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	07/14/2025

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 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. (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 0656 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 comprehensive care plan was developed for 1 of 1 resident (R1) reviewed for pressure ulcersFindings include:R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had highly impaired hearing that required a hearing device. R1 had severe cognitive impairment, no speech, and was completely dependent on staff for all activities of daily living (ADL's). R1's diagnoses included acute and chronic respiratory failure (when the lungs can't adequately provide oxygen to the blood or remove carbon dioxide from it) with hypoxia (when the body doesn't receive enough oxygen), encounter for tracheostomy (a surgical procedure creating an opening in the trachea (windpipe) to facilitate breathing) and anxiety disorder. Further identified R1 was at risk for pressure ulcers. R1's care area assessment (CAA) dated 6/17/25, identified Section 3; Visual function: identifying triggers indicated an ability to see in adequate light (with glasses or other visual appliances) was impaired. Analysis of findings identified R1 had impaired vision related to multiple comorbidities, used glasses on a daily basis. Overall objective for care planning was to minimize risks. Section 4 Communication triggering conditions identified R1's ability to hear was highly impaired. Analysis of findings identified R1 was at risk for communication difficulty related to multiple comorbidities. R1 had no speech, sometimes understands and sometimes make self-understood. R1 had impaired vision, impaired hearing, does not use hearing aide/device. Will proceed to care plan. Staff will repeat messages as necessary to assure communication has been successful.R1's Nurse Practitioner (NP) visit dated 6/27/25, identified R1 was severely hard of hearing with hearing device responds appropriately. R1's Care Plan Audit Report for R1 Printed: 7/14/25 Revision Date: 7/5/25Focus: Communication R1 experienced altered communication due to a tracheostomy (chronic respiratory failure), hearing impairment, and lack of speech. R1 often refuses to remove her pocket talker device (an amplified hearing tool).Interventions: 4/9/25: Staff to apply hearing box when communicating with R1; speak clearly, face R1, use writing tools; minimize background noise (e.g., TV, suctioning machine). 7/7/25: Ensure R1 wears headphones when communicating or watching TV, per her preference. 7/9/25: Ensure R1 has box talker device at all times and within reach.Focus: Vision R1 has altered vision and wears glasses consistently, often refusing to remove them even during sleep with a revision date of 7/5/25.Interventions: 7/5/25: Assist with daily wear of glasses; monitor/document vision changes or eye pain; ensure call light is accessible; monitor for eye infection; staff responsible for care and maintenance of glasses; schedule ophthalmology appointments as needed/requested. 7/7/25: Encourage R1 to remove glasses while resting and at HS. Care plan was reviewed and did not identify interventions for skin breakdown for eyeglasses or headphones for pocket talker even though according to the care plan R1 had a history of refusing to remove and R1 was at risk for pressure ulcers according to the assessment dated [DATE]. During an interview on 7/10/25 at 12:28 p.m., registered nurse (RN)-B stated he was the nurse manager for R1and indicated R1 kept her eyeglasses and headphones for her pocket talker on 24 hours a day seven days a week. RN-B reviewed R1's care plan, then stated the care plan did not identify this and there were no prevention interventions implemented to prevent pressure ulcers to her nose or her ears and there should have been. During an interview on 7/10/25 at 2:17 p.m., the director of nursing (DON) stated staff shared with him that R1 was resistive to having her glasses and headphones removed. R1 was a mechanical ventilator resident who was fully dependent with ADL's putting her at high risk for pressure ulcer development. DON further stated R1's care plan should have identified R1 was at risk for pressure ulcer development if R1's glasses and headphones were not removed, and prevention interventions should have been developed to prevent pressure ulcers to these areas. Facility Care Planning policy revised 11/2024, identified.comprehensive care plan: the interdisciplinary team (IDT), in conjunction with the resident and the resident representative, will develop and implement a comprehensive individualized care plan no later than the 21st day of admission of the resident. The care plan interventions are derived form a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive person-centered care plan will be consistent with the resident's rights to identify problem areas and their causes and develop interventions that are targeted and meaningful to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident 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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - 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 that 1 of 3 residents (R1) reviewed for pressure ulcers received care and services to prevent occurrence of newly developed pressure ulcers. The facility's failure resulted in actual harm to R1 when R1's skin was not comprehensively assessed and failed to develop a care plan for pressure ulcer prevention that resulted in six (6) pressure ulcers including Stage 4 pressure ulcer to R1's nose and deep tissue injuries to R1's ear. Findings include Findings include:According to the State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, revised 08-08-2024, included the following definitions:-Pressure Ulcer/Injury (PU/PI) refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear.- Stage 4 pressure ulcer refers to full thickness skin and tissue loss with exposed or directly palpable fascia, muscle tendon, ligament, cartilage, or bone in the ulcer. Slough and /or eschar may be visible on some parts of the wound bed.- Eschar refers to dead or revitalized tissue that is hard or soft in texture; usually black, brown or tan in color, and may appear scab like, Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides and edges of the wound.- Unstageable pressure ulcer refers to a full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If the slough or eschar is removed, a stage 3 or 4 pressure ulcer will be revealed. - Deep tissue pressure injury (DTPI) refers to intact skin with localized area of non-blanchable deep red, maroon or dark purple discoloration due tot eh damage of underlying soft tissue.- Avoidable means that the resident developed a pressure ulcer/injury, and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.R1's Braden Scale for Predicting Pressure Sore Risk dated 6/11/25, identified a score of 13 indicating R1 was at moderate risk due to the following factors: 1. Sensory perception-very limited, responds to only painful stimuli.2. Moisture-occasionally moist requiring an extra linen change once a day, 3. Activity-chairfast ability to walk severely limited or non-existent, cannot bear own weight and must be assisted into a chair or wheelchair. 4. Mobility-very limited makes occasional slight changed in body or extremity position but unable to make frequent or significant changes daily. 5. Nutrition was adequate.6. Friction and Sheer-a problem required moderate to maximum assistance in moving. Complete lifting without sliding against sheets was impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had highly impaired hearing that required a hearing device and had impaired vision with corrective lenses. R1 had severe cognitive impairment, no speech and was completely dependent on staff for all activities of daily living (ADL's). R1's diagnoses included acute and chronic respiratory failure (when the lungs can't adequately provide oxygen to the blood or remove carbon dioxide from it) with hypoxia (when the body doesn't receive enough oxygen), encounter for tracheostomy (a surgical procedure creating an opening in the trachea (windpipe) to facilitate breathing) and anxiety disorder. R1 was at risk for pressure ulcers and had no identified skin concerns.R1's MDS triggered Care Area Assessments (CAA) for pressure ulcers, vision, and communication. R1's Pressure ulcer CAA dated 6/17/25 identified R1 at risk for skin breakdown related to decreased mobility, incontinence. R1 requires assistance from staff with mobility, transfers, and toileting needs R/T physical limitations but R1 can make some position changes on her own however, staff assist with repositioning and offloading as needed. Staff will monitor skin and report changes for evaluation/intervention/treatment as appropriate. R1's vision CAA identified R1 had impaired vision related to multiple comorbidities and used glasses on a daily basis. R1's Communication CAA identified R1's ability to hear was highly impaired related to multiple comorbidities. R1 did not use hearing aide/device. Will proceed to care plan. According to R1's care plan audit report (printed on 7/14/25) did not specifically include a pressure ulcer focus nor identify R1 was at risk for pressure ulcers. However, the care plan did include a Skin care plan focus that was created and initiated on 4/9/25, which identified R1 was at risk for impaired

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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. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to ensure medical records were accurate and readily accessible for 1 of 1 resident (R1) reviewed for pressure ulcers. Findings include:On 7/14/25 the facility had provided electronic health record (EHR) access to review resident records. The viewable access to R1's record included care plan history dates, however, when printed the dates were inconsistent with what was displayed that was readily accessible. The facility provided R1's care plan on 7/14/25 at 7:51 a.m. This care plan included a communication focus that identified an initiated date of 4/9/25, Resident has Alteration in communication R/T [related to] Placement of Tracheostomy D/T [do to] chronic respiratory failure, HOH [hard of hearing], No speech. and Resident often refuses to remove pocket talker device. The corresponding goals were initiated on 4/9/25 with revision dates of 7/9/25 (did not identify what the revisions were); the goals included resident will have adequate communication as evidenced by: ability to communicate basic needs and Residents needs will be anticipated and met by staff. There were no other dates that were included in the focus area column and the interventions did not include any dates including when they were initiated. R1's care plan that was provided on 7/14/25 at 7:51 a.m. also included a focus area for vision that was initiated on 6/19/25; Resident has Alteration in vision AEB (as evidenced by): related to: Resident wearing glasses. Resident has history of refusing to remove glasses and will often sleep with them on. The corresponding goals had an initiated date of 7/5/25 with a revision date of 7/9/25 which was not consistent with when the vision care plan focus was initiated. The interventions did not include any dates of initiation or revision. The facility then provided another copy of R1's care plan on 7/14/25 at 8:46 a.m. via email from the administrator in which the administrator wrote, See attached. I had to have Corporate change the configuration for CP [care plan] The attachment was labeled cp with revisions. This care plan included the focus area of communication with the initiated date of 4/9/25, the goals remained the same and included dates the interventions were initiated. The interventions were all initiated on 4/9/25, with the exception of staff to ensure resident has her headphone one [sic] when communicating . which was 6/19/25, and Staff to ensure resident has his [sic] box talker . which was dated 7/5/25. This version of the care plan included an intervention that was not reflected on the first version provided at 7:51 a.m. which was Encourage resident to remove pocket talker while resident and at HS [at night] with initiated date of 7/3/25. -In the same copy of the care plan provided at 8:46 a.m. was the vision focus that was initiated on 6/19/25. The goals were unchanged between this copy and the previous copy that was provided at 7:51 a.m. The interventions that were listed all identified they were initiated on 7/5/25 with the exception of Encourage resident to remove glasses while resident and at HS which identified an initiated of 7/3/2025. There was no revision dates identified for any interventions listed. The facility then provided Care Plan Audit [resident initials] via email on 7/14/25 at 10:50 a.m. The audit report identified the focus of communication was created and initiated on 4/9/25 and had a revision date of 7/5/25. The corresponding goals identified they were created and initiated on 4/9/25 and had a revision date of 7/9/25. The audit report identified most of the interventions had been created on and initiated on 4/9/25, except for one intervention that was created by the administrator and one intervention was created by registered nurse (RN)-B in which those interventions had a created-on date after the initiation date. The intervention Encourage resident to remove pocket talker while resting and at HS Date was created on 7/7/25 by the administrator, however the initiated date of the intervention was 07/03/2025. The intervention Staff to ensure resident has her headphone one [sic] when communicating and watching TV per her choice was created on 7/9/2025 by registered nurse (RN)-B however the initiated date of the intervention was 6/19/25. -In the same copy of the Care plan Audit report that was provided at 10:50 a.m. included the vision focus which identified RN-B created the focus on 7/5/25 and the administrator revised the focus on 7/5/25, but the initiated date was 6/19/25. The corresponding goals were created on 7/5/2025 and revised on 7/9/25 by RN-B. The intervention Encourage resident to remove glasses while resting and at HS was created on 7/7/25 by the administrator however the care plan identified the initiated date was 7/3/25. All of the interventions were created and initiated on 7/5/25 by RN-B. The care plan did not identify any revision dates. During an interview on 7/14/25 at 10:17 a.m., administrator stated she was unsure why the care plans when printed showed the wrong dates. Administrator stated she initiated the focus of R1's refusal of removing pocket talker on 7/5/25 after her hospitalization on 7/4/25. Administrator further stated R1 focus of vision with history of refusing to remove her glasses was not implemented until 7/5/25. Administrator was unsure why the care plan was printing out with inaccurate dates. During an interview on 7/14/25 at 10:33 a