STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emeralds at St Paul LLC	420 Marshall Avenue Saint Paul, MN 55102

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 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on interview and document review, the facility failed to evaluate a resident's discharge needs to ensure self or appropriate discharge location could accommodate his medical needs including blood sugar checks, insulin administration, and wound care, for 1 of 1 resident (R6) who was discharged to a homeless shelter that was unable to meet R6's complex medical needs. This resulted in the potential for serious harm, injury, impairment, or death to R6. The immediate jeopardy began on 7/23/24, when R6 was discharged from the facility when facility transportation dropped R6 off at Union Gospel Mission, a homeless shelter that was not equipted to meet R6's medical needs. The administrator, director of operations, and the director of nursing were notified of the immediate jeopardy at 5:22 p.m. on 7/26/24. The immediate jeopardy was removed on 7/27/24, but noncompliance remained at the lower scope and severity level D scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R6's admission Minimum Data Set (MDS) dated [DATE], indicated R6 admitted to the facility on [DATE], from the hospital, did not have a change in mental status, had verbal behavioral symptoms directed toward others 1 to 3 days that significantly interfered with R6's care, participation in activities, or social interactions, used a wheelchair, was independent with most activities of daily living (ADLs) and required supervision or touching assistance with transfers. Additionally, ambulation and picking objects up was not attempted due to medical condition or safety concerns and was admitted due to amputation, multidrug resistant organism (MDRO) infection, diabetes mellitus, acute osteomyelitis (bone infection) of the left and right ankle and foot, frostbite with tissue necrosis (death of body tissue) of right and left toes. The MDS further indicated R6 used tobacco, had recent major surgery, was at risk of developing pressure ulcers, had an infection of the foot, surgical wounds, had pressure reducing devices for the chair and bed and had surgical wound care. The MDS indicated R6 had insulin injections 7 of 7 days. R6's care area assessment (CAA) dated 6/18/24, was not triggered for a referral to return to the community. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R6's 48-hour care plan form dated 6/12/24, indicated a self-care deficit related to amputation to bilateral feet and had an alteration in mobility due to a non-weight bearing status on the left foot and needed assist with transfers and bathing. Additionally, R6 had pain issues due to amputations to bilateral feet, had an alteration in skin integrity and had sutures via surgery to bilateral feet. R6 had an alteration in mood and behavior with a history of substance abuse, and was on enhanced barrier precautions (EBP), (an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities.) R6 was at risk for falling due to non-weight bearing on the left foot R6's history and physical dated 6/2/24, indicated R6 was admitted to the hospital on 6/2/24, for evaluation of a foot infection. Additionally, R6 had prediabetes and a history of type 2 diabetes mellitus but was not on any chronic medications and appeared to be diet controlled. Additionally, the notes indicated R6 started insulin glargine (a long-acting insulin) 100 units/milliliter (ml) 10 units at bedtime on 6/6/24, along with insulin lispro (a fast-acting insulin) 2 to 10 units three times a day with meals. R6's hospital discharge summary dated 6/11/24, indicated R6 was at a homeless shelter and discharge diagnoses included the following: diabetic foot infection, cellulitis and abscess of foot, osteomyelitis of toe, maggot infestation, open wounds of the right and left foot, acute osteomyelitis of the left foot, methicillin resistant staphylococcus aureus (MRSA) (an infection resistant to certain antibiotics), and a left retinal detachment. R6 arrived at the hospital on 6/2/24, for evaluation of bilateral foot infections. R6 had bilateral frostbite in April 2024, R6 was unable to maintain follow up and both feet became significantly infected. The left foot had multiple digits that were infected with maggots and a maggot born bacteria, ignatzschineria, as well as MRSA that was identified on blood cultures. R6 was taken to the operating room on 6/2/24, and had a left foot TMA (transmetatarsal amputation, a surgery to remove part of the foot) and right foot partial amputation and recommendations indicated R6 should continue non-weightbearing to the right lower extremity. The discharge summary included a medication list that indicated R6 needed to start taking insulin glargine-yfgn 100 units per milliliter (ml), inject 10 units subcutaneously daily at bedtime for type two diabetes, insulin lispro 100 units/ml inject 1-5 units subcutaneously three times a day with meals as needed for diabetes: 1 unit for a blood glucose of 150 to 200, 2 units for a blood glucose of 201 to 250, 3 units for a blood glucose of 251 to 300, 4 units for a blood glucose of 301 to 350, 5 units for a blood glucose of 351 to 400, and call the provider if blood glucose is greater than 401. Further, the summary included instructions to change how R6 took the following medications: Tylenol, and oxycodone and provided instructions to continue taking a list of medications that included gabapentin, multivitamin, and rosuvastatin. Additionally, documentation indicated a referral was sent to a long- term care facility in anticipation R6 would no longer need a transitional care unit (TCU) once medically ready. R6's admission assessment dated [DATE], indicated R6 had an amputation to both feet, and had an IV. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R6's Resident Discharge Plan form dated 6/12/24, indicated R6 was homeless and would need a place to stay and was awaiting a medical grant to be approved for R6 to get his own place, and would need a wheelchair upon discharge. Under the heading, What is the capacity of the resident and or caregivers to meet the needs of resident upon discharge/transfer indicated R6 was homeless and was unable to adequately care for himself and a discharge or transfer was feasible. The form identified other sections, How was the resident involved in discharge plan development Is the resident interested in receiving information regarding return to the community If so, was referral made to the local contact agency Date evaluation results were discussed with the resident/resident's representative. These areas were left blank. R6's Orders form in the electronic medical record (EMR) indicated the following orders: 6/13/24, staff to follow contact precautions for MRSA in wounds every shift. 6/21/24, wound care to surgical site TMA left #2 surgical site first MTP joint right instruction: cleanse with Vashe or sterile normal saline. Apply Betadine and allow to dry completely before covering wound with sterile 4 by 4 dressing, then wrap with Kerlix and ACE wrap. Change daily every shift for surgical wound. 7/10/24, Tobramycin ophthalmic solution 0.3% instill 1 drop in left eye four times a day for chronic total retinal detachment (a condition that affects vision and can lead to blindness if not treated). 7/10/24, Atropine Sulfate ophthalmic solution 1% instill 1 drop in the left eye two times a day for chronic total retinal detachment. 7/10/24, prednisolone acetate ophthalmic suspension 1% instill 1 drop in the left eye four times a day for chronic total retinal detachment. 7/19/24, R6 can get bilateral extremities wet in shower but should not submerge the feet. Elevate and ice as needed. 7/19/24, therapy to order orthotic and shoes from Tillges due to diabetes and history of amputation bilaterally. 7/22/24, Ok to discharge to Union Gospel Mission (homeless shelter) on 7/23/24, with remaining medication. 7/22/24, Lantus SoloStar 100 u/ml (units per milliliter) inject 15 units subcutaneously at bedtime. 7/22/24, mechanical wheelchair for impaired mobility. 7/22/24, glucometer with testing supplies to check blood sugars twice daily. 7/22/24, appointment for foot and ankle follow up on 8/19/24 at 1:00 p.m. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R6's medication administration record (MAR) and treatment administration record (TAR) for July 2024, indicated the following: a check box was marked indicating wound care (surgical site TMA Left and first MTP joint right, cleanse with Vashe or Sterile NS. Apply Betadine and allow to dry completely before covering wound with sterile 4 by 4 then wrap with Kerlix and ACE wrap) was administered on the following dates: 7/6/24, 7/10/24, 7/11/24, and 7/21/24. Wound care was completed 4 times out of 23 opportunities. a check box was marked indicating Tobramycin ophthalmic drops were administered 41 times from 7/10/24, to 7/22/24. Tobramycin was administered 41 time out of 54 opportunites. a check box was marked indicating Atropine Sulfate ophthalmic drops were administered 21 times out of 27 opportunities from 7/10/24, to 7/22/24. a check box was marked indicating prednisolone acetate ophthalmic suspension 1% drops were administered 41 times out of 54 opportunities from 7/10/24, to 7/22/24. a check box was marked indicating R6 received 12 units of Lantus SoloStar insulin at bedtime 11 times out of 21 opportunities from 7/1/24, to 7/21/24, and did not receive 15 units on 7/22/24. R6's blood sugar was checked 26 times out of 68 opportunities from 7/1/24, to 7/22/24, and ranged from 113 to 341. R6's Resident Family Education form dated 6/17/24 at 1:39 p.m., indicated R6, and family/caregiver were present when refusal of cares, medications, and verbal vulgarity were discussed. R6 was educated on the importance of communicating needs to staff and respecting other residents and staff. R6's discharge potential was expected in the next 90 days and R6 understood basic information. R6 continued to be agitated. R6's nurse practitioner (NP) note dated 7/8/24, indicated R6 was refusing cares consistently and was verbally abusive to staff, threatening physical abuse and staff had concerns for crack cocaine use that R6 denied and did not allow the foot dressing to be changed. Additionally, R6 had also refused some doses of his antibiotics and the NP was concerned about the wound status and infection given R6's refusal to adhere to antibiotics, dressing changes. R6's nursing progress notes dated 7/8/24 at 11:58 a.m., indicated a late entry was entered from administration that it had been reported R6 was smoking crack (an illegal substance) all weekend on the smoking patio and was seen purchasing drugs across the street from the facility. R6 agreed to a room search and denied smoking crack and selling crack to another resident. A marijuana pipe with a cleaner, pill bottle with multivitamins, and a pocketknife was found. R6's Risk vs Benefits form dated 7/11/24, in progress and saved on 7/26/24 at 10:30 a.m., indicated R6 refused to go to his follow up eye surgery appointment and staff explained it was important to follow up to promote healing. (continued on next page)

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F 0660

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Note: The nursing home is disputing this citation.

R6's progress notes dated 7/11/24 at 11:59 a.m., indicated a referral was sent to River Oaks residential treatment facility for review, R6 had a history of aggressive behaviors due to MH (mental health) and substance use that was exhibited regularly at the facility. R6's relocation worker was notified who was looking into whether R6 could enter the residential facility found for R6 by 7/12/24, but if not, would like to know the outcome of the River Oaks referral.

R6's progress note dated 7/11/24 at 12:26 p.m., indicated R6's relocation coordinator was not able to get R6 into the residential facility anytime soon and was ok with R6 going to River Oaks if accepted and were awaiting an update from River Oaks residential facility.

R6's progress note dated 7/11/24 at 4:10 p.m., indicated a referral was sent to Victory Health and Rehab, a nursing facility.

R6's facility referral form to River Oaks of Minnesota dated 7/11/24, from the director of social services indicated R6's case manager had his MH diagnoses and further indicated the facility had issues with R6 having substance issues causing safety concerns. The record did not identify if admission was accepted or denied.

R6's nurse practitioner (NP) note dated 7/12/24, indicated R6 was aggressive and abusive and declined all cares and assessments of wounds.

R6's progress note dated 7/12/24 at 11:57 a.m., indicated R6's family member contacted the facility and was belligerent and the call was ended, and the director of nursing was informed of the conversation.

R6's skin and wound evaluation note dated 7/15/24, indicated R6 had 13 sutures to the right dorsum 1st digit amputation site that measured 0.6 centimeters (CM) long by 4.5 cm deep with no drainage and was healable, the dressing was dry, and the progress was stable.

R6's skin and wound evaluation note dated 7/15/24, indicated R6 had 35 sutures to the left transmetatarsal amputation site that measured 0.9 cm long by 7.6 cm wide with no drainage, the wound was healable, and the dressing was dry, and the area was stable.

R6's Integrated Wound Care progress note dated 7/15/24, indicated wounds were healing well to the left TMA with 35 sutures in place, and to the first MTP (metatarsophalangeal) joint (the joints between the metatarsal bones of the foot and the proximal bones of the toes) on the right with 13 sutures in place. The treatment recommendation for both sites included cleansing with Vashe or sterile normal saline, application of Betadine and allow to dry completely before covering wound with sterile 4 by 4 dressing then wrap with Kerlix and ACE wrap and change daily. Additionally, the note indicated the following factors that affected wound healing: diabetes, neuropathy, obesity, non-compliance, age, pain, limited weight bearing status, general weakness, reduced mobility, and tobacco. Additionally, miscellaneous orders included partial weight bearing status, optimize nutrition, and diabetes control.

R6's progress notes dated 7/17/24 at 10:55 a.m., indicated R6 had an appointment at the HealthPartners infection clinic and wound treatment was completed and the PICC (peripherally inserted central catheter) was removed and discontinued.

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R6's doctor of podiatric medicine (DPM) note dated 7/19/24, indicated R6's sutures were removed and R6 could get bilateral extremities wet in the shower but should not submerge the feet and elevate and apply ice as needed and a prescription for orthotics/shoes from Tillges due to diabetes and history of amputations bilaterally. R6's signed physician discharge summary dated 7/22/24, indicated R6's follow up podiatry appointment was on 7/19/24, in which sutures were removed and surgical sites were healed and R6 was being fitted for orthotic shoes and did not need any routine follow up with podiatry. R6 refused to remove socks on physical exam so the surgical sites could be evaluated. R6 was weight bearing as tolerated using a wheelchair for longer distances. The note also indicated R6 would benefit from a manual wheelchair because R6 had difficulty walking due to bilateral partial foot amputations which impaired the ability to accomplish mobility related ADLs safely and was unable to bear weight for normal mobility. Under the heading, Changes in Chronic Problems/Medications, indicated R6 had diabetes mellitus and started on daily Lantus insulin and was receiving a sliding scale insulin that was stopped before discharge. Additionally, discharge medications included: atropine 1% eye drop solution 1 drop into the left eye twice daily. prednisolone acetate 1% eye drop 1 drop into left eye 4 times a day. Tobramycin 0.3% eye drop solution place 1 drop into the left eye 4 times a day. insulin glargine (Lantus SoloStar) 100 unit/ml pen inject 15 units subcutaneously daily at bedtime. An email from the facility administrator dated 7/22/24 at 2:23 p.m., to Growth Services (a support organization to help reduce barriers for people with disabilities or disabling conditions to find and keep housing), indicated they felt it was in the best interest of the facility to expedite R6's discharge due to his illicit drug use and complaints made to the Minnesota Department of Health, as R6 posed a safety risk to other residents. The administrator requested a response to the email or a returned voicemail as soon as possible to get a plan in place. An email from the facility administrator dated 7/22/24 at 2:53 p.m., to Growth Services indicated the administrator spoke with Union Gospel Mission (UGM) intake who stated they could take R6 in their transitional care while waiting for his group home to open and the administrator communicated this to R6 who verbalized understanding he would discharge 7/23/24. The administrator's progress note dated 7/22/24 at 2:48 p.m., indicated the administrator called and spoke with Union Gospel Mission (homeless shelter) intake who stated they could take R6 in their transitional care while awaiting his group home to open and would need a valid photo ID, cannot be a level three sex offender and the information was communicated to R6 who verbalized understanding he would discharge 7/23/24, a ride was set up for 1:00 p.m., and a call and email was sent to R6's relocation coordinator. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	An email from Growth Services to the facility administrator dated 7/22/24 at 4:06 p.m., indicated Growth Services was still waiting to hear back from the group home who assessed R6 the previous week and was waiting to hear back from the CADI (community access for disability inclusion, a program that provides home and community based services to children and adults with disabilities who require the level of care provided in a nursing facility) case manager to help process paperwork for R6 to move in and there was nothing Growth Services could do on their end until those things happened. The director of social service's progress note dated 7/22/24 at 4:46 p.m., indicated R6 will be discharged from the facility and going to Union Gospel Mission (UGM) and R6 verbally agreed to the plan and an order for a wheelchair would be sent to Reliable to be delivered to Union Gospel Mission and R6 would take the wheelchair he had from the facility until he received the new one. Additionally, a referral for orthotics would go with R6 at the time of discharge and R6's family member and relocation coordinator were notified. R6's hand written physician orders dated 7/22/24, indicted the following orders: discontinue scheduled tylenol Tylenol 560 milligrams (MG) by mouth three times a day as needed for pain. Discontinue insulin sliding scale increase lantus to 15 units subcutaneously every day for diabetes. glucometer with testing supplies to check blood sugars twice daily mechanical wheelchair for impaired mobility ok to discharge to Union Gospel Mission with remaining medications. The hand written physician orders lacked information regarding whether wound care orders should be changed or discontinued. The order for wound care (surgical site TMA Left and first MTP joint right, cleanse with Vashe or Sterile NS. Apply Betadine and allow to dry completely before covering wound with sterile 4 by 4 then wrap with Kerlix and ACE wrap) was not discontinued in R6's electronic medical record. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R6's Discharge Instructions and Summary form dated 7/22/24, indicated R6 was discharging to Union Gospel Mission (Homeless shelter). Under the heading, Reason for Discharge, the reason for discharge was blank. Under the heading, Reason for Discharge/Transfer indicated R6 completed IV antibiotics and sutures to bilateral feet were removed and goals were met. Additionally, R6 is homeless and not able to care for his feet and developed a severe infection. R6 refused to work with therapy, swore, was non-compliant with cares, and had retinal reattachment surgery to the left eye and continued eye drops and was discharged to Union Gospel Mission (UGM) with remaining medications. R6 had an order for a new wheelchair that will be sent to Reliable Medical and delivered to R6 at UGM and a referral R6 will take in hand for orthotics. Under the heading, Ability to See in Adequate Light with Glasses or Other Visual Appliances indicated R6 was impaired. Under the heading, Medications, indicated R6 had Lantus Solostar 100 units/ml inject 12 units subcutaneously at bedtime for diabetes, along with Humalog KwikPen 100 units/ml with instructions to administer according to a sliding scale and was last administered on 7/21/24. Under the heading, Treatments, Specific Skin Treatment Instructions indicated amputation to bilateral feet with no additional treatment instructions documented. Under the heading, Activity, indicated non weight bearing. There were no orders for a home health nursing referral, and under the heading, Mood/Behavior/Psychosocial Wellbeing: the resident has a history of verbal aggression, substance use and non-compliant with cares while at the facility. Under the heading, Follow Up Appointments, UGM will access (sic) for needs. Under the heading, Information to be Communicated to Receiving Health Care Institution or Provider, no physician name or phone number was identified. Under the heading, Items Provided, gave options for check boxes for advance directives, copy of most recent labs, most recent MD consultation, most recent MDS, comprehensive care plan including goals, most recent H&P. All items were left blank and under the heading, List of Any Other Documents Attached to Ensure a Safe and Effective Transition of Care indicated a referral for orthotics. In bold type indicated this form including reconciled medication list was sent with resident, family and or caregiver, subsequent provider and home health care if indicated by paper. Under the heading, Other Special Instructions/Isolation Precautions, indicated R6's relocation worker's name and phone number. Additionally, R6 signed the form below a heading, Client/Patient/Resident verbalized understanding of instructions, explanations regarding medications and other instructions on 7/23/24. The form lacked information R6 was sent with a prescription for a blood glucose monitor, or that one was provided, that an assessment for self-administration of insulin, eye drops, and other medications was completed, and that an assessment indicating R6 was able to check his own blood glucose was completed. The above referenced instructions included medication and dose amount, but lacked instruction for how to administer insulin, eye drops, and how to check a blood glucose level. R6's medical record was reviewed and lacked information R6 was provided instruction or education on how to self-administer eye drops, insulin, or check his own blood glucose, or that a medication self-administration assessment was completed. R6's discharge Minimum Data Set (MDS) in progress, dated 7/23/24, indicated R6 had a planned discharge with a return not anticipated on 7/23/24. R6's discharge status location for section A2105 was not completed. Additionally, on section A2121, 'did the facility provide the resident's current reconciled medication list' was not documented if it was provided to the subsequent provider, along with A2122 'the route of the current reconciled medication list transmission to the subsequent provider' was also not documented. R6 was cognitively intact, had verbal behavioral symptoms 4 to 6 days, rejected care daily, was on a scheduled pain regimen, and a referral to a local contact agency was not made because the discharge date was three or fewer months away. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R6's care plan printed 7/25/24 at 9:49 a.m., indicated R6 would have an appropriate discharge plan with a goal R6 and family would make safe and appropriate decisions regarding discharge and staff would make necessary referrals as needed to carry out R6's discharge goals. The administrator's progress note dated 7/23/24 at 11:50 a.m., indicated the administrator contacted UGM to confirm R6 was able to admit, and the administrator gave a short handoff that R6 was independent with cares and activities of daily living (ADLs), IV antibiotic was discontinued, and surgical sutures were removed on 7/19/24, and the primary care physician felt R6 was stable for discharge to UGM. R6's nursing progress note from licensed practical nurse (LPN)-A dated 7/23/24 at 1:27 p.m., indicated R6 discharged to UGM and was discharged with belongings, all medications, one insulin pen and R6 would follow up with primary physician. The progress note lacked information how R6 would receive medication refills or that R6 was able to demonstrate self-administration of medications and understanding of how to use medications and glucometer. The administrator's progress note dated 7/23/24 at 3:45 p.m., indicated R6's sister called to inform her that UGM declined to allow R6 in the building and R6 was sitting on the sidewalk. The administrator contacted a staff person from UGM who told the administrator R6 looked like he required more care and the administrator called and spoke with the director at UGM who stated they could not accept R6, and the administrator asked what their plan was since R6 was discharged from the facility. The director of UGM indicated they planned to send R6 to the hospital. The administrator's progress note dated 7/23/24 at 4:10 p.m., indicated R6's family member contacted the facility and stated she intended to sue the facility due to discharging R6. The administrator explained to R6's family member that the primary care physician felt R6 was stable to discharge to UGM due to no longer requiring IV antibiotic and having surgical sutures removed and R6's family member hung up the phone. The administrator's progress note dated 7/23/24 at 4:16 p.m., indicated she received a call from a staff person at UGM who informed her R6's family member (FM)-A took R6 home before they could contact the hospital. R6's progress note dated 7/23/24 at 5:40 p.m., indicated R6's RSC was notified of the situation via email. An email from the facility administrator to Growth Services dated 7/23/24 at 5:44 p.m., indicated R6 discharged at 1:00 p.m. to Union Gospel Mission and upon arrival, could not provide appropriate care for R6 and allowed R6 to sit on the patio until they could figure out where to send R6 since he was discharged from the nursing facility. R6's family member took R6 home before UGM could send R6 to the hospital. An email dated 7/26/24 at 12:52 p.m., from the director of emergency services (DOES)-C at Union Gospel Mission indicated standard questions asked about potential guests included: are you [AGE] years old or older, do you have a government issued ID, are you a level three sex offender. Additionally, if there were concerns of someone's condition, they asked whether they are independent and ambulatory. DOES-C indicated the facility informed DOES-C that R6 was fully independent and required no additional care. Additionally, DOES-C indicated UGM did not provide a higher level of care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emeralds at St Paul LLC	420 Marshall Avenue Saint Paul, MN 55102

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

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A text from family member (FM)-A sent on 7/25/24, at approximately 4:30 p.m., included images FM-A stated was R6's foot, and socks with a reddish-brown discolored area located on the socks. The image of R6's left foot showed an incision site and all R6's toes were absent. A dark line was present along the incision line and the foot appeared to have dry flaky skin to the surrounding incision. During interview on 7/25/24 at 10:44 a.m., family member (FM)-A stated the facility was going to discharge R6 two weeks ago, they were going to throw him on the street and told the relocation coordinator. FM-A further stated the facility told her UGM could accommodate R6. FM-A stated UGM did not have rooms and could not take people in wheelchairs and added that R6 was dropped off on the sidewalk with 7 bags and the wheelchair and R6 did not know what to do and contacted FM-A. FM-A further stated she wished she would have stayed with R6 when she went to help R6 pack adding R6 was traumatized. FM-A stated RC-A had three emails the facility planned to discharge R6. FM-A stated she had pictures of R6's foot and added R6 could only walk a few steps on flat surfaces and stated he was with FM-A in her apartment and stated she did not know what to do with R6's foot because she has never done wound care and added one foot had one toe amputated which she felt looked good, but added the left foot had 5 toes amputated and was concerned about the appearance. FM-A further stated she did not receive any instructions for R6's eye and stated R6 could not retain any of that information. FM-A stated R6 did not want to leave the facility, the facility told him they were discharging him and ensured R6 he was discharging to a care place and added it seemed like R6 was discharged like trash. FM-A stated she was notified R6 was discharging on 7/22/24. Further FM-A stated R6 had no glucose monitor and wondered how they were supposed to give insulin if they did not know the level and stated if someone measured insulin, he could give himself insulin. FM-A stated R6 had drainage his socks and stated her wound nurse friend suggested R6 go to the hospital because she did not think R6's foot looked ok. She did not think the facility had R6 demonstrate how to self-administer insulin and stated she did not know how to give eye drops. FM-A stated she spoke with staff at UGM who informed her no one had contacted them about R6's care and stated they did not have a room for R6. During interview on 7/25/24 at 11:03 a.m., R6 stated he was notified of discharge the day prior on 7/22/24, when the facility told him he would be discharging to UGM. R6 stated the driver pushed him to the door and R6 went inside and gave paperwork over. R6 was then told UGM could not help him and could not accommodate people in a wheelchair so R6 picked up his bag and went outside and contacted FM-A and stated he was still in pain and his feet were still healing. R6 further stated he did not receive instruction on how to administer insulin and stated he had never taken insulin before hospitalization . R6 stated he had no way to check his blood sugars, the facility did not go over discharge instructions, and stated the first night he was discharged , R6 slept in FM-A's vehicle because he was unable to ascend the stairs to FM-A's apartment. The following day R6 received help from some people to navigate the stairs to FM-A's apartment. R6 further stated, They dropped me like a lost dog. During interview on 7/25/24 at 12:13 p.m., UGM administration staff (A)-B stated UGM does not provide any personal care, nor do they administer medications or complete wound care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During interview on 7/25/24 at 12:31 p.m., R6's relocation coordinator (RC)-A from Growth Services stated he worked with homeless clients to find housing. RC-A stated he met R6 on the street and R6 had frostbite. RC-A worked to get R6 certified disabled to receive a waiver for services and was involved in finding placement during R6's hospitalization . R6's goal was to end up somewhere like an assisted living facility that could provide the care R6 needed. When R6 discharged from the hospital he went to the facility and was supposed to be there for 6 to 9 weeks and worked with Minnesota Choices Underground who handled the waiver. RC-A stated he met with the facility and looked at a few assisted living facilities and the facility was on board with the plan and somewhere along the line, whether due to behaviors, they wanted to discharge R6 and received emails R6 had to leave and could no longer stay at the facility. RC-A told the facility you can't just put him back on the street and added the facility was not happy with him. RC-A stated it was about two and a half weeks ago they were told R6 could not be there any longer and stated the next couple of weeks things slowed down because they knew they could not kick him out. RC-A stated they sent a referral to Oaks but did not hear back. Then, this past Monday, RC-A stated he received [TRUNCATED]