STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emeralds at Faribault LLC	500 Southeast First Street Faribault, MN 55021

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure four of five residents (R1, R4, R2, and R5) reviewed for financial exploitation were free from misappropriation of personal property and financial exploitation when facility staff stole resident credit/debit cards or card information and made unauthorized transactions totaling over $5,000. This had the potential to affect all residents residing at the facility. Findings include:R1R1's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R1 had moderately impaired cognition and required partial to substantial assistance from staff for most activities of daily living (ADL's). R1's facesheet dated 7/9/25, indicated he was his own responsible party and his emergency contact was his spouse, R4. R1's diagnoses included unspecific dementia. R1's care plan dated 6/11/25, identified he was a vulnerable adult and at risk for decreased cognitive and physical abilities. Interventions included: staff will continue to follow the facility vulnerable adult and abuse reporting policy; and local ombudsman, adult protection, police, and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed. R1's progress note dated 6/12/25, indicated the business office manager (BOM) alerted the social services direct (SDD) of suspicious activity on R1's banking statement and a large amount of missing money. R1 stated he had not given his banking information to anyone or made any new purchases. BOM and R2 called the bank and communicated there were many purchases on the account R1 didn't make. The bank put a stop on the account. Police were called and a report filed. Police spoke to the bank and stated a bank employee would come to the facility to assist R1 with filling out paperwork related to the fraudulent purchases. R1's bank form titled Cardholder Statement of Disputed Items dated 6/12/25, included a list of disputed transactions with dates, dollar amounts, and merchants for cardholder name of R1. Disputed transactions marked as unauthorized/counterfeit transactions (cardholder did not authorize or engage in the transaction) dated 5/19/25 through 6/11/25. There were 65 disputed transactions totaling $4, 040.18. R1's bank statement dated 5/30/25, included the following transactions:- $279.61 on 5/23/25 to LULULEMONCOM- $136.56 on 5/27/25 to VALLEYFAIR ONLIN[E]- $168.00 on 5/27/25 to LULULEMONCOM R1's bank statement dated 6/30/25, included the following transactions:- $75.06 on 6/4/25 to eBay- $108.00 on 6/6/25 to Nike.com- $225.00 on 6/6/25 to Nike.com- $39.99 on 6/9/25 to SUGARBABYCARE- $69.80 on 6/9/25 to SUGARBABYCARE- $129.00 on 6/9/25 to LULULEMONCOM- $168.00 on 6/9/25 to LULULEMONCOM- $263.80 on 6/9/25 to Nike.com- $223.45 on 6/10/25 to VF Outdoor, LLC (a subsidiary of VF Corporation, an apparel, footwear, and accessories company that owns brands including Timberland)- $27.75 on 6/11/25 to TIKTOK SHOP- $35.94 on 6/11/25 to eBay- $168.00 on 6/11/25 to LULULEMONCOM- $198.00 on 6/11/25 to VF Outdoor, LLC- $198.00 on 6/11/25 to VF Outdoor, LLC a second time- $65.76 on 6/12/25 to eBay Nursing Home Incident Report submitted to the state agency (SA) dated 6/17/25, identified an allegation of financial exploitation for R1. Description of the incident included, On June 12, 2025, facility identified $4,047.67 in unauthorized transactions on resident [R1's] bank account, occurring between May 16 through June 12, 2025. [R1] did not approve these charges. Today, we confirmed the address linked to the transaction belongs to a facility employee. Alleged perpetrators identified in the report included one nursing assistant (NA), NA-A. Investigation follow-up report submitted to the SA dated 6/23/25, identified NA-A was interviewed after a Valley Fair (local amusement park) purchase made with R1's card was traced to NA-A's first name and a separate purchase from Sugar Baby Crush was linked to the same street address as NA-A's documented address, but with a one-digit difference in the apartment number. NA-A denied involvement in the transactions. NA-B was interviewed when online orders under his name were linked to the unauthorized use of another resident, R2's, financial information with shipments sent to NA-B's address on file. NA-B stated this was his previous address and he now lived at the address linked to the Sugar Baby Crush on R1's bank statement. NA-B denied involvement. Staff members with linked address were suspended pending further investigation. Investigation conclusion noted, the allegation was verified based on evidence collected during the investigation. During an interview on 7/1/25 at 11:16 a.m. , R1 stated he was not sure of the exact amount, but people had taken his money without him knowing or authorizing this. His card was not taken, but money was taken out of his associated checking account some way or another. He previously kept his card in his wallet and wallet in his pocket or on the dresser. Now he kept it in a lockbox. R1 had worried this would continue to happen, but now had a new card. He was upset that his money was disappearing without him knowing and worried he might try to go shopping and have his

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and document review, the facility failed to implement its policy to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of property when pre-employment background screening procedures were not completed for one of 11 staff members reviewed for background screening. This had the potential to affect all 71 residents residing in the facility as the staff member worked on all units. Findings include:Findings include:Untitled undated facility personnel document, identified nursing assistant in training (NAIT)-A was a new hire for position of NAIT with start date of 1/29/25. NAIT-A's employee status was full time.Criminal Background Study Information form undated, contained personal and demographic information required to complete a criminal background study for NAIT-A. A box on the form labeled office use only contained date results received space for date to be written in. This space was blank. Review of NAIT-A's employee file did not identify a completed pre-employment background screening. Review of NAIT-A's timesheets indicated she worked shifts at the facility from 1/29/25 through 6/24/25. During an interview on 7/8/25 at 11:26 a.m., NAIT-A stated she began working at the facility at the end of January as an NAIT. She stated she worked everywhere including the facility's unit on the second floor and both units on the first floor. During an interview on 7/1/25 at 1:26 p.m., the director of nursing (DON) stated keeping residents safe included the hiring process. Background screening was done and references checked to ensure whoever was brought into the facility to care for residents was cleared. This was part of the hiring process for everyone in the facility.During an interview on 7/7/25 at 2:33 p.m., the administrator stated the requested background clearance for NAIT-A could not be located. She noted NAIT-A had completed a background study form online but never went for fingerprinting, so there was no background clearance in NAIT-A's file. The administrator was not previously aware NAIT-A's background screening procedure was not completed, and facility procedure was to complete this prior to an employee starting work. This needed to be done to ensure the facility brought in individuals who were competent, safe, and allowed to work in healthcare.Facility policy titled Abuse Prohibition/Vulnerable Adult Policy dated 4/2025, identified the purpose of the policy included protecting residents against abuse by anyone, including facility staff. The Prevention section included employee screening and noted, The Minnesota Department of Health requires Criminal Background Studies to be completed on all facility employees (Sections 144.40 to 144.58). Potential employees are screened for a history of abuse, neglect, or mistreating residents. Licensing verification checks, and Nursing Assistant Registry checks are completed on facility employees when indicated.Facility policy titled Background Study Policy dated 12/2016, identified it was the facility's policy to complete criminal background studies on all employees. Upon hire or facility transfer, employees completed a facility background study form. The Human Resources Director would verify the information was correct and submit an online background study request. Further, The employee may not begin working until the results of the request are received and indicate the applicant is not disqualified or may work unsupervised while a study is being completed. If an employee was not disqualified, the applicant could then be scheduled to work and results were filed in employee personnel file. Staff personnel files containing study results were maintained by the [NAME] President of Human Resources.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure allegations of financial exploitation were reported to the State Agency (SA) within 24 hours for four of five residents (R1, R2, R3, and R4) reviewed for allegations of financial exploitation. Findings include:Findings include:R1R1's facesheet dated 7/9/25, indicated he admitted to the facility on [DATE] and was his own responsible party. R1's emergency contact was his spouse, R4.R1's care plan dated 6/11/25, identified he was a vulnerable adult. Interventions included: staff will continue to follow the facility vulnerable adult and abuse reporting policy; and local ombudsman, adult protection, police, and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed.Nursing Home Incident Report #360867 was submitted to the SA on 6/17/25 at 2:57 p.m. The report identified an allegation of financial exploitation for resident R1. The business officer manager (BOM) was the initial reporter and became aware of the incident on 6/17/25 at 2:00 p.m. Details included, facility found out that resident's bank statement has unauthorizes purchases which is linked to employee's address. Description included, On June 12, 2025, facility identified $4,047.67 in unauthorized transactions on resident [R1's] bank account, occurring between May 16 through June 12, 2025. [R1] did not approve these charges. Today, we confirmed the address linked to the transaction belongs to a facility employee.During a joint interview on 6/30/25 at 3:42 p.m., the BOM stated she assisted R1 monthly to check his bank account and print the statement. She noticed unusual activity on R1's bank statement on 6/12/25 and notified administration right away. The administrator in training (AIT) stated he filed a Minnesota Adult Abuse Reporting Center (MAARC) report initially and then when the facility later noticed that some of the transactions were linked to employee names, an Office of Health Facility Complaints (OHFC)/State Agency (SA) report was filed.During an interview on 7/7/25 at 10:44 a.m., the administrator stated the facility first became aware of concerns regarding suspicious activity on R1's bank account on 6/12/25 when the facility identified $4,047.67 in unauthorized charges. A police report and MAARC report were filed on 6/12/25 but the report to the SA was not filed until 6/17/25 when addresses linked to the transactions were identified as belonging to employees. She was not present on 6/12/25 and did not know why it was not reported to the SA at that time, she would expect the allegations to have been reported to the SA on 6/12/25. The administrator stated alleged financial exploitation should be reported to the SA within 24 hours. R2R2's facesheet dated 7/9/25, indicated he admitted to the facility on [DATE] and had a financial power of attorney.R2's care plan dated 5/20/25, identified he was a vulnerable adult. Interventions included: staff will continue to follow the facility vulnerable adult and abuse reporting policy; and local ombudsman, adult protection, police, and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed. Investigation Report with submission date 6/23/25 at 4:06 p.m., was submitted to the SA as the follow-up for Nursing Home Incident Report #360867 regarding R1. The investigation report noted similar incidents had been identified including a case involving R2. Unauthorized transactions had been discovered on R2's bank account beginning around 5/15/25. The BOM had confirmed this with R2's power of attorney (POA), POA-A. Police were notified and investigation ongoing.Nursing Home Incident Report #360946 was submitted to the SA on 6/25/25 at 11:48 a.m. The report identified an allegation of financial exploitation for resident R2. The BOM was the initial reporter and became aware of the incident on 6/20/25 at 1:30 p.m. Description included, upon review/investigation of an open OHFC [report] relating to financial exploitation, business office manager reviewed resident's bank statement and discovered suspected fraudulent activity.During an interview on 7/1/25 at 1:07 p.m., the BOM stated she became aware of the concerns when POA-A spoke to the social services director (SSD) who came and got her. The SSD told her POA-A noticed some things on R2's bank statement. The BOM reviewed the bank statement with POA-A and identified concerns for fraudulent activity like that seen on R1's account.During an interview on 7/7/25 at 7:55 a.m., POA-A stated she identified concerns with R2's credit card on 6/19/25 when she tried to use the card to obtain a storage unit for R2 and it was declined due to fraudulent activity. POA-A went to the facility the next day on 6/20/25 and mentioned this to the SSD. R2 had his bank statements, which POA-A reviewed with facility staff who stated there was an investigation going on and this had happened to another resident. The facility notified the police, who came and spoke with R2 regarding the fraudulent activity. During an interview on 7/7/25 at 10:44 a.m., the administrator stated the facility became aware of concerns about financial exploitation related to R2 on 6/20/25 when his bank statement was reviewed with the BOM and suspected fraudulent activity identified

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and document review, the facility failed to identify and protect all residents at risk of financial exploitation during investigations into 4 of 4 residents (R1, R2, R3, R4) reviewed who made allegations of financial exploitation. This had the potential to affect all 67 other residents who were residing in the facility, including R5, whose representative subsequently identified and reported additional allegations of financial exploitation. Findings include:Untitled resident questionnaire documents dated 6/17/25 and 6/18/25, included dates, resident names, interviewer signatures, and three questions. Questions included: have you noticed any unusual transactions on your bank account recently; Have you noticed any missing valuables, money, checks, credit cards or debit cards recently; and do you know how to report facility concerns, lost, missing, or damaged items. Questionnaires were completed for 29 residents. One questionnaire had a resident name written down and crossed out with no further information, and one questionnaire had a resident name, R5, date of 6/17/25, and note at the bottom indicating R5 was hospitalized /on a leave of absence. Facility document titled Attendance Record dated 6/18/25, identified it was for resident education on storing valuable items. The record included resident names/signatures or staff signatures on behalf of residents unable to sign and resident room numbers. The record identified education was completed with 47 residents, per listed room numbers. Facility document titled Resident Education Regarding Valuables in the Facility undated, was a one-sheet page with printed information. The information included, It is important to be aware that while residing in the facility, there will be multiple staff that frequently enter and exit residents' private living spaces. Checkbooks, cash, credit cards, and valuable jewelry should not be left unsecured in residents' private living space. Residents may wish to obtain a lockbox to secure items should they decide to keep these items at the facility. It is recommended that valuables be kept with family if possible. It is important to be aware that physical credit cards do not need to be taken, thieves have taken pictures of credit cards and used the images to permit theft. You should never share your financial PIN [personal identification number] numbers or passwords with anyone. If you suspect a crime has occurred, report it immediately to staff. During an interview on 7/7/25 at 10:44 a.m., the administrator stated the facility first became aware of allegations of financial exploitation on 6/12/25 when the facility identified $4,047.67 in unauthorized charges/suspicious activity on R1's bank account statement reviewed by the business office manager (BOM). On 6/17/25, the facility identified addresses linked to the transactions belonged to employees. The facility became aware of concerns regarding financial exploitation of R3 on 6/18/25, when an interview was conducted with R3 who reported her debit card was missing but had no fraudulent transactions because she had cancelled the card. The facility became aware of concerns about financial exploitation related to R2 on 6/20/25 when his bank statement was reviewed with facility staff and suspected fraudulent activity identified. The facility became aware of concerns about financial exploitation related to R4 on 6/26/25 when they realized R1's bank account was shared with R4, her spouse. The administrator would expect the allegations of financial exploitation of R4 to have been identified on 6/12/25 when the facility identified the fraudulent activity on the account because R4's name was clearly on the bank statement/account. In a follow-up interview at 3:32 p.m., the administrator stated the fraudulent charges on R2's account totaled $709.97. During a joint interview on 6/30/25 at 3:42 p.m., the administrator in training (AIT) stated after the facility identified potential financial exploitation of R1 was linked to employee addresses and names via transactions, identified staff members were suspended. In addition, the facility checked in with other residents who managed their own finances to see if they had issues. The social services director (SSD) stated she completed this along with the social services designee and the receptionist. This was a list of questions, a safety questionnaire, she discussed with about 20 to 30 residents. The AIT stated this was when R3 notified the facility she had a missing bank card. During an interview on 7/1/25 at 9:11 a.m., the SSD stated after the BOM noticed fraudulent activity on R1's bank account, staff including herself completed questionnaires with residents and asked them if they had noticed anything similar. Education was provided that if they wished to purchase a lock box they could. She stated secure storage for resident valuables was not offered to residents unless they asked for it, and the admission contract contained information about storage of valuables. During a follow-up interview on 7/7/25 at 12:11 p.m., she confirmed safety questionnaires were completed on 6/17/25 and 6/18/25. She was advised to complete them only with residents who oversaw their own finances. Staff also rounded with an educational paper given to all residents about lock boxes and keeping personal items safe. It did not notify residents of the financial

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many Note: The nursing home is disputing this citation.	Post nurse staffing information every day. Based on observation and interview, the facility failed to post accurate data reflecting the total number and actual hours worked per shift by nursing staff directly responsible for resident care on a daily basis. This had the potential to affect all 71 residents residing in the facility and their visitors who may wish to review the information. Findings include:On 7/9/25 at 8:50 a.m., the facility's nurse staff posting form dated 7/9/25, was located on top of a chest of drawers by the front desk. The posting included the daily resident census, total number of nursing staff hours, and sections for the facility's three units and section labelled agency. Each section was further broken down into sections of day shift, evening shift, overnight shift, and adjustments with spaces in each for registered nurse (RN), licensed practical nurse (LPN), trained medication aide (TMA), certified nursing assistant (NA), and nursing assistant in training (NAIT). Information written on the paper indicated the number of staff working in each role on each shift on each unit with corresponding number of total staff hours worked per role per shift per unit (i.e. one RN and eight hours or two LPN's and 16 hours). The sheet did not identify the actual hours worked for any of the identified nursing staff roles. During an interview on 7/9/25 at 8:50 a.m., the director of nursing (DON) reviewed the nurse staff posting form dated 7/9/25. The DON indicated the posting was written to show how many people were working in each role for the shift and then the total hours worked by those people. The DON stated the actual hours worked by nursing staff were reflected in the schedules for staff posted at the nursing stations. He acknowledged those schedules were not the facility's nurse staff posting. He confirmed the actual hours worked by nursing staff were not included in the facility's daily nurse staff posting. Facility policy titled Nursing Hours Posting dated 10/2/2022, identified it was facility policy to post nursing staffing data on a daily basis at the beginning of each shift. The posting was to include facility name, current date, resident census, and the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. Categories included registered nurses, licensed practical nurses or licensed vocational nurses, and certified nursing assistants. Policy interpretation and implementation identified federal law required Medicare and Medicaid certified nursing homes to post the number of staff who are directly responsible for resident care in the facility on each shift.