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	07/30/2025

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure call light was accessable for 1 of 1 residents (R61) reviewed for call lights. Findings include: R61's quarterly Minimum Data Set)MDS) dated [DATE], indicated R61 was cognitively intact and had diagnoses of respiratory failure and quadriplegia (unable to move arms or legs). Furthermore, R4 was dependent on staff for all cares.R61's care plan revised 6/5/25, indicated R61 was a risk of falls and staff were to ensure R61's call light was within reach.An observation on 7/27/25 at 12:39 p.m., R61 was laying in bed. R61's head was on a pillow and on the right side of the pillow was a tent call light. R61 was unable to move his head to hit the call light if staff assist was needed. When interviewed on 7/27/25 at 12:42 p.m., R61 was able to answer yes and no questions and mouthed words. R61 indicated it was sometimes hard to breath and they waited on staff for help. R61 shook their head no when asked if able to turn on the call light from where it was located. An observation on 7/28/25 at 1:54 p.m., R61 was laying in his bed watching their tablet. To the right of R61's pillow was a tent call light. R61 indicated no when asked if he could turn it on if assistance was needed. When interviewed on 7/28/25 at 2:05 p.m., registered nurse (RN)-B stated R61 was able to use the call light to alert staff for assistance. R61 was able to nudge it with his head. RN-B verified R61 was not able to reach their call light. RN-B placed the tent call light on R61's pillow close to their head and asked R61 to put it on to ensure it was in reach. When interviewed on 7/28/25 at 2:23 p.m., RN-C stated call lights should be placed where residents could use them. RN-C further stated that is an important part of how residents let staff know they need help. When interviewed on 7/30/25 at 10:59 p.m., the Director of Nursing (DON) expected staff to ensure call lights were in reach for all residents. DON further stated this was needed to ensure residents can get assistance when needed. A facility policy titled Call Light Policy revised 5/16/23, directed staff to ensure call lights, cords or other communication devices must be placed where they are within reach of each resident.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a Provider Order for Life Sustaining Treatment (POLST) was updated to reflect the current wishes for 1 of 1 residents (R7) reviewed for advanced directives. Findings include:R7's Minimum Data Set (MDS) dated [DATE], indicated R7 had severely impaired cognition and never made decisions. R7's diagnoses included chronic respiratory failure, quadriplegia (inability to move arms and legs) and locked in state (lacked motor responses used to measure responsiveness). Furthermore, R7 had a tracheostomy (a surgical incision into the windpipe to assist with breathing) and required mechanical ventilation. R7's provider order dated 8/9/24, indicated R7 did not want resuscitation and was Do Not Resuscitate (DNR). R7's POLST dated 9/4/24, indicated R7 was DNR with selective treatment. Selective treatment included no intubation, advanced airway and no mechanical ventilation. Along side of the selective treatment section read per brother DNR/Do not Intubate (no advanced airway).R7's provider order dated 8/9/24, indicated R7 did not want resuscitation and was Do Not Resuscitate (DNR). R7's hospital Discharge summary dated [DATE], indicated R7 was hospitalized with acute on chronic hypoxic respiratory failure (an exacerbation of respiratory failure that led to low oxygen saturations). The summary further indicated R7 had been dependent on a tracheostomy prior to hospitalization and had not required oxygen supplementation or mechanical ventilation. R7 now needed mechanical ventilation as needed during the day and be placed on mechanical ventilation at night upon discharged .R7's care conference form dated 3/21/25, indicated R7's POLST was reviewed with resident/representative. When interviewed on 7/28/25 at 1:47 p.m., licensed practical nurse (LPN)-C stated the nurse manager reviewed the POLST with the resident or family when admitted . LPN-C wasn't sure how often a POLST was reviewed after that. When interviewed on 7/28/25 at 2:24 p.m., registered nurse (RN)-C stated a POLST was reviewed with the resident or family upon admission and then should be reviewed with any changes, at care conferences and hospitalizations. Full recusation and DNR was explained to the resident/family to help them decide what was wanted. They sign and then the nurse practitioner signed. RN-C verified R7's current POLST indicated R7 wanted to be DNR/DNI, however R7 had a tracheostomy and used a mechanical ventilator. RN-C further stated this did not make sense and R7 had a change after a hospitalization and had been using the ventilator for a while. RN-C stated R7's brother who was the medical decision maker, would need to be notified so R7's POLST could be clarified as R7's brother was involved and knew the status of the ventilator use. RN-C further stated during care conferences, while the POLST was discussed, the actual form was not reviewed for accuracy. When interviewed on 7/30/25 at 10:59 a.m., the Director of Nursing (DON) expected the resident's wishes and POLST to be verified and completed during admission and reviewed as needed, which included when residents returned from the hospital. Furthermore, the DON stated this was important to ensure the residents received the care they wanted. A facility policy titled POLST Documentation Procedure revised 4/2025, directed staff to complete a routine audit of POLST documentation to ensure consistent and accurate documentation of the POLST form, provider orders and care plan entry.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure target behaviors were monitored for 1 of 5 residents (R3) who received psychotropic medications (medications that affect mood, thoughts, or behaviors). Findings include:R3's quarterly Minimum Data Set (MDS) dated [DATE], indicated R3 was cognitively intact and had diagnoses of acute respiratory failure, Amyotrophic Lateral Sclerosis (disease that affects the spinal cord causing loss of muscle use), and major depressive disorder. R3 was ventilator dependent and was taking psychotropic medications.A review of R3's current provider orders indicated R3 required:-as of 4/3/2025, Clonazepam (psychotropic medication) 0.5 milligrams (mg) via gastrostomy tube (G-tube) at noon for anxiety. -as of 4/2/25, clonazepam .025 mg twice daily for anxiety related to major depressive disorder. R3's orders lacked monitoring for target behaviors for anxiety. R3's care plan revised 11/11/2024, indicated R3 had potential for psychotropic drug adverse drug reactions related to daily use of psychotropic medications. Interventions included to administer medications as ordered, monitor for adverse reactions, and pharmacy to review medications. However, R3's care plan lacked identification or monitoring of target behaviors. When interviewed on 7/28/25 at 10:20 a.m., registered nurse (RN)-D stated R3 took medications for anxiety and has for a while. RN-D stated staff look for restlessness. R3 had been very anxious at times, especially when needing suctioning. R3 had recently been declining and at one point was going to go onto hospice, however decided not to. RN-D verified there was no documentation of target behaviors related to R3's anxiety or psychotropic medications and stated there was no longer daily documentation of any specific anxiety behaviors or anything to that extent. Currently, nurses only document if R3 had a change in condition. When interviewed on 7/29/25 at 2:25 p.m., RN-C stated R3 had recently deteriorated and almost signed on to hospice a few months ago. R3 used to be able to mouth his words, and now he can only blink to communicate. R3 used to be very anxious with repositioning and used to over breathe the vent. Currently, R3 had good days and bad days with the anxiety, breathing and repositioning. RN-C verified R3 had orders to monitor for side effects of the psychotropic medications, however there was no monitoring of target behaviors related to R3's anxiety and need for the medications. When interviewed on 7/30/25 at 10:19 a.m., the Director of Nursing (DON) expected residents who were taking psychotropic medications to have monitoring for target behaviors related to those medications. DON further stated it was important to understand if the medications were effective and if they were supporting a positive outcome for the resident. A facility policy titled Psychotropic Medication Use Policy revised 5/2025, directed staff to identify and monitor target behaviors when a resident was prescribed psychotropic medications.

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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 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 document review the facility failed to provide nail care for 1 of 1 (R79) resident reviewed for activities of daily living (ADL).Findings include:R79's quarterly Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition and diagnoses of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side and vascular dementia. It further indicated R79 had an impairment on one side of his upper extremities and required staff assistance with most ADL's and mobility.R79's care plan dated 6/18/25, indicated current functional performance was assist of 1 with ADLs. R79's skin assessments for the month of July 2025 (7/6/25, 7/13/25, 7/20/25, 7/27/25) indicated trimming fingernails was not necessary. During observation and interview on 7/27/25 at 3:01 p.m., R79's fingernails (on both hands) were approximately an inch long and he stated he wanted them cut. During observation on 7/28/25 at 8:08 a.m., R79 was sitting in his wheelchair, waiting in line to go outside to smoke. His fingernails were observed to be approximately one inch long. During observation and interview on 7/28/25 at 10:00 a.m., nursing assistant (NA)-E stated the nurses were responsible for cutting the residents nails, especially when they were diabetic and it should be done at least once a week on bath day. If the resident refused, it should be documented. NA-E also verified R79's nails were long, and they appeared to have not been trimmed in a few weeks. R79 repeatedly asked NA-E to cut his nails during this time. During interview on 7/28/25 at 10:46 a.m., licensed practical nurse (LPN)-B stated NA's and nurses were responsible for cutting the resident's fingernails unless they were diabetic. If the resident was diabetic, then the nurses were responsible for cutting them. This should be done weekly on bath day and refusals should be documented.During interview on 7/28/25 at 3:04 p.m., LPN-A stated the NA's or activities staff were responsible for cutting the resident's nails (unless they were diabetic). If they were diabetic, then the nurses were responsible for cutting them. The residents' nails should be cut once a week on bath day and refusals should be documented. During interview on 7/30/25 at 12:42 p.m., the director of nursing (DON) stated the nurses or podiatry were responsible for cutting residents nails if they were diabetic. If the resident was not diabetic, then the NAs were responsible for doing it. The DON further stated the resident's nails should be cut at least once a week on bath day, along with the skin assessment. The nurses were responsible for documenting it was completed, and refusals should be documented. The facility's policy regarding ADL's dated 3/31/23, indicated a resident who is unable to carry out activities of daily living will receive the necessaryservices to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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F 0688 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 observation, interview and document review, the facility failed to ensure a hand splint/brace was used consistently for 1 of 1 resident (R37) reviewed for range of motion (ROM).Findings include:R37's annual Minimum Data Set (MDS) dated [DATE], indicated R37 has minimal cognitive deficit, had limited ROM with impairment of upper extremities on one side, dependent with upper body dressing, and received zero minutes of ROM or splint/brace assistance in the 7 day lookback period. R37's diagnoses included hemiplegia and/or hemiparesis (weakness/paralysis affecting one side of the body) following a stroke affecting left non-dominant side.R37's care plan dated 4/14/25, indicated R37 severe contractures (condition where muscles or tendons become permanently shortened, causing loss of movement) of extremity. R37's care plan indicated hand splint to left arm, on in a.m. up to six hours and off at 2:00 p.m. and to wash both hands every shift before applying left hand splint/hand protector.R71's provider order dated 7/10/25, indicated apply hand splint to left arm, on with a.m. cares.R71's provider order dated 7/10/25, indicated remove left arm splint at the end of day shift at 1400 [sic].After the electronic medical record reviewed on 7/29/25, no evidence in R37's progress notes of physician notification of potential pain during usage of the left hand splint. Further, no evidence of any therapy orders during the year of 2025. During observation on 7/27/25 at 1:00 p.m., R37 in bed with no splint noted to left hand/arm.During observation on 7/28/25 at 8:04 a.m., R37 was up in wheelchair (w/c) in room with no splint noted to left hand/arm.During observation on 7/28/25 at 11:49 a.m., R37 up in w/c in room with no splint noted to left hand/arm.During observation on 7/28/25 at 1:47 p.m., R37 in bed with no splint noted to left hand/arm.During observation on 7/29/25 at 7:14 a.m., R37 in bed with no splint noted to left hand/arm.During observation on 7/29/25 at 8:01 a.m., R37 in bed with no splint noted to left hand/arm.During an interview on 7/29/25 at 8:43 a.m., nursing assistant (NA)-F stated not being aware of R37 requiring a splint to either hand and further stated R37 only requires the blue boots to the legs/feet only. NA-F verified R37 did not have a splint on the left hand/arm.During an interview on 7/29/25 at 8:46 a.m., trained medication aide (TMA)-A stated being aware of the blue boots for R37's legs/feet however, was not aware R37 required anything for the hands/arms. TMA-A pulled up the point of care documentation and noted there was no area to document a splint for R37's left arm. TMA-A pulled up the kardex for R37 on the laptop and noted there was documentation which indicated R37 required a splint to left arm to be applied in the a.m. and to be removed at 2 p.m. on day shift. TMA-A verified R37 did not have a splint on the left hand/arm. During an interview on 7/29/25 at 8:50 a.m., registered nurse (RN)-F stated R37 used to wear a splint to the left arm however, the staff are unable to find the splint for months. RN-F stated therapy was informed the splint was missing months ago however, denied following up on the missing splint status. During an interview on 7/29/25 at 8:54 a.m., RN nurse manager (RN)-G stated R37 refuses to wear the left arm splint due to pain however, further stated Health Partners was called and an order for therapy was received and therapy has been working with R37 regarding the splint. Further, RN-G stated R37 hadn't wore the splint to the left arm in months. During an interview on 7/29/25 at 9:02 a.m., certified occupational therapy assistant (COTA)-A stated R37 hadn't been on case load for therapy since 2024 and at the time it was an evaluation only due to a return from a hospital stay. Further COTA-A stated the last time R37 had been on therapy case load for the splint to the left arm was during 2021. COTA-A verified R37 needed the splint for pain management and to maintain what movement R37 has in the left arm.During an interview on 7/29/25 at 9:08 a.m. director of nursing (DON) stated if a splint was missing or causing pain the provider should be notified and therapy orders obtained as well as a new splint should be reordered and fitted. DON verified it was important for R37 to utilize the splint to maintain as much range of motion to the area as possible.Splint usage policy requested on 7/29/25 however, was not provided.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. (continued on next page)

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F 0699 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 document review and interview, the facility failed to identify triggers to avoid potential re-traumatization and failed to develop the care plan to include individualized trauma-informed approaches for 1 of 1 resident (R6) who had a history of trauma. Findings include:R6's Comprehensive Minimum Data Set assessment (MDS) dated [DATE], indicated cognitively intact, had a diagnosis of major depressive disorder with anxiety and PTSD (post traumatic stress disorder) on admit on 4/22/25. R6 had a diagnosis of quadriplegia required full cares with bed mobility and transfers, unable to walk, and required total assistance with dressing and hygiene.R6's admission Psychosocial assessment dated [DATE] was not triggered for a care area assessment, therefore, not placed on care plan.R6's admission Trauma Questionnaire dated 4/23/25, identified the resident had a diagnosis of PTSD and R6 declined to talk about it.R6's physician visit note dated 4/25/25, identified R6 had major depressive disorder with anxiety, aggressor identification syndrome and PTSD.R6's physician orders on 4/28/25 and 6/3/25, identified orders for ACP Psychiatry consult to evaluate and treat. R6's vulnerability care plan dated 7/24/25, lacked individualized trauma-informed approaches or interventions and lacked identification of triggers to avoid potential re-traumatization.During an interview on 7/27/25 at 6:09 p.m., R6 stated someone, thinks it was social work employee, came in and talked, but I didn't want to talk at that time, I should see someone, I have been in a panic mode, they stated just trying to get everything all together.During an interview on 7/28/25 at 2:13 p.m., R6 spoke rapidly, changing subjects quickly I'm a little depressed, and concerned about keeping things in order, phone in mothers name right now, I wanted own line. Social worker was here about 1.5 weeks ago, I need to see a therapist, social services was going to do it but hasn't happened yet. I am in kind of panic mode. R6 rambled about Lake City, Milwaukee, packing up stuff and wanting to leave. They mentioned Bayview, it closed. There is nothing to do around here, no shopping, no restaurants, nothing to do outside. They talked about being in restraints in an ambulance and hospital. They were unaware of why they were taken to the hospital nor any outbursts or behaviors that would have caused that to happen to them. They claimed they called KTTCP and had an administrator fired for embezzling money. They stated they raged on Facebook against family, for not helping them. R6 stated they are in constant pain, Oxy doesn't touch the pain, worried about getting hooked on drugs. R6 also mentioned had a hard time sleeping, severe insomnia. They stated they were an advocate and did community service in Lake City and Red Wing.During an interview on 7/29/25 at 8:48 a.m., certified nursing assistant (CNA)-A met R6 needs by doing everything they ask, clean them up, had items next to them. The behavioral health training provided by the facility is on Med Trainer, a computer program, no hands-on or teach back methods utilized. CNA-A was unable to give a specific time frame for education, they replied the education happened, pretty often. They stated R6 mood was fairly stable, if there were any behaviors they would mark yes in the electronic medical record (EMR). That was the only place and information documented, no interventions or what type of behaviors displayed.During an interview on 7/29/25 at 9:00 a.m., licensed practical nurse (LPN)-A stated a resident received mental and psychological counseling by calling provider, obtain an order, inform the nurse manager and the family of appointment. If a resident was a trauma survivor, it would be written in a report and communicated in shift report. The approach to a resident with PTSD would be different, if the environment is too loud, too bright, if the resident is stressed. The behavioral health training provided was on Med Trainer, a computer program.During an interview on 7/29/25 at 11:14 a.m., LPN-A manager stated the processes in place to provide individualized care for a resident was in the care plan. The types of communication were used to keep floor staff aware of cares, changes in condition, behavioral issues were in the nurse-to-nurse report, 24-hour book, and in EHR. The process for a resident to receive mental and psychological counseling was to have social worker put them on a list and will notify who they should see every morning. It is the expectation that doctors' orders are to be followed. It is the expectation that a resident would be seen if two orders are placed. The interdisciplinary team (IDT) meets every morning with nurses, director of nurses, administrator, social worker, physical therapy, occupational therapy and speech, address behaviors, discuss upcoming meetings, update treatment administration record (TAR) and put in progress notes.During an interview on 7/30/25 at 8:47 a.m., social service director (SSD)-A stated to obtain mental and psychological counseling services, review hospital charts, there is a 48 admit process, notify provider, obtain orders, get consent from resident, referrals to ACP Psychiatry. Discuss with the resident provide effective listening, have the resident feel safe

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. (continued on next page)

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F 0742 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 document review and interview, the facility failed to identify triggers to avoid potential re-traumatization and failed to develop the care plan to include individualized trauma-informed approaches for 1 of 1 resident (R6) who had a history of trauma. Findings include:R6's Comprehensive Minimum Data Set assessment (MDS) dated [DATE], indicated cognitively intact with depression. R6 had a diagnosis of major depressive disorder and PTSD (post-traumatic stress disorder) on admit on 4/22/25. R6 had a diagnosis of quadriplegia required full cares with bed mobility and transfers, unable to walk, and required total assistance with dressing and hygiene.R6's admission Psychosocial assessment dated [DATE] was not triggered for a care area assessment, therefore, not placed on care plan.R6's admission Trauma Informed Care history dated 4/23/25, identified the resident had a diagnosis of PTSD and R6 declined to talk about it. Further, R6 responded yes to having been through anything life threatening or traumatic but did not give any further details on traumatic event. However, assessment lacked further details regarding triggers to prevent re-traumatization.R6's physician visit note dated 4/25/25, identified R6 had major depressive disorder with anxiety, aggressor identification syndrome and PTSD.R6's physician orders on 4/28/25 and 6/3/25, identified orders for ACP Psychiatry consult to evaluate and treat. R6's vulnerability care plan dated 7/24/25, lacked individualized trauma-informed approaches or interventions and lacked identification of triggers to avoid potential re-traumatization.During an interview on 7/27/25 at 6:09 p.m., R6 stated someone, thinks it was social work employee, came in and talked, but I didn't want to talk at that time, I should see someone, I have been in a panic mode, they stated just trying to get everything all together.During an interview on 7/28/25 at 2:13 p.m., R6 was speaking rapidly, changing subjects quickly, I'm a little depressed, and concerned about keeping things in order, phone in mothers name right now. I wanted own line. Social worker was here about 1.5 weeks ago,to see a therapist, social services was going to do it but hasn't happened yet. I am in kind of panic mode. R6 rambled about Lake City, Milwaukee, packing up stuff and wanting to leave. They mentioned Bayview, it closed. There is nothing to do around here, no shopping, no restaurants, nothing to do outside. They talked about being in restraints in an ambulance and hospital. They were unaware of why they were taken to the hospital nor any outbursts or behaviors that would have caused that to happen to them. They claimed they called KTTCP and had an administrator fired for embezzling money. They stated they raged on Facebook against family, for not helping them. R6 stated they are in constant pain, Oxy doesn't touch the pain, worried about getting hooked on drugs. R6 also mentioned had a hard time sleeping, severe insomnia. They stated they were an advocate and did community service in Lake City and Red Wing.During an interview on 7/29/25 at 8:48 a.m., certified nursing assistant (CNA)-A met R6 needs by doing everything R6 asked, cleaned them up, had items next to them. The behavioral health training provided is on Med Trainer, a computer program, no hands-on or teach back methods utilized. CNA-A was unable to give a specific time frame for education, they replied the education happened, pretty often. They stated R6 mood was fairly stable, if there were any behaviors they would mark yes in the electronic medical record (EMR). That was the only place and information documented, no interventions or what type of behaviors were displayed.During an interview on 7/29/25 at 9:00 a.m., licensed practical nurse (LPN)-A stated a resident received mental and psychological counseling by calling provider, obtain an order, inform the nurse manager and the family of appointment. If a resident was a trauma survivor, it would be written in a report and communicated in shift report. The approach to a resident with PTSD would be different, if the environment is too loud, too bright, if the resident is stressed. The behavioral health training provided was on Med Trainer, a computer program, no additional education provided.During an interview on 7/29/25 at 11:14 a.m., LPN-A manager stated the processes in place to provide individualized care for a resident was in the care plan. The types of communication were used to keep floor staff aware of cares, changes in condition, behavioral issues were in the nurse-to-nurse report, 24-hour book, and in EHR. The process for a resident received mental and psychological counseling was to have the social worker put them on a list and notify ACP of whom they should see every morning. It is the expectation that doctors' orders are to be followed. It is the expectation that a resident would be seen if two orders are placed. The interdisciplinary team (IDT) meets every morning with nurses, director of nurses, administrator, social worker, physical therapy, occupational therapy and speech, they address behaviors, discuss upcoming meetings, update treatment administration record (TAR) and put in progress notes.During an interview on 7/30/25 at 8:47 a.m., social service director (SSD)-A stated

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	245295	A. Building B. Wing	07/30/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure proper cleaning of snack/nourishment refrigerators maintained with food items are dated and labeled to prevent the potential for foodborne illness for 3 of 3-unit refrigerators. Findings include: During observation on 7/27/25 at 12:50 p.m., the refrigerator for residents on the 4th floor had an open gallon jug of milk, expiration date 7/9/25 no label on the container stating when milk was opened. A clear Tupperware container wrapped in a Macy's bag without a label. A Menards's bag with food container inside, had a resident's name, no date on item. A drawer contained: one open unlabeled package of saltine crackers, open bag of carrots and a peach. In the door of refrigerator there was an opened unlabeled chocolate pudding, a yogurt no label, expiration date 6/25, a bag with no label, open containers of Pace hot sauce, ketchup, Jalapenos, strawberry jam, Core Power beverage, Top of the Tator dip, expiration date 5/25, all items unlabeled. The bottom of the refrigerator, under the drawers had a red, dried liquid substance on it. The freezer had a [NAME] jar with a grayish substance in it, labeled with date 4/31/25 no name. An unlabeled open container of glycerin swabs sticks. A frozen unlabeled loaf of bread used by date 5/29/25. An unlabeled frozen bag of long grain white rice expiration 5/24. A bag from Culver's with resident's name, no date on it. Lastly, a frozen [NAME] frozen deluxe pizza expiration date 3/22/25 no label on item. Observed nursing assistant (CNA)-D removed a plaid thermos from refrigerator and placed it on top of refrigerator. During observation on 7/27/25 at 1:41 p.m., the refrigerator for residents on the 3rd floor contained an open package of hot dogs with white, green and brown fuzzy coating on them, unlabeled, expiration 6/25. A white bag with food items in it, unlabeled. Lastly, a bottle of Bio salad dressing, expiration date 5/25. The freezer had a Styrofoam cup with frozen red substance, unlabeled. One cold compress, unlabeled. During observation on 7/27/25 at 2:02 p.m., the refrigerator for residents on the 2nd floor contained a TPN (Total Parenteral Nutrition) container unlabeled with an expiration date of 11/24. During observation on 7/28/25 at 8:35 a.m., the refrigerator on the 4th floor still had red, dried liquid substance on bottom of it, all remaining items are labeled and dated, no expired items, additionally, the plaid thermos was on top of refrigerator. During observation on 7/29/25 at 8:25 a.m., the refrigerator on the 4th floor still had red, dried liquid substance on the bottom of it, additionally, the plaid thermos remained on top of refrigerator. During observation on 7/30/25 at 10:28 a.m., fridge was cleaned, and plaid thermos was removed from top of 4th floor refrigerator. During interview on 7/27/25 at 1:11 p.m., certified nursing assistant (CNA)-B stated the housekeeping department was responsible for cleaning and the disposal of unlabeled and expired items. CNA-B verified items unlabeled and expired in the 4th floor refrigerator. During interview on 7/27/25 at 1:17 p.m., CNA-D stated the kitchen staff was responsible for cleaning and the disposal of unlabeled and expired items. CNA-D verified items unlabeled and expired. They removed items from the refrigerator and put into trash, however, did remove an unlabeled plaid thermos and placed it on top of refrigerator on the 4th floor. During interview on 7/27/25 at 1:53 p.m., CNA-C verified unlabeled and expired items in 3rd floor refrigerator. During interview on 7/27/25 at 2:11 p.m., registered nurse (RN)-A stated they were unsure of which department was responsible for cleaning and disposal of unlabeled or expired items. They verified the unlabeled and expired items in the 2nd floor refrigerator. They stated ice compresses were to be stored in the medication fridge, not in resident's refrigerator. During interview on 7/29/25 at 7:22 a.m., dietitian-A stated there is a policy for residents receiving food from outside of facility. During interview on 7/29/25 at 7:25 a.m., culinary director (CD)-A stated nurses and CNA's check dates on items and disposes of any unlabeled or expired items, the dietary staff check and document temperatures, and housekeeping is responsible for cleaning the inside and outside of resident refrigerators on each floor. During interview on 7/29/25 at 8:47 a.m., housekeeping-A stated refrigerators were cleaned every Wednesday on all floors, items not labeled, check with nurse manager before disposing of items. If a container is open for more than two days, it is to be disposed of. Also, no items are to be on top of refrigerators. During interview on 7/29/25 at 9:17 a.m., CNA-A stated kitchen staff or aides clean fridges on the floors. Items should have dates and name of resident. During interview on 7/29/25 at 9:25a.m., licensed practical nurse (LPN)-B stated mostly nurses and managers clean the fridges on the floors. Items need to be labeled with name and date. if an item is expired, inform resident that the item was disposed of. A facility policy titled Food Receiving and Storage implemented on 7/29/25, indicated the refrigerator and freezer cleanliness will be maintained by housekeeping services. The labeling, monitoring and assisting residents/family of incoming product labeling

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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 0880 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 observation, interview and record review the facility failed to ensure staff followed transmission-based precautions (TBP) for 1 of 2 residents (R7) reviewed for TBP. Furthermore, the facility failed to ensure hand hygiene was completed during medication administration for 3 of 11 residents (R15, R21, R78) observed for medication administration. Findings include:R7's Minimum Data Set (MDS) dated [DATE], indicated R7 had severely impaired cognition and diagnoses included chronic respiratory failure, quadriplegia (inability to move arms and legs) Furthermore, R7 had a tracheostomy (a surgical incision into the windpipe to assist with breathing) and hepatitis B (liver disease that was spread through infected blood and bodily fluids) and Carbapenem-Resistant Pseudomonas aeruginosa (CRPA, a multidrug resistant infection that is transmitted via contact). R7's provider orders dated 10/8/24, indicated R7 required enhanced barrier precautions (EBP) for colonized multidrug resistant organism (MRDO) while providing high contact cares every shift for CRPA. R7's electronic medical record banner special instructions no date, directed staff to follow EBP for CRPA and history of hepatitis B. R7's care plan revised 8/12/24, indicated R7 required EBP related to tracheostomy, history of hepatitis B, and wound care to left toe. Interventions included use of appropriate communication to follow RBP, explain reason for EBP use, and for staff to don/doff personal protective equipment when providing high contact care. An observation on 7/27/25 at 6:08 p.m., R7's door was open. On the door was an orange sign that read Contact Isolation. The sign directed all staff who enter the room to perform hand hygiene and don a gown and gloves. An observation on 7/28/25 at 1:19 p.m., R7 was laying in their bed with the door open. On the door was an orange sign that read Contact Isolation and directed all staff who enter to perform hand hygiene and don gown and gloves. Central supply staff- A performed hand hygiene and donned gloves and entered R7's room without donning a gown. Central supply staff-A brought a box of supplies into the room and exited with an empty box. With gloves in place, the empty box was broken down and placed on a cart. Central supply staff-A then removed gloves and performed hand hygiene before entering the next room. When interviewed on 7/28/25 at 1:23 p.m., Central supply staff-A stated gloves were worn when delivering supplies to resident rooms in case something was needing to be moved. Central supply staff-A stated a gown was needed if supplies were stored close to the resident or the resident belongings. Since R7's box was not near him or his personal items, a gown was not needed. Central supply staff-A verified R7's sign that read Contact Isolation and further stated she was told if going in and out and not touching resident or resident items, only gloves were needed. When interviewed on 7/29/25 at 2:04 p.m., nursing assistant (NA)-B verified the sign on R7's door and stated R7 was on contact isolation for an infection or bug they had and that was to protect staff from his infection. Furthermore, R7 required staff to don a gown and gloves when providing personal or hands on cares with the resident. NA-B stated it was fine to enter the room without a gown or gloves to turn off the light or open the blinds, but if the bed was going to be touched, then a gown and gloves must be worn. When interviewed on 7/29/25 at 2:15 p.m., registered nurse (RN)-C stated when residents were on EBP, staff can perform hand hygiene and enter the room. If staff were to provide any hands on cares, gloves and a gown was required. Contact isolation required gown and gloves each time staff entered the room. RN-C verified the discrepancy between R7's contact isolation sign on the door and the orders in R7's medical record indicating R7 was on EBP and stated staff should follow the contact isolation sign. RN-C believed the contact isolation was in place when R7 had been actively infected with something but had to clarify if R7 still required contact isolation. Follow up information was received and RN-C verified R7 required EBP for hepatitis C and CRPA. Medication administration:R15's significant change MDS dated [DATE], indicated was cognitively intact and diagnoses of chronic respiratory failure with tracheostomy, had trouble swallowing, and had a gastrostomy tube (G-tube, a tube placed in the stomach to help with nutrition/tube feeding). R15's providers orders lacked indication R15 required EBP. R15's electronic medical record banner special instructions no date, directed staff to follow standard precautions. R21's quarterly MDS dated [DATE], indicated R21 was cognitively intact and had diagnoses ofR78's significant change MDS dated [DATE], indicated R had mild cognitive impairment and diagnoses of A medication observation on 7/30/25 at 12:05 p.m., RN-E was preparing R15's medication before going to R15's room. R15 was lying in bed with the door open. A sign on the door read Enhanced Barrier Precautions and directed staff to don gown and gloves when providing contact cares such as transferring, ADLs and repositioning. RN-E performed hand hygiene, donned gloves and without donning a gown, entered R15's