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	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emeralds at Fairbault 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain a safe environment for 2 of 2 residents (R4, R5) who were observed with wet floors and no indication that floor was wet while either residing in room or when returning to room. Findings include:R4R4's face sheet dated 6/12/26, identified diagnoses of left femur osteonecrosis (bone cell death), difficulty in walking, and urinary incontinence.R4's admission Minimum Data Set (MDS) dated [DATE], identified R4 had no difficulties with hearing or speech. R4 had no cognition issues. R4 had behavioral issues directed at others one to three days. R4 required supervision/touch assist with transfers.R5R5's face sheet dated 6/12/26, identified diagnoses of unspecified dementia, and weakness.R5's admission MDS dated [DATE], identified R5 had minimal hearing difficulties and wore glasses. R5 had no cognition issues. R5 required supervision/touch assist with transfers.During a continuous observation on 6/9/26 from 11:50 a.m. through 12:22 p.m., the following was observed:11:50 a.m.- R4's room floor was visibly wet. No wet floor sign in front of room. R4 was not in the room. R5's room floor was also visibly wet. R5 was asleep in a recliner chair in room. No wet floor sign was noted in front of R5's room.11:53 a.m.- R4 had propelled herself to the entrance to her room with her walker, saw the floor was wet and did not enter the room.During an interview and observation on 6/9/26 at 11:54 a.m., registered nurse (RN)-A and R4 were present. RN-A stated she would expect the housekeeper to have a wet floor sign in front of R4 and R5's doors. R4 was verbally upset there was not a wet floor sign and no fan to dry her room. RN-A stated R5 did not know the floor was wet. RN-A explained to R5 the floor was wet and she should call if she wanted to move from the recliner. R5 stated understanding. R4 stated, Why doesn't this place have fans? That is a lawsuit waiting to happen. RN-A walked into R4's room and put R4's small personal fan on the floor and turned it on. RN-A asked R4 if she knew who the housekeeper was as she had not returned and the housekeeping cart was in the hallway. At 11:59 a.m., R4 wheeled into her room on her walker and called RN-A a, dumbass, picked up the fan and pointed it to the floor. I might as well just fucking sit here and dry it. A lot of useless assholes around here the government is paying them to be here. At 12:00 p.m., R4 stated it was, humid as hell, in here. R4 stood up without locking the brakes on the walker and walked to her window and opened it. The floor was still wet. R5's floor was also wet. At 12:02 p.m., physical therapist (PT)-A was by R4's room. R4 requested her room door be shut with her in the room and the floor still wet. At 12:13 p.m., Administrator in training came to R4's and R5's rooms and placed wet floor signs in front of them. At 12:14 p.m., RN-A stated R4's and R5's floors were still wet. R4 had been standing in her doorframe and shut the door on RN-A. At 12:22 p.m., R5's floor was dry. It is unknown if R4's floor was dry as her door was shut and she did not want to be disturbed again.During an interview on 6/9/26 at 12:04 p.m., PT-A stated it is a fall risk if the floors are wet and the residents are in the room with a wet floor. Rooms should have wet floor signs after being mopped. R4 and R5 are both at risk for falling if they would attempt to transfer on a wet floor.During an interview on 6/12/26 at 1:53 p.m., director of nursing (DON) stated she would expect housekeepers to place wet floor signs in front of wet floors so residents and staff were aware the floor was wet.The facility Walls and Floors policy dated 9/2012, (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified Floors: sweep well, wash with hot water and non-sudsing cleaning solution, rinse well using mop, remove as much water as possible. Wipe with sanitizing solution, permit to air dry. Place wet floor signs to warn others of potential danger.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide oral hygiene to 1 of 3 residents (R2) observed for oral hygiene cares. Findings include:R2's face sheet dated 6/11/26, identified diagnoses of displaced bicondylar fracture (break of both sides of tibia below knee which compromises knee weight bearing surface) of right tibia, displaced bicondylar fracture of left tibia, muscle weakness, and chronic pain.R2's annual Minimum Data Set (MDS) dated [DATE], identified R2 had some difficulty with understanding and wore glasses. R2 had moderate problems with thinking and memory. R2 had no behaviors. R2 had no natural teeth and was on a mechanically altered diet. R2 was dependent on staff for oral hygiene.R2's care plan dated 6/24/25, identified R2 had alteration in dental care related to edentulous (no natural teeth or tooth fragments) status. Interventions included dental visits as needed, monitor if R2 was tolerating current diet, oral cares a.m./h.s (hour of sleep) and per R2's request.During an observation on 6/11/26 at 7:52 a.m., nursing assistants (NA)-B and NA-C were providing morning cares for R2. NA-C put on gloves and took dentures from denture cup. NA-C went to the sink and rinsed dentures. NA-C handed R2 the bottom denture and placed in her mouth without denture paste. NA-C handed R2 the top denture and there was a translucent substance coming off the dentures hanging down in a glob that came off the dentures. NA-C took the top denture and denture cup back to the sink and rinsed it off. NA-C returned and put top denture in R2's mouth. NA-C did not clean R2's mouth prior to denture insertion.During an interview on 6/11/26 at 8:27 a.m. NA-B stated R2's gums should have been brushed prior to putting dentures in her mouth.During an interview on 6/11/26 at 8:36 a.m., NA-C stated R2's gums should have been brushed prior to putting dentures in her mouth.During an interview on 6/11/26 at 10:54 a.m., NA-D stated oral care for dentures included cleaning the dentures and providing gum care to the residents. A little sponge is used to clean overnight saliva and the mouth to freshen it before putting dentures in.During an interview on 6/12/26 at 1:53 p.m., director of nursing (DON) stated she expected staff to complete oral cares on residents in the morning and before bed, including cleaning the gums before inserting dentures.The facility Oral Care Assistance procedure undated, identified to assist the client with maintaining and promoting a healthy mouth environment, minimizing the change of tooth decay and bad breath. This included brushing teeth and tongue, brushing dentures, and assisting patients to use toothbrush or mouth swab to clean gums.

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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 record review the facility failed to follow physician's orders for negative pressure wound therapy (wound vac) (device that applies gentle suction to help complex, large, or slow-healing wounds close) care for 1 of 2 residents (R1) who did not receive wound vac changes as scheduled. In addition, the facility failed to update the physician when attempt to reapply the wound vac failed for 1 of 2 residents (R1) reviewed for wound care and failed to update the physician for 1 of 1 residents (R2) who had a choking incident and required the Heimlich maneuver. Findings include:R1R1's face sheet dated 6/11/26, identified R1 had diagnoses of atherosclerosis of native arteries (progressive buildup of fatty plaque inside original, non-surgical arteries) of other extremities with ulceration, non-pressure chronic ulcer of other part of unspecified foot with unspecified severity, atherosclerosis of native arteries of extremities with intermittent claudication (muscle pain, cramping or fatigue that occurs during physical activity and resolves with rest) of right leg, peripheral vascular disease, and unspecified open wound right foot.R1's Perspective Payment System (PPS) Minimum Data Set (MDS) dated [DATE], identified R1did not have memory issues, and was able to communicate effectively. R1 required partial/moderate assistance with dressing and toileting. R1 was independent with rolling, lying to sitting on side of bed, and rolling left/right. R1 was dependent on staff to walk and move in wheelchair. R1 had surgical wounds.R1's care plan dated 6/1/26, identified alteration in skin integrity. Interventions included to document on skin condition and keep physician informed of changes.R1's hospital Discharge summary dated [DATE], identified R1 had been hospitalized from [DATE]-[DATE] for dehiscence (splitting or bursting open) of wound. R1 had a negative pressure wound vac system placed on the right groin and right lower extremity to improve healing time and increase compliance in dressing changes and wound management. Current wound measurements were right groin 7.0 centimeters (cm) length X 5.0 cm width X 1.5 cm depth and right lower extremity calf measured 11 cm X 3.0 cm X 0.5 cm depth. Instructions included: sponge to be placed in the wound and sealed with the plastic clear paper. The drain is to be set to low continuous suction at 125 millimeters of mercury (mmHg), wound vac system to be changed every 48 hours on a Monday, Wednesday, and Friday schedule, if the device becomes non-functional or cannot tolerate the wound vac system, moist to dry dressing changes should be performed. Kerlix should be used for wound packing. Kerlix to be soaked in normal saline and squeezed hard to remove most of moisture. Kerlix should be only slightly moist. Moist kerlix should be packed in the wound and covered with dry gauze. Dressing changes should be performed three times daily (TID). If the wound gets too moist and liquid is seen pooling in the wound, convert to dry dressing TID. The dry kerlix should also be packed in the wound. Wound vac is to continue until re-evaluation by surgical team and will most likely continue for many weeks, possibly up to a few months. Hospital surgical phone numbers for business hours and emergency situations were provided.R1's Admission/Initial Data Collection V-9 dated 5/26/26 at 12:29 p.m., identified Skin: groin and right inner ankle. No type or measurements identified. Narrative identified R1 had a surgical site present to the going area and lower portion of right leg above ankle. Surgical incision sites were assessed and monitored. No concerns noted. Staff will continue to monitor surgical sites for signs and symptoms of infection, drainage, increased redness, warmth, or swelling. R1 had a wound vac placed. Staff will update provider with any changes or concerns.R1's treatment administration record (TAR) for May 2026, identified:Wound care: right groin and thigh with wound vac. Change Monday, Wednesday, and Friday in the evening with a time of 4:00 p.m. Administration for 5/27/26, had a 9 and for 5/29/26, a checkmark for completed. R1's TAR chart code legend identified 9 as other/see nurse note.Wound vac: monitor for signs and symptoms of infection around wound vac site. Update provider as needed every shift. These correlated with check boxes for day, evening, and night to sign when completed. These were completed every shift.R1's default progress note for electronic medication record dated 5/27/26 at 3:20 p.m., identified wound (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care: right groin and thigh with wound vac. Change Monday, Wednesday, Friday in the evening. Wound care and wound vac dressing changed last night.During a phone interview on 6/10/26 at 3:15 p.m., registered nurse (RN)-C stated he had never changed R1's wound vac but was aware and had been taught how to change it. RN-C stated he consulted with the nurse manager on 5/27/26, as R1 had just returned from the hospital and had the wound vac placed. RN-C stated the nurse manager directed him to not change the wound vac on 5/27/26 as it was scheduled on the TAR.R1's TAR for June 2026, identified:Wound care: right groin and thigh with wound vac. Change Monday, Wednesday, and Friday in the evening with a time of 4:00 p.m. On 6/1/26, a 9 was marked, on 6/3/26, a checkmark for completed, and on 6/5/26, a 9 was marked.R1's default progress note for electronic medication record dated 6/1/26 at 7:42 p.m., identified wound care: right groin and thigh with wound vac. Change Monday, Wednesday, and Friday in the evening. Wound care and wound vac dressing to be changed tomorrow.During an interview on 6/11/26 at 1:17 p.m., licensed practical nurse (LPN)-A stated he worked 6/1/26. LPN-A consulted about changing the wound vac with RN-F who told him it would be changed on 6/2/26. The wound vac was working and had no leakage. Pressure was maintained at 125 [mmHg].R1's Wound Evaluation dated 6/3/26 at 7:06 p.m., identified RN-F completed the assessment. Wound measured 3.80 centimeters (cm) length by (x) 3.94 cm width on the right anterior (toward the front) groin. Tissue had exposed muscle. Yellow fibrin (shiny layer that forms during early phase of wound healing) present in wound, tissue temperature cool, tissue firmness was soft. Wound was blanchable (temporarily skin turns white when pressure applied), no evidence of infection, heavy serosanguineous (thin, watery fluid) drainage, wound edges not attached to base, no odor from wound. Non-pitting edema (swelling related to accumulation of fluid) > (greater than) 4 cm around wound. Anterior right lower leg wound measured 10.85 cm length x 4.86 cm depth. Tissue had exposed muscle. Periwound (surrounding) skin condition at risk. Yellow fibrin present in wound, tissue cool, blanchable, heavy serosanguineous drainage. Wound edges not attached to wound base. No odor. Skin color surrounding wound was bright red and blanches to touch. Non-pitting edema extends < (less than) 4 cm around wound. Interventions for both wounds were negative pressure wound therapy.R1's progress note dated 6/5/26 at 1:00 a.m., identified wound vac was changed early this morning by LPN-B and RN-D. During assessment, R1's leg was noted to be red, warm to the touch, and leaking fluid. R1 complained of pain during cares. Nurses attempted multiple times to reapply and troubleshoot the wound vac; however, the drape film would not adhere properly, causing a continuous leak. Due to inability to maintain suction, RN-D removed the wound vac, packed the wound and wrapped the leg until the morning shift could further assess and address the wound vac concerns.During an interview on 6/11/26 at 8:30 a.m., LPN-B stated R1's leg was red on 6/5/26 but thought it could have come from the film being taken off for the wound vac dressing.During a follow-up interview on 6/10/26 at 1:05 p.m., LPN-B stated RN-D was the other nurse who assisted with R1's wound vac change on 6/5/26. LPN-B could not recall if the physician was notified and could not find notification to physician in R1's record about the wound vac not being successfully changed on 6/5/26. LPN-B stated RN-D explained that the facility had 12 hours where they could pack the wound and not use the wound vac. LPN-B stated she left the facility after she assisted RN-D to remove the wound vac and gave the night nurse report. LPN-B stated she reported the incident to RN-F and director of nursing (DON).During an interview on 6/10/26 at 1:13 p.m., RN-D stated when he and LPN-B were unsuccessful getting the wound vac changed, he packed the wound with gauze. RN-D did not notify the physician that they were not able to apply the wound vac. RN-D notified the DON between 1:00 a.m. and 2:00 a.m. and was told LPN-B and RN-F would attempt to reapply in the morning. RN-D stated he followed the hospital discharge orders for dressing when wound vac could not be applied.During an interview on 6/11/26 at 11:20 a.m., RN-E stated on 6/5/26, at shift report it was reported the wound vac was off. Staff had tried to change it and could not get it to adhere so placed a dressing over it. RN-E notified medical doctor (MD)-A midmorning as MD-A was at the facility. RN-E had not observed R1's leg until after MD-A had examined him. RN-E thought someone was going to put the wound vac (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on but had wanted MD-A to examine it first. R1's wound on the groin looked red, and some irritation and slough. The leg wound was just red and irritated. RN-E did not think R1 had a lot of edema to his leg it, just looked like it was angry. RN-E stated MD-A was not happy the wound vac was off and had not been done on the proper schedule. RN-E did not notify the surgeon that the wound vac was off.During a phone interview on 6/11/26 at 11:21 a.m., RN-F stated she had been the nurse manager at facility. RN-G, another nurse manager, completes wound management on resident. The floor nurses are supposed to complete the Wednesday; Friday wound dressing changes and RN-G would complete Monday. On 5/29/26, RN-F completed wound vac change with RN-D. On 6/1/26, RN-F was given instructions that RN-G would complete wound vac change. RN-G told RN-F that wound care could not follow R1. RN-F reported the information to DON. DON informed RN-F that RN-G would look at the wound. RN-F stated she requested to get the wound care done and DON told her to wait until 6/2/26. RN-F stated RN-B was available and could help with dressing change on 6/1/26 but DON was insistent that it wait until 6/2/26 so RN-G could look at the wound. On 6/2/26, RN-F requested to DON that RN-D was available and could change the wound vac with her. DON stated to wait until 6/3/26, so RN-G could look at the wound as RN-G was not available on 6/2/26 and they could get pictures of the wounds. On 6/3/26, RN-F went in with initiative and changed the wound vac. R1 had a lot of drainage from the wounds. Drainage did not smell or look like an infection was present. R1 had edema and his leg was irritated from the dressing. On 6/5/26, LPN-B and RN-D attempted to change the wound vac. The vac was not suctioning so they applied a dressing. MD-A was onsite 6/5/26, and RN-F wanted MD-A to see R1's wound. RN-F stated she would expect the nurses to do their job and follow physician orders.During an interview on 6/11/26 at 1:46 p.m., RN-G stated she completed weekly wound rounds with the wound care provider. RN-G told RN-F on 6/1/26, that they could not look at R1's wounds because R1 did not meet the criteria as he was still followed by a surgeon so Medicare would not cover the facility wound care staff. RN-G told RN-F she could help her later with changing the wound vac but RN-F stated she was fine and did not need help. RN-G had not heard the wound vac had not been changed until 6/5/26 around 10:00 a.m. RN-G had never visualized R1's wounds. During a phone interview on 6/11/26 at 11:18 a.m., LPN-C stated he began work around 2-2:30 p.m. on 6/5/26. LPN-B had been informed in shift report by RN-E, something about wound dressing not changed, but was unsure of how many days or what the issue was. RN-F assisted LPN-C with removing the dressing that was applied during the evening shift on 6/4/26. LPN-C and RN-F put an abdominal pad (large, soft dressing) and wrapped the wound with gauze. LPN-C stated there was minimal drainage to the wounds. The groin was open and deep. The one on the leg looked superficial and not too deep. Drainage was pink and a little yellow in color from both.During an interview on 6/10/26 at 11:58 a.m., DON stated the wound vac did not get changed from 5/29/26-6/3/26. Nurse managers are expected to change the wound vacs. A follow-up interview on 6/12/26 at 1:53 p.m., DON expected physician to be notified when wound vac was not able to be changed as ordered.During an interview on 6/12/26 at 11:29 a.m., MD-A stated she would have expected a call from facility on 6/5/26 during normal business hours, at least by 7:00 a.m., that the wound vac was off R1. MD-A would expect the next shift to try and apply the wound vac and if that would not work to go to, plan C. If the wound would have been, goopy, yucky, or festering, she would have expected a phone call immediately.R2R2's face sheet dated 6/11/26, identified diagnoses of encounter for palliative care, non-pressure chronic ulcer of unspecified part of unspecified lower leg with unspecified severity, and muscle weakness.R2's annual MDS dated [DATE], identified R2 had some difficulty with understanding others and wore glasses. R2 had some cognitive issues. R2 had no behaviors. R2 had no teeth and a mechanically altered diet. R2 had impairment on both sides of lower extremities and was dependent on staff for activities of daily living.R2's care plan dated 5/21/26, identified R2 had a texture modified diet due to choking incident. Interventions included R2 ate meals in the main dining room with direct supervision, staff to assist with cutting up meals, diet per physician order.R2's progress note dated 5/21/26 at 9:38 p.m., identified nursing assistant (NA) alerted RN-F that R2 was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	choking. RN-F performed CPR on R2 and cleared two big chunks of bread with peanut butter. Advised staff not administer food without consulting nurse first.R2's physician order dated 6/9/26 at 3:59 p.m., identified an order to start minced and moist diet with think liquids per facility starting on 5/28/26.During a phone interview on 6/11/26 at 1:10 p.m., RN-H stated on the evening of 5/21/26 between 8:30 p.m. and 9:00 p.m., she was told to come to the R4 who was unresponsive. R4 was in a Broda (specialized wheelchair designed for people who need advanced positioning, support and comfort) wheelchair. RN-H saw a small tray with peanut butter bread and assumed choking had started. RN-H lifted R4 up and used her legs to support her and began abdominal thrust with both hands folded on abdomen with R4's back to RN-H's chest. R4 vomited two boluses (round mass) of bread with peanut butter and a big lump of bread during the Heimlich. RN-H stated she called the DON and hospice provider but found out later she had the wrong contact information for the hospice provider, so they were not updated.During an interview on 6/12/26 at 10:24 a.m., team director for hospice (TD)-A reviewed hospice information. On 5/21/26, there was no record of a triage call. On 5/23/26, the facility reported an incident of choking from 5/21/26. On 5/28/26, hospice received an updated diet order for minced and moist. TD-A notified R4's family member of incident on 5/23/26. Hospice prefers to be notified immediately of any incidents that occur with residents in their care for continuity of care between hospice and providers.During an interview on 6/12/26 at 1:53 p.m., DON stated she would expect the physician to be notified immediately of a change of condition.The facility Notification of Changes policy dated 3/2024, identified changes in a residents condition or treatment be reported to attending physician or delegate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow infection prevention protocols including enhanced barrier precautions (EBP) when providing care to 2 of 3 residents (R2 and R4) observed during cares. Findings include: According to the Centers for Disease Control (CDC): EBP is primarily intended to apply to care that occurs within a resident's room where high-contact resident care activities, including transfers, are bundled together with other high-contact activity, such as part of morning or evening care. This extended contact with the resident and their environment increases the risk of a MDRO (multi-drug resistant organism) (type of bacteria or microbe resistant to multiple antibiotics) spreading to staff hands and clothes. Outside the resident's rooms, Enhanced Barrier Precautions should be followed when performing transfers and assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility. Hand hygiene is recommended before and after resident contact.R2R2's face sheet dated 6/11/26, identified diagnoses of non-pressure chronic ulcer of unspecified part of unspecified lower leg with unspecified severity, displaced bicondylar fracture (break of both sides of tibia below knee which compromises knee weight bearing surface) of right tibia, and displaced bicondylar fracture of left tibia.R2's annual Minimum Data Set (MDS) dated [DATE], identified R2 had some difficulty with understanding and wore glasses. R4 had moderate problems with thinking and memory. R2 had no behaviors. R2 had impairment on both sides of lower extremities and was dependent on staff for activities of daily living.R2's treatment administration record (TAR) for 6/2026, identified follow EBP while providing wound cares and other high contact care activities every shift.During an observation and interview on 6/11/26 at 7:52 a.m., nursing assistants (NA)-B and NA-C went to R2's room and performed morning cares which included dressing, grooming, changing incontinent product, and transferring. NA-B and NA-C did not wear EBP while completing tasks.During an interview on 6/11/26 at 8:27 a.m., NA-B stated EBP is worn if a resident has a wound, catheter, or colostomy. NA-B stated EBP should have been worn while providing cares on R2 as she has wounds. During an interview on 6/11/26 at 8:36 a.m., NA-C stated EBP should have worn EBP during cares with R2 because she had wounds. R4R4's face sheet dated 6/12/26, identified diagnoses of left femur osteonecrosis (bone cell death), difficulty in walking, and urinary incontinence.R4's admission MDS dated [DATE], identified R4 had no difficulties with hearing or speech. R4 had intact cognition. R4 had behavioral issues directed at others one to three days. R4 required supervision/touch assist with transfers.R4's care plan dated 5/19/26, identified R4 was on EBP related to [left blank]. Interventions included staff to follow EBP; use appropriate communication to follow EBP; explain reason for use of EBP; staff to put on/remove EBP per enhanced barrier precautions when providing high contact cares.R4's physician order dated 6/3/26, identified negative pressure wound therapy (wound vac) in place for 14 days from surgery.R4's TAR for 6/2026, identified follow EBP while providing wound cares and other high contact care activities every shift.During an observation and interview on 6/10/26 at 7:55 a.m., registered nurse (RN)-B went to R4's room. R4 was sitting in her recliner watching television. RN-B applied a pair of gloves and assessed for edema, redness, and warmth on R4's legs. RN-B did not wear a gown while performing high contact care. RN-B removed gloves and left R4's room without sanitizing hands. RN-A walked out of a resident room with the vital sign machine, did not disinfect the machine, and RN-B took the machine to R4's room with an ipad to call the physician. RN-B did not apply EBP or disinfect vitals machine before placing blood pressure cuff, and oximeter on R4. While on the ipad video call with the physician, RN-B again checked R4's edema in legs, redness, and warmth. RN-B did not wear EBP. R4 ended the phone call, left R4's room with the vital sign machine, sanitized hands outside the door, and brought the vital sign machine to the medication cart at the nurses station. RN-B did not disinfect the machine. RN-B stated he should have worn EBP and disinfected the (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	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emeralds at Fairbault 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	vital signs machine before and after using it for R4.During an observation on 6/10/26 at 8:23 a.m., director of nursing (DON) entered R4's room as R4 was screaming very loudly. DON sat on R4's bed while R4 was in the recliner and rubbed R4's back and hair to soothe R4. DON was not wearing EBP during this contact. DON stood up from the bed, walked to the door, removed a gown and gloves from the EBP station on the door, asked R4 if she could shut the door, and shut the door.During an interview on 6/10/26 at 9:49 a.m., DON stated she did not have to wear EBP when she was with R4 because she was just touching her. After reviewing CDC EBP recommendations with the DON, she stated, Oh, yeah, I would have to.During an observation on 6/10/26 at 10:05 a.m., hospital lab (HL)-A entered R4's room to draw blood. HL-A wore gloves but no gown. HL-A drew blood from R4's right arm. HL-A removed gloves, sanitized hands, and left room.During an interview on 6/10/26 at 10:16 a.m., HL-A stated she was told by the DON not to wear a gown today, because state was in the building and I can't wear gowns in the hallways. HL-A said technically she was supposed to have a lab coat because she is drawing blood. HL-A drew blood on approximately 20 residents this day and was very upset that she could not wear her lab coat. HL-A usually does not have to worry about EBP because she wears a gown for every patient. HL-A stated the DON was going to call HL-A's manager and talk about the issue.During an interview on 6/12/26 at 1:53 p.m., DON stated she would expect that staff followed EBP precautions when performing high contact cares on residents.The facility Enhanced Barrier Precautions policy dated 4/1/24, identified the facility implemented EBP for the prevention of transmission of multi-drug resistant organisms. High contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care: any skin opening requiring a dressing.