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	06/25/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and document review, the facility failed to report lack of supervision incident (6/7/25) and elopement (6/13/25) was reported timely to the State Agency (SA) for 1 of 1 resident (R1) reviewed for elopement. Findings include:R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had intact cognition, no behaviors, used a walker and wheelchair, was independent with walking and wheeling, had no upper or lower extremity impairments, and used a wander/elopement alarm daily. Diagnoses included diabetes, dementia, malnutrition, anxiety disorder, depression, and post-traumatic stress disorder (PTSD). R1's most recent elopement assessment on 11/13/24, identified R1 had a habit/history of wandering or attempts to leave the unit/building and was able to ambulate or able to self-propel his wheelchair. R1's nurse progress note dated 6/7/25 at 9:34 a.m., identified R1 was found seated at the back of the building near the kitchen door. Reception staff reported R1 left the building around 5:30 a.m. and had his Wanderguard in his pocket. R1 returned at 7:20 a.m. and appeared to be fine. R1 did not recall how he exited the building. The Wanderguard had been secured on his ankle. Would do 15-minute safety checks every shift. Director of Nursing (DON) and nurse manager were notified. R1's administrator progress notes on 6/7/25 at 9:34 a.m., R1 stated he was trying to go outside to smoke and mistakenly went to employee smoking area instead of resident smoking area. R1 stated he was not trying to leave the facility. Staff confirmed R1 was smoking and returned inside afterward. R1 was reoriented to resident smoking area. During an interview on 6/24/25 at 8:00 a.m., the administrator identified the video footage of R1's 6/7/25 incident was not reviewed and was no longer available to be viewedR1's smoking assessment dated [DATE], indicated R1 had cognitive loss, smoked two to five cigarettes a day, smoked morning, afternoon, evenings, and nights, was found to be able to smoke safely and independently. However, the smoking assessment did not define the location where R1 was deemed safe to smoke and there was no indication the facility had thoroughly investigated the incident on how/why R1 was found in the employee smoking area. During an observation on 6/24/25 at approximately 1:00 p.m. the facility's outside secured resident smoking area noted an area of grass and concrete with locked gates surrounding the area. The back of the facility where R1 was found unsupervised in the staff smoking area was facing the alley where there was also delivery area and had ungated concrete steps to the lower level of the facility, dumpster's. There was a locked and coded door to re-enter the facility. There was no resident access areas accept from the front side of the building which would entail crossing a parking lot, public sidewalk, and public alley. During an interview on 6/25/25 at 2:13 p.m., receptionist (RCP)-C indicated she worked the night shift of 6/6/25 at 11:00 p.m. to 7:00 a.m. on 6/7/25. RCP-C was aware R1 went outside early that morning because she had to shut the door alarm off. RCP-C identified she thought it was about 6:50 a.m. or 6:55 a.m. RCP-C had historically been directed by someone (could not recall who that if a resident were to go outside she was supposed to not chase after the resident but instead report it to the nurse. When RCP-C called the charge nurse (was not sure which nurse she talked to) she was told, this is just what he [R1] does with no further direction given. RCP-C further identified no one was ever available to relieve her when she took her breaks, so would leave the floor unsupervised during those times. During an interview on 6/24/25 at 11:18 a.m., registered nurse (RN)-A identified she was working day shift on 6/7/25 and a resident informed her at approximately 7:10 a.m. that. R1 was sitting outside the back of the building by the kitchen door and employees smoking area and had been out there since 5:30 a.m. RN-A indicated R1 was not in a resident area or a safe area and should not have been there. R1 was noted to have his Wanderguard in his pocket and it alarmed when he entered the building. RN-A stated R1 did not know how he had gotten out of the building or how he had gotten to the back of the building. RN-A indicated she would consider R1's leaving the building unsupervised an elopement and notified the DON and the nurse manager; implemented 15-minute checks; and reapplied R1's Wanderguard. The Minnesota Adult Abuse Reporting Center did not contain any facility reported incidents or investigations related to R1's reported elopement on 6/7/25. A facility reported Vulnerable Adult Maltreatment Report submitted to the State Agency on 6/14/25 at 3:10 p.m., identified on 6/13/25 at approximately 6:00 p.m., R1 was able to elope through the front doors of the facility and make it down to the corner of Western and Marshall Avenue in his wheelchair. R1's behavior progress noted on 6/14/25 at 1:13 p.m., indicated social service designee (SSD) was informed by another resident (later identified as R4) that R1 had eloped from the facility the evening prior [6/13/25]. R4 found R1 on the corner of [intersection of two streets] between 6:30 p.m. - 7:00 p.m. R1

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

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure a thorough investigation for an incident that involved the lack of required supervision for 1 of 3 residents (R1) reviewed who required supervision. R1 was found outside the facility on 6/7/25 in an unsafe unauthorized area.Findings include R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had intact cognition, no behaviors, used a walker and wheelchair, was independent with walking and wheeling, had no upper or lower extremity impairments, and used a wander/elopement alarm daily. Diagnoses included diabetes, dementia, malnutrition, anxiety disorder, depression, and post-traumatic stress disorder (PTSD). R1's nurse progress note dated 6/7/25 at 9:34 a.m., identified R1 was found seated at the back of the building near the kitchen door. Reception staff reported R1 left the building around 5:30 a.m. and had his Wanderguard in his pocket. R1 returned at 7:20 a.m. and appeared to be fine. R1 did not recall how he exited the building. The Wanderguard had been secured on his ankle. Would do 15-minute safety checks every shift. Director of Nursing (DON) and nurse manager were notified. R1's administrator progress notes on 6/7/25 at 9:34 a.m., R1 stated he was trying to go outside to smoke and mistakenly went to employee smoking area instead of resident smoking area. R1 stated he was not trying to leave the facility. Staff confirmed R1 was smoking and returned inside afterward. R1 was reoriented to resident smoking area. During an interview on 6/24/25 at 8:00 a.m., the administrator identified the video footage of R1's 6/7/25 incident was not reviewed and was no longer available to be viewedR1's smoking assessment dated [DATE], indicated R1 had cognitive loss, smoked two to five cigarettes a day, smoked morning, afternoon, evenings, and nights, was found to be able to smoke safely and independently. However, the smoking assessment did not define the location where R1 was deemed safe to smoke and there was no indication the facility had thoroughly investigated the incident on how/why R1 was found in the employee smoking area. During an observation on 6/24/25 at approximately 1:00 p.m. the facility's secured resident smoking area noted an area of grass and concrete with locked gates surrounding the area. The back of the facility where R1 was found unsupervised in the staff smoking area was facing the alley where there was also delivery area and had ungated concrete steps to the lower level of the facility, dumpster's. There was a locked and coded door to re-enter the facility. There was no resident access areas accept from the front side of the building which would entail crossing a parking lot, public sidewalk, and public alley. During an interview on 6/25/25 at 2:13 p.m., receptionist (RCP)-C indicated she worked the night shift of 6/6/25 at 11:00 p.m. to 7:00 a.m. on 6/7/25. RCP-C was aware R1 went outside early that morning because she had to shut the door alarm off. RCP-C identified she thought it was about 6:50 a.m. or 6:55 a.m. RCP-C had historically been directed by someone (could not recall who) that if a resident were to go outside she was not supposed to chase after the resident but instead report it to the nurse. When RCP-C called the charge nurse (not sure which nurse she talked to) she was told, this is just what he [R1] does with no further direction given. RCP-C further identified no one was ever available to relieve her when she took her breaks. During an interview on 6/25/25 at 2:03 p.m., RCP-B indicated when she arrived for her shift on 6/7/25 at 7:00 a.m., the night receptionist was not at the front desk, she was not aware of where she was, and the alarm was not sounding. The overnight nurse left but did not report R1 was outside. A resident told RCP-B (but could not recall which resident) that R1 had left the building and was sitting outside in the back of the facility by the alley. RCP-B stated she told R1 that he was not supposed to be out there, it was not safe, and tried to get R1 to come in but he refused to come in. She reported it to the charge nurse. The charge nurse and a nursing assistant (NA) came down and got him back in the building. RCP-B indicated the only way R1 could have gotten out was the front entrance door, down the sidewalk, over a curb, and around to the back-alley way. RCP-B further stated she found an unsigned note on the receptionist desk that said R1 had left the building about 5:00 a.m. but was not sure who wrote the note and threw the note away. During an interview on 6/24/25 at 11:18 a.m., registered nurse (RN)-A identified the receptionist on first floor was responsible for monitoring the Wanderguard system and the doors 24/7. The Wanderguard alarms did not alert to the 2nd, 3rd, or 4th floors so staff would not be aware if a resident tried to get out of the facility through the main entrance on the first floor. RN-A indicated she was working day shift on 6/7/25. At approximately 7:10 a.m. a resident (she could not recall which resident) had informed her that since 5:30 a.m., R1 was sitting outside the back of the building by the kitchen door and employees smoking area. R1 was not in a resident area or a safe area and should not have been there. R1 had his Wanderguard

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide adequate supervision and identify a foreseeable hazard for 1 of 3 residents (R1) reviewed who required supervision. R1's was found unsupervised on two occasions; On 6/7/27 while outside in the staff smoking area and on 6/13/25 as a result of nonfunctional wanderguard and the facility not performing physician ordered 15-minute checks was found at a busy intersection. This resulted in an immediate jeopardy for R1 health and safety.The Immediate Jeopardy (IJ) began on 6/7/25, was corrected on 6/14/25 when the facility implemented interventions to prevent reocurrance. The Administrator, Director of Nursing (DON), Regional Director of Operations, and Regional Nurse Consultant were notified of the IJ on 6/24/25 at 5:50 p.m. The facility implemented immediate corrective action on 6/14/25 to prevent recurrence, so the IJ was issued at past none compliance. Findings include:R1's St. Louis University Mental Status Exam dated 7/19/24 (SLUMS- is a screening tool used to detect mild cognitive impairment and dementia in older adults) identified R1's score was indicative of dementia. R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had intact cognition, no behaviors, used a walker and wheelchair, was independent with walking and wheeling, had no upper or lower extremity impairments, and used a wander/elopement alarm daily. The MDS also identified R1 required care and monitoring for diagnoses of diabetes, dementia, malnutrition, anxiety disorder, depression, and post-traumatic stress disorder (PTSD). R1's Care Plan Report focus initiated 7/23/24, identified R1 was at risk for elopement related to diagnoses of bipolar affective disorder (disorder with episodes of mood swings), alcohol abuse, dementia with behavioral disturbances, and history of elopement attempt. R1 had a history of cutting off the Wanderguard device (off his person). The goals identified R1 would not leave the building alone and would follow the facility leave of absence (LOA) policy. The interventions initiated on 7/23/24, directed staff to invite R1 to all activities of choice; answer door alarms promptly; monitor Wanderguard per manufacturer's guidelines; new wander guards were kept at the receptionist desk or/and the director of nursing (DON) office; and Wanderguard was to be monitored for proper functioning, placement, and expiration date per orders. R1's most recent elopement assessment on 11/13/24, identified R1 had a habit/history of wandering or attempts to leave the unit/building and was able to ambulate or able to self-propel his wheelchair. The assessment resulted in a score of three which did not meet the facility's guideline of four or greater to indicate at risk for elopement. Despite the score of three, an elopement risk care plan was indicated with the goals and interventions listed in R1's care plan. R1's medical record did not include quarterly elopement assessments for February 2025, May 2025.R1's nurse progress note dated 6/7/25 at 9:34 a.m., written by registered nurse (RN)-A, identified R1 was found seated at the back of the building near the kitchen door. Reception staff reported R1 left the building around 5:30 a.m. and had his Wanderguard in his pocket. R1 returned at 7:20 a.m. and appeared to be fine. R1 did not recall how he exited the building. The Wanderguard had been secured on his ankle. Would do 15-minute safety checks every shift. Director of Nursing (DON) and nurse manager were notified. R1's Medication Administration Record (MAR) dated June 2025, identified an order entered on 6/7/25 directed staff to do hourly safety checks due to increased risk for elopement. Document any exit seeking behaviors or comments in the progress notes and update provider, as needed. Another order entered on 6/7/25 directed staff to do 15-minute checks every shift for confusion and were signed by staff as completed. R1's administrator progress notes on 6/7/25 at 9:34 a.m., R1 stated he was trying to go outside to smoke and mistakenly went to employee smoking area instead of resident smoking area. R1 stated he was not trying to leave the facility. Staff confirmed R1 was smoking and returned inside afterward. R1 was reoriented to resident smoking area. During an interview on 6/24/25 at 8:00 a.m., the administrator identified the video footage of R1's 6/7/25 incident was not reviewed and was no longer available to be viewedR1's smoking assessment dated [DATE], indicated R1 had cognitive loss, smoked two to five cigarettes a day, smoked morning, afternoon, evenings, and nights, was found to be able to smoke safely and independently. However, the smoking assessment did not define the location where R1 was deemed safe to smoke and there was no indication the facility had thoroughly investigated the incident on how/why R1 was found in the employee smoking area. Further, despite R1 going to the wrong smoking area on 6/7/25, R1's record did not include a follow-up assessment that identified if R1 continued to be safe to leave the building to smoke independently after 6/725. Additionally even though 15-minute checks were implemented it was not evident R1's care plan was updated