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	03/11/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure care plan interventions related to anticoagulant therapy were effectively communicated to direct care staff responsible for observing and reporting changes in condition and failed to develop a comprehensive individualized care plan that addressed cardiac management for 1 of 3 residents (R2) reviewed for quality of care who had a significant cardiac history and administered blood thinning medications. Findings include:R2's face sheet identified the following diagnoses; acute diastolic congestive heart failure (sudden worsening of heart failure where the heart becomes stiff and cannot fill with blood properly, leading to fluid buildup), personal history of transient ischemic attack (TIA) temporary blockage of blood flow to the brain causing stroke-like symptoms), cerebral infarction without residual deficits (stroke with no lasting effects), atrial fibrillation (abnormal heartbeat that can cause blood clots or stroke), presence of aortocoronary bypass graft (heart bypass surgery to restore blood flow around blocked arteries), hypertension (high blood pressure), ischemic cardiomyopathy (weak heart muscle caused by poor blood flow from blocked heart arteries), atherosclerotic heart disease of native coronary artery without angina pectoris (plaque buildup in the heart's own arteries, but not causing chest pain), and ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall (heart attack in the lower part of the heart caused by a blocked artery and long term anticoagulation.R2's admission minimum data set (MDS) dated [DATE], identified R1's cognition was intact. R2 required staff to assist with activities of daily living (ADL)'s and used a wheelchair for mobility. R2's order summary dated 3/6/26 identified warfarin sodium 2 milligram (mg) tablet by mouth every evening for long term use of anticoagulants. On 2/13/26 monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, shortness of breath (SOB) and nose bleeds.R2's care plan was reviewed on 3/9/26 and lacked cardiac management related interventions and goals. Care plan dated 1/17/26, identified a problem-potential for alteration in blood formation and coagulation related to the use of anticoagulant medication. Diagnosis of coronary artery without angina pectoris. Interventions identified anticoagulant medication as ordered by MD, monitor and notify the MD of signs and symptoms of bleeding and monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, shortness of breath (SOB) and nose bleeds.Review of R2's undated Kardex and nursing assistant care guide sheets did not include interventions or instructions for monitoring or reporting signs and symptoms of bleeding or that R2 was on blood thinning medication.R2's ED note dated 2/9/26, identified a suspected GI source of anemia as R2 was told he was having some dark stools although he did not witness these. During an interview on 3/9/26 at 4:21 p.m., R2 stated he was hospitalized from [DATE] to 2/12/26 for gastrointestinal bleeding. R2 reported that a male staff member had informed him a couple of days prior to hospitalization that he was having dark stools. R2 stated he uses a bedpan for toileting and staff manage the bedpan, so he did not directly observe the stool. R2 reported he assumed staff were monitoring this condition since they informed him of the (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	change.During an interview on 3/10/26 at 4:39 p.m., nursing assistant (NA)-A stated that she was not aware R2 was on blood thinning medication. She reported, I am not sure what signs and symptoms I would have to tell the nurse about if a resident received blood thinning medications. It doesn't say anything about that on our care sheets. That information should be on there. If you had to monitor for signs and symptoms of a bleed, I am not sure what that would be. Did When asked about specific symptoms, NA-A stated she was not familiar with what a tarry stool was and indicated that many residents have bruising and she does not report every bruise, as she believes nursing staff can observe them.During an interview on 3/11/26 at 8:48 a.m., NA-B stated she had no way of knowing which residents were on blood thinning medications. She indicated that while she would report visible blood in stool to the nurse, she was not aware of other signs and symptoms to monitor for bleeding. NA-B stated it would be helpful if this information was included on care sheets so staff would know what to observe and report. She further stated she was unaware that residents on blood thinners may bruise easily or experience weakness and indicated she may delay reporting such findings until the end of her shift if she did not recognize them as significant. NA-B reported she was unsure if she had access to the kardex. When asked about specific symptoms, NA-B was unable to describe what a tarry stool was and stated she does not report every bruise observed on a resident.During an interview on 3/11/26 at 10:32 a.m., NM-A confirmed that the kardex and care guides for direct care staff did not include interventions or instructions for monitoring or reporting signs and symptoms of bleeding for residents on anticoagulants. NM-A stated the care guide is intended to direct daily care and communication with staff. NM-A also confirmed that R2's care plan lacked individualized interventions for monitoring and responding to cardiac symptoms, including chest pain, shortness of breath, or other signs of cardiac distress.During an interview on 3/11/26 at 11:29 a.m., the DON confirmed that R2's care plan lacked individualized interventions for monitoring and responding to cardiac symptoms, including chest pain, shortness of breath, and other signs of cardiac distress. The DON also confirmed that the Kardex and care guides for direct care staff did not include interventions or instructions for monitoring or reporting signs and symptoms of bleeding for residents taking anticoagulants. He stated that the care guide serves as the primary tool for directing daily care and informing staff how to monitor and report resident needs.Facility policy, Care Planning, revised 11/24, outlines that each resident must have a person-centered, individualized care plan developed by the interdisciplinary team to address medical, physical, psychosocial, and functional needs. A baseline care plan is to be developed within 48 hours of admission to meet immediate needs, followed by a comprehensive care plan developed no later than the 21st day of admission. The comprehensive care plan is intended to derive interventions from a thorough assessment and be meaningful and targeted to the resident, used by staff to guide daily care, and updated as the resident's condition changes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a timely comprehensive cardiac assessment and response when 1 of 3 residents (R2) exhibited acute cardiac symptoms and requested emergency medical evaluation, which resulted in delayed provider notification and emergent hospital transfer, reviewed for quality of care. Findings includeR2's face sheet identified the following diagnoses; acute diastolic congestive heart failure (sudden worsening of heart failure where the heart becomes stiff and cannot fill with blood properly, leading to fluid buildup), personal history of transient ischemic attack (TIA) temporary blockage of blood flow to the brain causing stroke-like symptoms), cerebral infarction without residual deficits (stroke with no lasting effects), atrial fibrillation (abnormal heartbeat that can cause blood clots or stroke), presence of aortocoronary bypass graft (heart bypass surgery to restore blood flow around blocked arteries), hypertension (high blood pressure), ischemic cardiomyopathy (weak heart muscle caused by poor blood flow from blocked heart arteries), atherosclerotic heart disease of native coronary artery without angina pectoris (plaque buildup in the heart's own arteries, but not causing chest pain), and ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall (heart attack in the lower part of the heart caused by a blocked artery, shown on the heart test (ECG).R2's admission minimum data set (MDS) dated [DATE], identified R1's cognition was intact. R2 required staff to assist with activities of daily living (ADL)'s and used a wheelchair for mobility. R2's care plan that was reviewed on [DATE] did not include a cardiac-focused problem and individualized interventions to guide staff in monitoring and responding to potential changes in cardiac status, despite the residents' extensive cardiac history.During an observation and interview on [DATE] at 4:21 p.m., R2 was lying on the left side of his bed with his back facing the wall. R2 stated that on [DATE], before 5:00 p.m. (suppertime) he experienced acute, severe left side chest pain radiating down the left arm, shortness of breath, nausea, and anxiety, consistent with possible cardiac distress. R2 reported a history of extensive cardiac disease including 13 stents, 3 prior heart attacks, open heart surgery (CABG), atrial fibrillation on warfarin, and a prior stroke. R2 stated he had put his call light on because he was having chest pain and initially a female staff answered his light, he told her he was having chest pain that felt like a heart attack, she said she would get the nurse. R2 explained a black male nurse came into his room asked him what was going on and he told the nurse he was having chest pain going down his left arm and thought he was having a heart attack and wanted to be sent to the ED. R2 stated the nurse refused to call an ambulance despite repeated requests, telling him that his vital signs were fine and he did not need to go. He described receiving only a blood pressure check, pulse oximetry, and temperature measurement, with no auscultation of the heart or lungs or other cardiac assessment performed. R2 stated that he was eventually taken to the hospital after family member (FM)-A intervened by contacting the administrator and was not sent to the ED until well after 6:00 p.m. R2 reported he tried to use his cell phone to dial 911 himself but it wasn't working. R2 expressed that he felt frantic and unsafe due to the delay in care and described the facility's response as negligent, noting that staff did not respond adequately to the severity of his symptoms. R2 stated, he called FM-A the first time when staff refused to send him and continued to call because the staff were not listening to him or taking him seriously. R2 stated, I truly thought I was having a heart attack, I was scared! R2 stated he could not figure out why staff would not send him, if it turned out to be nothing at least he was checked.During a phone interview on [DATE] at 11:21 a.m., FM-A stated on [DATE], R2 called him frantically four times, reporting chest pain radiating down his left arm and stating, I'm having a heart attack, but staff would not send him to the ED despite his requests. FM-A further stated that R2 told him the nurse checked his vitals and said they were within normal limits and did not require emergent treatment. The calls occurred at 4:53 p.m., 5:33 p.m., 5:41 p.m., and 5:49 p.m. FM-A explained that in between calls, he attempted to contact the administrator. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He texted twice and called once, alerting her that staff were refusing to send R2 to the emergency department (ED). FM-A further explained the administrator responded in a text message that she would take care of it and that she was sending the director of nursing (DON) to handle it. FM-A stated, The facility staff should have listened to R2's urgent requests to be sent to the ED, and he should not have had to have me intervene for him to get emergent care promptly with his history of cardiac problems. He reported that from the onset of symptoms to the time 911 was called, over and hour had passed, and expressed concern given R2's history of heart attacks, stents, CABG, atrial fibrillation, and current GI bleeding with hemoglobin 5.7. FM-A further stated, I am not a medical person, but seeing as R2 was saying he was having a heart attack, and he wanted to be checked out at the ED, and he ended up with a low hemoglobin requiring 3 blood transfusions and all those stomach ulcers, I believe he would have died had I not intervened. He emphasized that staff should have called an ambulance when R2 complained of chest pain and requested it; he shouldn't have had to call me four times and for me to call the administrator to get him to the ED. FM-A stated with R2's previous heart attacks his vital signs were considered normal as well and FM-A believed that was not an indicator that ruled out a heart attack.R2's progress note dated [DATE] at 6:05 p.m., documented transfer to the hospital for chest pain rated 10/10. The hospital diagnosis listed was ST-elevation myocardial infarction (STEMI- which is not consistent with the hospital diagnosis of non-STEMI) involving the inferior wall of another coronary artery (heart attack in the lower part of the heart caused by a blocked artery). Vital signs at 6:03 p.m. were blood pressure 113/61, pulse 68 regular, respiratory rate 20 temperature 97.6 F, oxygen saturation 96% on room air. Pain was 10/10. R2 was alert and oriented, usual cognition intact. No behavioral concerns were noted.R2's ambulance report dated [DATE] indicated that EMS received an emergent call at 6:12 p.m. for chest pain and arrived on scene at 6:18 p.m. EMS found R2 lying in bed, alert and oriented x 4, reporting crushing chest pain radiating down his left arm for approximately 30 minutes, stating it felt like his previous heart attacks. He denied shortness of breath, dizziness, or recent illness. EMS performed vital signs monitoring, 12-lead ECG, and physical assessment, noting normal skin, head, neck, heart, neurological, and mental status, except for chest pain. EMS administered aspirin, sublingual nitroglycerin, and oxygen. R2 was transferred from bed to stretcher, transported in a position of comfort, and remained hemodynamically stable during transport. He was delivered to the ED, and care was transferred to hospital staff.R2's progress note dated [DATE] at 7:02 p.m., documented a hospital transfer for acute chest pain rated 10/10 with a hospital diagnosis of ST-elevation myocardial infarction (STEMI) involving the inferior wall of another coronary artery. At approximately 6:00 p.m., R2 reported sudden chest pain and shortness of breath. Vital signs were temperature 97.6 F, respiratory rate 20, pulse 68 regular, blood pressure 113/61, oxygen saturation 96% on room air. The resident was alert, oriented, and cognitively intact. Interventions offered included nitroglycerin, oxygen therapy, and head-of-bed elevation, all initially refused by the resident, who stated he wanted hospital transfer. The primary nurse notified the nurse practitioner (NP) at 6:03 p.m. and the facility RN at 6:10 p.m. Emergency Medical Services (EMS) was activated, and chewable aspirin was given after education. Chest pain decreased slightly to 8/10. EMS assessed R2, obtained repeat vital signs (BP 105/75), and offered nitroglycerin, which was eventually accepted. R2 was transported to the ED at 6:34 p.m., alert, verbal, and in stable condition, with all pertinent documentation sent with him.Review of R2's record reflected documentation of vital signs and pain assessment; however, there was no documentation of a comprehensive cardiac assessment or further clinical evaluation of the reported chest pain.R2's ED note dated [DATE], identified the R2 presented for evaluation of chest pain at 6:44 p.m. The record documented R2 had an extensive cardiac history including prior myocardial infarctions in 1997, 2004, 2009, and 2010, coronary artery disease (heart's arteries are narrowed or blocked, which can reduce blood flow and lead to heart problems), ischemic cardiomyopathy, atrial fibrillation, heart failure, and prior stroke in 2015. The record also identified a history of coronary artery bypass graft surgery in 2011 and multiple coronary artery stent placements (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and angioplasties (procedure to open a narrowed or blocked artery in the heart to improve blood flow). The ED note documented R2 presented from the facility with left-sided chest pain that began at approximately 5:00 p.m. on [DATE] and radiated to the left arm. R1 reported the pain felt similar to previous heart attacks. The record documented facility staff administered nitroglycerin and that R1 requested staff call emergency medical services but reported it took staff awhile to do so. The ED documentation identified diagnostic testing including an Electrocardiogram (ECG) which showed ST depressions and laboratory testing with an elevated Troponin Test of 50, raising concern for NSTEMI (A heart attack caused by a partially blocked artery that damages some heart muscle). Additional laboratory results revealed severe anemia with a hemoglobin level of 5.7, suspected to be related to a gastrointestinal hemorrhage (stomach bleed). The record further documented R1 was on chronic anticoagulation therapy and had an oxygen saturation of 87% on room air upon arrival at the ED. R2 received blood transfusions and was transferred to the hospital for further evaluation and treatment with diagnoses including NSTEMI, severe anemia (serious condition where the blood cannot carry enough oxygen because red blood cell levels are very low), gastrointestinal hemorrhage, atrial fibrillation, chronic anticoagulation (taking blood-thinning medication regularly to help prevent dangerous blood clots) and hypoxia (low oxygen in the blood that can make the body and organs not work properly).R2's Discharge summary dated [DATE] to [DATE], identified admission for chest pain, severe anemia, and gastrointestinal bleeding from gastritis and ulcers. Labs showed troponin 50˜56 (heart muscle stress), hemoglobin 5.7, and EKG changes consistent with NSTEMI. He was transfused with 3 units of blood, which resolved his chest pain. Endoscopy identified bleeding ulcers that were treated, and hemoglobin stabilized to 9.3 at discharge. Warfarin therapy continued, and echocardiogram showed a small new area of reduced heart motion. The hospital recommended follow-up care for monitoring of heart and GI status.During an interview on [DATE] at 4:39 p.m., nursing assistant (NA)-A stated that R2 told her he might be having a heart attack, reporting severe pain in his left arm and noting his history of previous heart attacks. NA-A stated she immediately notified RN-A about R2's report. NA-A started her shift on [DATE] at 4:00 p.m., and estimated the incident had occurred around 5:00 p.m., before supper. She observed that it took a significant amount of time for R2 to be transported to the ambulance, which did not occur until after supper (around 6:00 p.m.). NA-A stated during that time R2 was visibly distressed, repeatedly pressing the call light at least three times, asking when the ambulance was coming. She reported that R2 looked very worried and upset, almost in tears, and that she was concerned about R2's safety. NA-A stated she did not know what to tell R2, as the nurses had not provided instructions, and she was not present when RN-A went into the room to speak with R2.During a phone interview on [DATE] at 4:59 p.m., registered nurse (RN)-A stated he was the nurse responsible for R2 on [DATE] during the evening shift. RN-A was unsure of exact times but stated a female aide informed him that R2 wanted to see him. The aide did not explain what R2 needed, and RN-A assumed the resident had fallen, so he brought equipment to check vital signs. RN-A stated that R2 was experiencing chest pain and appeared agitated. He reported he was unaware of R2's extensive cardiac history. When he attempted to assess the severity of R2's chest pain, R2 told him he just wanted to go to the ED. RN-A stated he was unaware of a specific facility policy or procedure for assessing cardiac symptoms. He indicated that he would consider blood pressure in the 150/90 range or pulse over 100 as a significant cardiac event. RN-A stated that he performed a full cardiac assessment, but he was unable to articulate what that included, and he did not document the cardiac assessment or R2's request to go to the ED in the resident's record. RN-A was unable to establish a clear timeline but thought that nurse manager (NM)-A had asked him around 5:50 p.m., when he was in the hallway outside of R2's room that FM-A had concerns that R2 was having heart attack symptoms and staff had refused to send to the ED. RN-A denied refusing care and stated NM-A got a set of vitals on R2 which were stable, called the provider and 911. R2 was then sent to the ED around 6:10 p.m.During an interview on [DATE] at 10:32 a.m., Nurse Manager (NM)-A stated he used to be the DON but was now a nurse manager. NM-A stated (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on [DATE], the administrator texted him at 5:46 p.m. reporting that FM-A indicated staff were refusing to send R2 to the hospital with symptoms of cardiac issues despite his request. NM-A went to the nursing station on R2's unit, asked RN-A if he refused a resident request to go to the hospital, and then proceeded to R2's room with vital signs equipment. NM-A observed R2 lying in bed and upset, reporting left-sided chest pain, a history of three heart attacks, stents, and open-heart surgery, and stating he wanted to go to the hospital immediately. R2 refused other interventions including oxygen and head-of-bed elevation. NM-A noted that vital signs were within normal limits but stated that vital signs can be normal during a heart attack. NM-A instructed RN-A to call 911 and contacted the NP just before 6:00 p.m. RN-A called EMS approximately five minutes later, and R2 was transported to the hospital, where he was found to have a GI bleed and ulcers. NM-A stated that as soon as R2 reported chest pain, he should have been sent to the ED immediately, a full cardiac assessment should have been performed, the provider notified, and all actions documented in the progress note. He further stated that a delay in care for a resident with extensive cardiac history experiencing cardiac symptoms could have resulted in a serious medical event.During an interview on [DATE] at 10:27 a.m., the administrator confirmed that FM-A attempted to call her on [DATE] but she had missed the call. She confirmed that FM-A texted her at 5:34 p.m., stating that R2 was having chest pain and arm pain, believed he was having a heart episode, and wanted to go to the hospital, but staff were refusing to send him. The administrator responded at 5:46 p.m., apologizing and stating that the DON was headed to the unit. FM-A clarified that R2 had a history of bypass surgery, two heart attacks, and 14 stents, emphasizing the seriousness of his complaints. In a follow-up text, FM-A stated that R2 called again, saying he could not wait, feared he was going to die, and wanted an ambulance called because his phone could not dial 911. The administrator stated that she followed through with FM-A's concerns and ensured that R2 was sent to the emergency department.During an interview on [DATE] at 11:39 a.m., DON stated he started at the facility on [DATE] and was familiar with R2. He reviewed the progress notes and confirmed that on [DATE], R2 reported chest pain rated 10/10 and shortness of breath. He stated that a comprehensive cardiac assessment should have been completed, including vital signs, pulse checks, evaluation for shortness of breath, chest pain, nausea, vomiting, diaphoresis, and dizziness, and documented in the progress note. He noted that no such cardiac assessment was documented. The DON stated that for residents with an extensive cardiac history and symptoms mimicking a heart attack such as R2, an immediate intervention would be to send the resident to the ED and notify the provider. DON confirmed that the administrator had messaged him on [DATE] about FM-A reported that a nurse refused to send R2 to the ED and that he verbally educated registered nurse (RN)-A that if a resident wants to go to the ED, staff should let them go; RN-A understood and agreed. The DON stated that no written education or competency testing on cardiac assessment and monitoring had been provided at that time to any of their staff.Facility document, undated Basic head to toe assessment, included a cardiovascular component, which required staff to assess apical pulse (rate and rhythm), peripheral pulses bilaterally (strength and equality), calf tenderness, edema (location, pitting or non-pitting), capillary refill and IV site condition and signs/symptoms of infection, including monitoring for antibiotic use.A comprehensive facility policy for cardiac assessment and monitoring was requested and not received.The policy should ensure timely recognition, evaluation, and intervention for residents experiencing acute or worsening cardiac symptoms, particularly those with a known cardiac history. The policy should require immediate assessment for symptoms such as chest pain, shortness of breath, palpitations, dizziness, diaphoresis, nausea, or pain radiating to the arm, jaw, or back, including a complete vital sign check (blood pressure, pulse, respiratory rate, temperature, oxygen saturation, and pain scale) and a systematic physical assessment of heart and lungs, peripheral pulses, edema, jugular venous distension, skin color, and capillary refill. It should specify continuous or frequent monitoring during acute events and routine monitoring for high-risk residents, with all findings documented in real time, including resident requests, refusals, and interventions. The policy must clearly outline notification (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and escalation procedures, requiring immediate provider notification and EMS activation whenever acute cardiac symptoms are present or a resident requests hospital evaluation, regardless of vital signs. In addition, staff education and competency verification on cardiac assessment, symptom recognition, and emergency response should be provided annually, including training for nursing assistants on prompt reporting changes in condition. Finally, the policy should include quality monitoring mechanisms, such as documentation audits and incident reviews, to ensure compliance and continuous improvement in the care of residents with potential cardiac events.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure complete and accurate documentation in the medical record when a nurse failed to document a cardiac assessment and the residents request for hospital evaluation for 1 of 3 residents (R2), reviewed for quality of careFindings includeR2's face sheet identified the following diagnoses; acute diastolic congestive heart failure (sudden worsening of heart failure where the heart becomes stiff and cannot fill with blood properly, leading to fluid buildup), personal history of transient ischemic attack (TIA) temporary blockage of blood flow to the brain causing stroke-like symptoms), cerebral infarction without residual deficits (stroke with no lasting effects), atrial fibrillation (abnormal heartbeat that can cause blood clots or stroke), presence of aortocoronary bypass graft (heart bypass surgery to restore blood flow around blocked arteries), hypertension (high blood pressure), ischemic cardiomyopathy (weak heart muscle caused by poor blood flow from blocked heart arteries), atherosclerotic heart disease of native coronary artery without angina pectoris (plaque buildup in the heart's own arteries, but not causing chest pain), and ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall (heart attack in the lower part of the heart caused by a blocked artery, shown on the heart test (ECG).R2's admission minimum data set (MDS) dated [DATE], identified R1's cognition was intact. R2 required staff to assist with activities of daily living (ADL)'s and used a wheelchair for mobility. During an interview on 3/9/26 at 4:21 p.m., R2 stated that on 2/9/26 before supper he experienced acute left-sided chest pain radiating down his left arm with shortness of breath and nausea. R2 reported a history of extensive cardiac disease including multiple stents, prior heart attacks, open heart surgery (CABG), atrial fibrillation, and prior stroke. R2 stated he activated his call light and informed staff he believed he was having a heart attack and requested to be sent to the emergency department (ED). R2 reported the nurse checked his vital signs but refused to call an ambulance, stating his vital signs were fine. R2 stated he continued to request hospital evaluation and contacted family member (FM)-A because staff were not sending him to the hospital. R2 stated he felt frightened and believed he was having a heart attack. R2 further stated he was later hospitalized where bleeding stomach ulcers were identified and required treatment and blood transfusions.During a phone interview on 3/11/26 at 11:21 a.m., FM-A stated he was R2's son. FM-A reported that on 2/9/26 R2 called him four times stating he was having chest pain radiating down his left arm and believed he was having a heart attack but staff were refusing to send him to the ED. FM-A confirmed the calls occurred at 4:53 p.m., 5:33 p.m., 5:41 p.m., and 5:49 p.m. FM-A stated he contacted the administrator to report staff were refusing to send R2 to the hospital. FM-A reported more than an hour passed from the onset of symptoms until 911 was called and stated staff should have called an ambulance when R2 complained of chest pain and requested hospital evaluation.R2's progress note dated 2/9/26 at 6:05 p.m. documented transfer to the hospital for chest pain rated 10/10. Vital signs at 6:03 p.m. were blood pressure 113/61, pulse 68 regular, respiratory rate 20, temperature 97.6 F, oxygen saturation 96% on room air. R2 was alert and oriented.R2's progress note dated 2/9/26 at 7:02 p.m. documented hospital transfer for acute chest pain rated 10/10. The note documented vital signs, notification of the nurse practitioner at 6:03 p.m., activation of Emergency Medical Services (EMS), and transport to the emergency department at 6:34 p.m.Review of R2's medical record did not include documentation of a comprehensive cardiac assessment or documentation of R2's repeated requests to be sent to the hospital during the onset of chest pain symptoms.During an interview on 3/10/26 at 4:39 p.m., nursing assistant (NA)-A stated R2 told her he might be having a heart attack and reported severe pain in his left arm. NA-A stated she immediately notified RN-A. NA-A reported R2 appeared very worried and repeatedly used the call light asking when the ambulance was coming. NA-A estimated the incident occurred around 5:00 p.m. and that R2 was not transported until after supper around 6:00 p.m.During a (continued on next page)

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	03/11/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	phone interview on 3/10/26 at 4:59 p.m., registered nurse (RN)-A stated he was the nurse responsible for R2 on 2/9/26 during the evening shift. RN-A stated a nursing assistant informed him that R2 wanted to see him. RN-A stated R2 reported chest pain and appeared agitated. RN-A stated he was unaware of R2's cardiac history. RN-A reported he attempted to assess R2 but the resident stated he wanted to go to the ED. RN-A performed a cardiac assessment but was unable to describe what the assessment included and acknowledged he did not document the cardiac assessment or R2's request to go to the ED in the medical record. RN-A stated nurse manager (NM)-A later obtained vital signs and contacted the provider and EMS; R2 was sent to the ED around 6:10 p.m.During an interview on 3/11/26 at 10:32 a.m., nurse manager (NM)-A stated when R2 reported chest pain a full cardiac assessment should have been completed, the provider notified, and the resident sent to the ED without delay. NM-A confirmed that RN-A was instructed to document his findings and did not do so.During an interview on 3/11/26 at 11:39 a.m., the director of nursing (DON) confirmed RN-A did not document a cardiac assessment or R2's requests for emergent care on 2/9/26 and stated this information should have been documented in the resident's medical record.Policy requested for resident records-identifiable information was requested and not received. Facility policy should address complete, accurate, and timely documentation in the resident's medical record and clearly identify documentation expectations for assessments, resident complaints, provider notification, and emergent transfers.