 a.m., registered nurse (RN)-A stated she was a regular floor nurse that worked on R1's unit. RN-A never saw R1 with her glasses and her headphones from her pocket talker off of her ears. R1 had never refused cares for her, "as long as you used R1's pocket talker to explain what you were doing [R1] did not refuse cares." RN-A explained the risk of never taking R1's eyeglasses and headphones off her ears would be a high risk for pressure ulcer development. During an interview on 7/10/25 at 2:17 p.m., the director of nursing (DON) stated staff shared with him that R1 was resistive to having her glasses and headphones removed after hearing from the hospital about R1's pressure ulcers. DON indicated R1 was a mechanical ventilator resident who was fully dependent with adl's putting her at high risk for pressure ulcer development. R1's care plan should have identified she would be at risk for pressure ulcer development if R1's		20900				

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20900	Continued from page 16 glasses and headphones were not removed, and prevention interventions should have been developed to prevent pressure ulcers to these areas. DON indicated R1's 7/2/25, skin assessment was missed and the staff at the hospital did notify the facility that R1 admitted to the hospital with pressure ulcers to her nose and left ear. DON stated comprehensive skin assessments must be performed weekly. DON indicated R1's pressure ulcers were preventable. A facility policy, "Skin Assessment and Wound Management," revised 2/2025 indicated Provide guidelines for assessing and managing wounds were: A pressure ulcer risk assessment (Braden Scale) will be completed per Monarch's Assessment Schedule/Grid. Implement appropriate preventative skin measures. Examples include, but are not limited to-nutritional interventions, mobility and repositioning plan, pressure redistribution plan. Skin Evaluation and Skin Risk Factors Form is completed before initial MDS, annually, and upon significant change. Staff will perform routine skin inspections (with daily care). Nurses are to be notified if skin changes are identified. Licensed staff will complete a weekly skin inspection. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20900				