STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245495	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emeralds at Grand Rapids LLC	**2801 SOUTH HIGHWAY 169 , GRAND RAPIDS, Minnesota, 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 6/14/26 to 6/17/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		07/02/2026
F0000	INITIAL COMMENTS On 6/14/26 to 6/17/26, a standard recertification survey (S5495041-0) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54952417C (2962885) H54952418C (2725401) H54958776C MN00114367 (1084858) H54952419C MN00113821 (1087358) NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations	F0000		07/02/2026

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 reverse for further 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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F0000	Continued from page 1 has been attained.	F0000		07/02/2026
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F0880	Immediate Corrective Action: Facility removed the linen cart from the communal hallway and moved the linen to a designated linen closet with door. Facility staff provided residents the opportunity to complete hand hygiene/sanitization prior to meals. Chart review completed on R2, R11, R13, R14, R4, R15, R16, R5, R6, R21, R22, R26, R29, R33, R36, R37, and R3 who were referenced to have diarrhea and no other residents besides R4 received a dx of Yersinia Enterocolitica. Corrective Action as it applies to others: Infection and Prevention Control Policy reviewed and remains current. Education was provided to nursing and housekeeping staff on infection prevention by keeping clean linen in proper storage areas to decrease the risk of contamination. Education was provided to dietary, TR, and nursing staff on infection prevention by way of washing or sanitizing resident hands prior to meals to remove bacteria and reduce risk of food contamination. Education was provided to licensed nurses, TMAs, and NARs on what kind of symptoms should be reported to the DON/IP for infection control and tracking purposes. Date of Compliance: 7/16/26 Recurrence will be prevented by: Audits of 5 residents' vital signs and bowel records will be reviewed for any trends, audits of linen closet doors remaining closed when not in use, and audits of washing/sanitizing of 5 resident's hands before meals will be completed weekly x4 weeks, then monthly x2 months to ensure a safe and sanitary environment and prevent the development and transmission of communicable diseases and	07/16/2026

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F0880 SS = F	Continued from page 2 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to keep linen carts covered that were in the communal hallways. The facility also failed to offer hand hygiene to the residents prior to meal service. Lastly the facility failed to identify and investigate a foodborne pathogen that was diagnosed in a resident. This had the potential to affect all residents in the facility. Findings include: Linen: During an observation on 6/14/26 at 2:05 p.m., the hallway clean linen cart on 300 hallway was not covered. During an observation on 6/15/26 at 9:47 a.m., the 300 hallway extra linen cart was again not covered. the green flap that should cover the cart was flipped all the way backwards and was covered with Kleenex and gloves so the flap could not be flipped forward to a closed and covered position. During an interview on 6/15/26 at 9:50 a.m., nursing assistant (NA)-A stated all carts that hold clean	F0880	Continued from page 2 infections. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON or Designee	07/16/2026

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F0880 SS = F	Continued from page 3 linens for resident use should be covered unless staff are actively at the cart removing items to use for resident care. NA-A looked at the 300-hallway cart and confirmed it had been left uncovered and no staff had been around it for several minutes. During an observation on 6/16/26 at 1:12 p.m., the 300-hallway linen cart was again uncovered. During an interview on 6/17/26 at 9:48 a.m., the director of nursing/infection preventionist (DON/IP) stated clean linen carts in the resident hallways should be covered at all times to assist decreasing contamination and possible spread of infection that might be in the facility. Hand Hygiene: During an observation on 6/14/26 at 4:59 p.m., in the main dining room, several staff were lined up outside the kitchen and take the meals plate by plate to the residents seated at tables. Residents were observed being assisted to put on clothing covers, but there were no hand cleaning wipes being offered. During an observation on 6/15/26 at 11:39 a.m., in the main dining room with several staff assisting residents to cover their clothing, bring their lunch plates, and assist some of the residents to eat their meals. Hand hygiene was not offered to any of the residents. During a continuous observation on 6/16/26 beginning at 7:13 a.m., in the main dining room it was noted there were no hand sanitizing wipes or solutions located in the work area by the entrance of the kitchen or on the dining tables where residents ate. R5 wheeled themselves into the dining room and to a table. A kitchen staff member cleared dishes from the table R5 had selected, wiped the table down, and took R5's order. Hand sanitization was not offered to R5. -At 7:25 a.m., a staff member delivered R5's food. R5 was not offered hand sanitization at that time. -At 7:28 a.m., a female resident wheeled self into dining room and to a table. Dining staff removed dirty dishes from the table and wiped the surface down. The female resident was not offered hand sanitization on arrival or when food was delivered. -At 7:32 a.m., staff wheeled in a female resident and parked resident at a table. R35 wheeled themselves	F0880		07/16/2026

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F0880 SS = F	Continued from page 4 in from the outside smoking area and parked themselves at a table. The female resident and R35's breakfast was delivered at 7:36 a.m. Neither resident was offered hand sanitization prior to eating breakfast. -At 7:49 a.m., a male staff wheeled a male resident in a Broda chair up to a table in the back of the dining room. Two other residents who had wheeled themselves into the dining area were moved to a table by the resident in the Broda chair. The male staff then washed their hands at the sink in the dining area and placed clothing protectors on the 3 residents. No hand sanitization was provided to the three residents before they ate their breakfast. R4: R4's significant change Minimum Data Set (MDS) dated 4/8/26, indicated R4 was cognitively intact. R4's Admission Record (also known as face sheet) dated 6/17/26, identified a diagnosis of Enteritis due to Yersinia Enterocolitica with onset date 6/2/26. Additional diagnoses included: neuromuscular dysfunction of bladder, enterocolitis due to clostridium difficile, congestive heart failure, stage IV pressure ulcer, osteomyelitis, and paraplegia. R4's care plan identified the review start date as 4/8/26. The care plan identified R4 was on contact precautions, had a foley catheter, an ostomy, and stage IV sacral pressure ulcer. R4's Grand Itasca emergency department note dated 6/1/26, identified R4's Enteric panel had tested positive for Yersinia enterocolitica. R4 had copious amounts of output from rectal stump with proctitis and sigmoid colitis that appeared infectious/inflammatory on CT imaging. The identified plan was to administer seven days of Bactrim. R4's Grand Itaska discharge documentation dated 6/2/26, indicated R4 had been hospitalized from 5/30/26 to 6/2/26, with the primary diagnosis of Colitis due to Yersinia enterocolitica. Follow-up appointments were scheduled for an ultrasound and surgeon visit. Additional recommendations included primary care follow-up at the facility and to ensure R4 had an infectious disease appointment. The CDC website Yersinia Infection Clinical Overview of Yersiniosis dated March 3, 2026, indicated yersinia enterocolitica was the most common form of yersiniosis with an incubation period of 4 to 6 days	F0880		07/16/2026

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F0880 SS = F	Continued from page 5 which could range from 1 to 14 days. Common clinical presentation included abdominal pain, diarrhea (can be bloody and persistent for several weeks), pain that mimics appendicitis, and sore throat. The Minnesota Department of Health Yersiniosis (Yersinia enterocolitica) fact sheet dated June 2007, indicated Yersinia enterocolitica was found in wild and domestic animals. Especially pigs, but it could also be found in birds, reptiles, rodents, rabbits, sheep, cattle, horses and dogs. Human infections usually resulted from: eating contaminated food, especially raw or under cooked pork products, contact with farm animals or pets, consuming unpasteurized milk or contaminated water, touching contaminated surfaces and then touching mouth, or eating food prepared by someone infected with yersinia who did not sanitize hands properly. The facility symptom tracking log provided by the facility IP included R4 and four other residents who did not have gastrointestinal symptoms. R4's documented symptoms included lethargy, malaise, increased BMs, and fever with an onset date of 5/29/26. R4 had stool sampled and received Sulfamethoxazole/trimethoprim for 7 days. The June log did not include any other residents with gastrointestinal symptoms or a positive Yersinia result for R4. The Bowel Movement report dated 5/15/26 to 5/30/26, included documentation of BM date, time, and consistency for all residents at the facility. The BM consistency of resident BM's was predominately documented as "not required" which made it difficult to ascertain accurate resident diarrhea rates. Other consistency descriptions included: formed/normal, putty like and loose/diarrhea-report to nurse ASAP! (as soon as possible). Report documentation identified the following residents as having had two or more loose/diarrhea stools during the report time period: R2, R11, R13, R14, R4, R15, R16, R5, R6, R21, R22, R26, R29, R33, R36, R37, and R3. During an observation on 6/14/26 at 5:10 p.m., R4's door had a contact isolation sign on the door. On 6/15/26 at 3:32 p.m., contact isolation signage remained on R4's door. On 6/16/26 at 1:24 p.m., contact isolation signage remained on R4's door. On 6/17/26 at 10:00 a.m., contact isolation signage	F0880		07/16/2026

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F0880 SS = F	Continued from page 6 remained on R4's door. During an interview on 6/15/26 at 2:41 p.m., the Minnesota Department of Health Infection Control Assessment and Response (ICAR) Program nurse specialist (PNS) stated Yersinia enterocolitica should be looked at as a foodborne illness. Illness often resulted from undercooked meat, or cross contamination during preparation of raw meat in the kitchen. Raw meat would be the most likely source, especially raw or improperly handled pork. However, there are other sources from outside of the facility that could have caused the yersinia. PNS stated they would expect the facilities infection prevention to work their review process when a resident was identified with a known foodborne illness. During an interview on 6/15/26 at 3:32 p.m., R4 stated they had been in the hospital so many times for different infections, that they couldn't recall what they had been told about what infection, they thought their significant other would know more. R4 stated "they all just ran together." Contact was attempted, but R4's significant other was not available for interview on 6/16/26. On 6/16/26, and 6/17/26, R4's nurse manager was not available for interview. On 6/17/26 at 9:38 a.m., the director of nursing DON and infection preventionist stated the facility performed real time symptom tracking on staff and residents. In addition, the antibiotic stewardship program also tracked symptoms, diagnostic testing and treatments. Resident symptoms such as diarrhea should be reported to the nurse, and then to IP so systems and status changes can be tracked and reviewed. The goal is to identify and detect outbreaks or illnesses like c-diff early. The DON showed symptom mapping done in May and June, each symptom was color coded. Diarrhea fell into the category described as other. Two residents were coded as other. Any resident who has experienced two or more episodes of diarrhea, should be reported to IP along with associated symptoms. The May staff log showed one non-direct care staff member had experienced diarrhea and probable norovirus (based on confirmed norovirus in their household). The facility had performed contract tracing in response to the staff illness. Resident paperwork should be reviewed by the receiving nurse when a resident is admitted or has returned to the facility after an appointment, ER visit, or hospitalization. Any infection prevention/control concerns like assessment findings, new antibiotics, lab results, or diagnoses, should then be reported to	F0880		07/16/2026

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F0880 SS = F	Continued from page 7 the IP for further review and tracking. R4's yersinia diagnosis should have been reported to IP when R4 returned from the hospital. Had the yersinia been identified and reported, a comprehensive review would have been completed. The dietary area would have been reviewed to see if there were any opportunities for education, BM logs would have been reviewed for possible correlations. Any needed follow-up would have been reviewed and acted upon. During an interview on 6/17/26 at 11:11 a.m., the culinary director stated most facility foods, especially the proteins and meats were raw. Raw foods went directly into the freezer and did not get pulled out until 3 days prior to them being served to allow them to thaw the correct way. When raw meat is being prepared to cook, the meat is placed in a lipped container. Only the raw meat can be on the prep table when it is being prepared. A review of the facility menu cycles on 6/17/26, showed that the facility regularly served pork products. The facility Handwashing Policy dated 2/2024, instructed to prevent the spread of infection hand washing should occur before, during and after preparing food, before eating, and after caring for someone who is sick, after using the toilet, after changing incontinent products, after touching animal or animal waste, after handling pet food or treats and after handling garbage. The facility Infection Prevention and Control Program dated 11/2024, identified the program mission was to maintain an infection prevention and control program to ensure a safe, sanitary, environment and to help prevent the development and transmission of communicable diseases and infections. The program addressed residents and staff IP and control. Key components identified included: surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection and employee health. Coordination and oversight included committee review to ensure information about culture results or antibiotic resistance was transmitted accurately and in a timely fashion and whether there was appropriate follow-up of acute infections. Culture reports, sensitivity data, and antibiotic usage reviews were to be included in surveillance activities. Prevention of infection activities included identifying possible infections or potential complications of existing infections and instituting measures to avoid complications or spreading. Monitoring Employee health included	F0880		07/16/2026

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F0880 SS = F	Continued from page 8 policies and procedures that included reporting infections including, but not limited to draining wounds, respiratory infection/symptoms, and frequent loose stools. The Prevention of infection section identified the IP program included identifying possible infections, instituting measures to avoid complications, and enhancing screening for possible significant pathogens. Resident and staff symptom tracking policies were requested but not received. Resident symptom tracking for May and June were requested in addition to the antibiotic stewardship logs but not received.	F0880		07/16/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints	F0605	Immediate Corrective Action: Hospice provider discontinued R34's prn olanzapine order on 6/16/26. Corrective Action as it applies to others: Audit was completed on all current residents who have prn psychotropics to ensure they have a stop date and have been seen by a provider to establish appropriateness prior to prn extension. Date of Compliance: 7/16/26 Recurrence will be prevented by: Audits of prn psychotropics for 5 residents will be completed weekly x4 weeks, then monthly x2 months. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON or Designee	07/16/2026

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F0605 SS = D	Continued from page 9 imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs	F0605		07/16/2026

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F0605 SS = D	Continued from page 10 receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to have a new order and a face-to-face provider visit every 14 days performed prior to renewing an as needed antipsychotic medication. This affected 1 of 5 (R34) residents reviewed for unnecessary medications. Findings include: R34's significant change Minimum Data Set dated 4/13/26, indicated R34 had significant cognitive impairment. Diagnoses included dementia with agitation and anxiety disorder. R34's care plan dated 3/2/26, indicated an alteration in behavior due to severe dementia with agitation, major depressive disorder, and anxiety disorder. Interventions included administer medications as ordered, monitoring for potential side effects. R34's care plan dated 4/3/26, also indicated on hospice cares related to Alzheimer's dementia with interventions that included medications as needed. R34's Order Summary Report dated 5/5/26 through 6/17/26, indicated an order for Olanzapine (antipsychotic medication) 2.5 milligrams (mg) by mouth every 6 hours (hr) as needed (PRN) for 14 days. This order had been reordered every 14 days through the listed time frame. R34's electronic medical record (EMR) dated 5/5/26, indicated	F0605		07/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245495	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/17/2026

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F0605 SS = D	Continued from page 11 hospice wrote the last order for Olanzapine 2.5mg by mouth every 6 hr PRN for 90 days. R34's EMR lacked documentation related to new orders for Olanzapine PRN written every 14 days as entered into the Order Summary Report since 5/5/26. R34's EMR also lacked documentation the provider did a face-to-face visit with the resident and justified the continued need for the antipsychotic prior to a new order being entered.During an interview on 6/15/26 at 11:25 a.m., registered nurse (RN)-B stated when a resident is on hospice and has behavior concerns, the hospice organization will order prn antipsychotics for the facility to utilize to assist in keeping the client non-behavioral and comfortable. RN-B was not sure how long the prn antipsychotic orders were good for or who made sure all of the required information is gathered prior to a new order is received. During an interview on 6/15/26 at 3:44 p.m., RN-C-cares stated hospice took care of writing and monitoring the prn medications for comfort such as pain medications and antipsychotics like Olanzapine. When hospice would write the orders for prn antipsychotics, the orders would usually be written for at least 90 days so the provider did not have to write the orders so often. The provider would only come on site and do actual face to face visits every 90 days for recertification visits. The provider never comes to the facility just for a medication renewal. The medication renewals were based on what the hospice staff reported to the provider. RN-C reviewed R34's EMR and confirmed hospice was responsible for renewing the Olanzapine 2.5mg every 6 hrs as needed order and the last written order was on 5/5/26. During an interview on 6/15/26 at 4:19 p.m., the director of nursing (DON) stated PRN antipsychotic orders were only good for 14 days, then there had to be a request made for a new order. The DON stated she was not sure of what else was required prior to getting a new order for PRN antipsychotics. There was an expectation the staff followed the policies related to medications and medication orders. Facility policy Psychotropic Medication Use dated 5/25, indicated prn orders for antipsychotics would be limited to 14 days, and not be renewed unless the provider evaluated the resident for appropriateness of the medication. The policy lacked information explaining if the evaluated needed to occur face to face or not.	F0605		07/16/2026

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F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the use of thromboembolism-deterrent stockings (TEDs) as ordered for edema care. This affected 1 of 1 (R45) resident reviewed for edema. Findings include: R45's 5-day Minimum Data Set (MDS) dated 6/2/26, indicated R45 was moderately cognitively impaired. Diagnoses included left lower leg closed fracture, hypertension, and arthritis. R45's provider orders dated 6/10/26, included TEDs stockings right leg on in a.m., off in p.m. every morning and at bedtime. R45's care plan reviewed 6/15/26, did not include right pedal edema or the prescribed intervention of TEDs. R45's treatment administration record (TAR) dated 6/2026, included TEDs stockings to right leg on in a.m., off in p.m. every morning and at bedtime, start date 6/10/26. During an observation on 6/14/26 at 3:31 p.m., R45 was sitting in bed with legs elevated, right foot noted to be edematous with no TEDs stocking. R45 stated they were concerned about their swollen right foot, and their provider told them to keep it elevated. During an observation on 6/15/26 at 12:57 p.m., R45 was in their wheelchair with feet elevated on bed, non-slip sock on right foot, no TEDs stocking. During an observation on 6/16/26 at 10:46 a.m., R45 was in their wheelchair in the dining room. R45 stated their right leg felt tight and lifted their pant leg to rub on right shin and calf. Right leg noted to	F0684	Immediate Corrective Action: R45's TED sock was applied to RLE. Corrective Action as it applies to others: Medication and treatment policy reviewed with licensed nurses and TMAs. Education was provided to licensed nurses, TMAs, and NARs regarding the need to follow MD orders for appropriate wear of TED socks. Date of Compliance: 7/16/26 Recurrence will be prevented by: Audits of appropriate wear of TED socks for 5 residents will be completed weekly x4 weeks, then monthly x2 months. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON or Designee	07/16/2026

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F0684 SS = D	Continued from page 13 be edematous into calf, with a sock and shoe on the right foot, no TEDs stocking. R45 stated they were going to physical therapy. During an interview on 6/15/26 at 2:08 p.m., nursing assistant (NA)-B stated when TEDs are ordered, day shift puts them on the resident and evening shift removes them at bedtime. NA-B stated R45 had an ACE wrap on the left foot and stated they were not aware R45 was to wear TEDs on the right leg. During an interview on 6/15/26 at 2:09 p.m., licensed practical nurse (LPN)-A stated the aides put TEDs stockings on residents when ordered. LPN-A stated R45 was new to them. After reviewing R45's orders, LPN-A confirmed R45 had an order for TEDs to the right leg, and stated the TEDs were important for treating R45's edema. During an interview on 6/16/26 at 12:31 p.m., director of nursing (DON) confirmed R45 had orders for TEDs to the right leg. DON reviewed TAR documentation and stated the nursing staff charted the TEDs application and removal for the last few days. During an interview on 6/16/26 at 1:33 p.m., other staff (O)-C stated R45 came to their therapy appointment around 11 a.m., with a sock and shoe on the right foot, and O-C applied TEDs to R45's right leg during the therapy appointment. O-C stated R45 had right foot and lower leg edema. Medication and Treatment Orders policy dated 2/2024, instructed orders for medications and treatments will be transcribed accurately and in a timely manner.	F0684		07/16/2026
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide monitoring to a dialysis site following a dialysis treatment for 1 of 1 resident (R9) reviewed for dialysis care.	F0698	Immediate Corrective Action: R9's dialysis site was observed for bleeding, and fistula was checked for bruit and thrill. Corrective Action as it applies to others: Hemodialysis policy was reviewed and remains current. Education was provided to licensed nurses on hemodialysis policy, monitoring dialysis site in a timely manner following dialysis run, and assessment of bruit and thrill of dialysis fistula.	07/16/2026

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F0698 SS = D	Continued from page 14 Findings include: R9's quarterly minimum data set (MDS) dated 6/10/26, identified intact cognition and diagnoses of end-stage renal failure, and anemia in chronic kidney disease. The MDS also reflected R9 had dialysis treatments while a resident. R9's provider orders dated 8/27/25, identified to offer rest and a snack after dialysis, to take and record vital signs after dialysis, to monitor fistula (a surgically created connection between an artery and a vein to provide access for dialysis treatment) for bruit (a whooshing sound heard with a stethoscope) and thrill (a powerful pulse felt at the top of the fistula) every shift and to notify provider if these were not found, and to monitor dialysis site every shift for bleeding and to call 911 if bleeding was noted. R9's care plan dated 9/25/24, identified a focus statement for alteration in blood formation and coagulation related to use of anticoagulant medication and included interventions to give anticoagulant medication as ordered, to monitor and notify provider of bleeding. On 6/18/25, a focus statement for risk for complications related to dialysis and included interventions to call 911 for uncontrolled bleeding at fistula, dialysis on Mondays, Wednesdays, and Fridays, to provide treatment and dressings to dialysis site per provider order, send communication folder to dialysis with each run, and fluid restrictions per provider order. During observations and interview on 6/15/26 at 4:04 p.m., R9 was sitting in her wheelchair at the counter in the activity area eating. R9 stated she had just returned from dialysis and the nurse had not seen her yet, normally they take her blood sugar and blood pressure. At 4:07 p.m., R9 was at the nurse's station and registered nurse (RN)-A was checking her vital signs, R9 was observed to be wearing a long-sleeve sweatshirt and RN-A asked her if the left arm was ok for blood pressures and R9 said "yes". RN-A remarked her blood pressure was a little high and was recording the value on a clipboard. R9 headed to her room, then came back down the hall at 4:15 p.m. with some coloring materials and went outside to the smoking area. At 4:21 p.m. RN-A stated the first thing they should do was to check vitals, check the thing in their arm, and give them their meal. RN-A confirmed she had not looked at R9's fistula yet. During an interview on 6/17/26 at 8:25 a.m., dialysis	F0698	Continued from page 14 Date of Compliance: 7/16/26 Recurrence will be prevented by: Audits of dialysis site monitoring and bruit and thrill assessment for 3 residents following dialysis will be completed weekly x4 weeks, then monthly x2 months. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON or Designee	07/16/2026

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F0698 SS = D	Continued from page 15 clinical manager (CM)-A stated it was important they were checking her fistula site once a shift, but it should be visualized and monitored right after she returns from the dialysis run because the resident would be at risk for bleeding or complications. During an interview on 6/17/26 at 10:36 a.m., the director of nursing (DON) stated her expectation was after a dialysis run, making sure to check the site any excessive bleeding, doing the vitals and any follow up with the communication they send back and forth. A policy, Hemodialysis dated 11/22/19, identified the facility will ensure that residents who require dialysis, receive such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Ongoing assessment and evaluation of the resident's condition and monitoring for complications should occur before and after dialysis treatments (i.e. infection and patency of fistula or graft).	F0698		07/16/2026
F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides.	F0732	Immediate Corrective Action: The weekend staffing sheets were reviewed, revised if needed, and posted by the charge nurse each weekend day. Corrective Action as it applies to others: Nursing staff were educated on reviewing, revising, and posting the daily staffing sheets every weekend day. Date of Compliance: 7/16/26 Recurrence will be prevented by: Audits will be completed weekly x4 weeks, then monthly x2 months to ensure daily staffing sheets are posted accurately each weekend day. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by:	07/16/2026

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F0732 SS = C	Continued from page 16 (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure daily staffing data was posted over the weekend. This deficient practice had the potential to affect any resident, family member, or visitor who wished to view the posting. Findings include: During an observation on 6/14/26 (Sunday) at 1:30 p.m., the facility staffing data sheet was posted in the main entrance. The documented read Day of week: Friday, Today's Date: 6/12/26. During an observation on 6/14/26 at 6:57 p.m., it was noted the 6/12/26 posted staffing data sheet had been taken down and replaced with a staffing data sheet for Sunday, 6/14/26. During an interview on 6/17/26 at 12:36 p.m., The administrator stated staffing sheets should be posted each morning and indicated it was the night staff's responsibility to review, make changes if needed, and then post. The administrator confirmed	F0732	Continued from page 16 Administrator or Designee	07/16/2026

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F0732 SS = C	Continued from page 17 Saturday and Sunday staffing sheets had not been posted in the morning as expected.	F0732		07/16/2026

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 2, 2026

Administrator
The Emeralds at Grand Rapids LLC
2801 SOUTH HIGHWAY 169
GRAND RAPIDS, MN 55744

RE: CCN:245495
Cycle Start Date: June 17, 2026

Dear Administrator:

On June 17, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department

of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 17, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 17, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will

not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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E0000	Initial Comments On 6/14/26 to 6/17/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		07/02/2026
F0000	INITIAL COMMENTS On 6/14/26 to 6/17/26, a standard recertification survey (S5495041-0) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54952417C (2962885) H54952418C (2725401) H54958776C MN00114367 (1084858) H54952419C MN00113821 (1087358) NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations	F0000		07/02/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245495	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emeralds at Grand Rapids LLC	**2801 SOUTH HIGHWAY 169 , GRAND RAPIDS, Minnesota, 55744**

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F0000	Continued from page 1 has been attained.	F0000		07/02/2026
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F0880	Immediate Corrective Action: Facility removed the linen cart from the communal hallway and moved the linen to a designated linen closet with door. Facility staff provided residents the opportunity to complete hand hygiene/sanitization prior to meals. Chart review completed on R2, R11, R13, R14, R4, R15, R16, R5, R6, R21, R22, R26, R29, R33, R36, R37, and R3 who were referenced to have diarrhea and no other residents besides R4 received a dx of Yersinia Enterocolitica. Corrective Action as it applies to others: Infection and Prevention Control Policy reviewed and remains current. Education was provided to nursing and housekeeping staff on infection prevention by keeping clean linen in proper storage areas to decrease the risk of contamination. Education was provided to dietary, TR, and nursing staff on infection prevention by way of washing or sanitizing resident hands prior to meals to remove bacteria and reduce risk of food contamination. Education was provided to licensed nurses, TMAs, and NARs on what kind of symptoms should be reported to the DON/IP for infection control and tracking purposes. Date of Compliance: 7/16/26 Recurrence will be prevented by: Audits of 5 residents' vital signs and bowel records will be reviewed for any trends, audits of linen closet doors remaining closed when not in use, and audits of washing/sanitizing of 5 resident's hands before meals will be completed weekly x4 weeks, then monthly x2 months to ensure a safe and sanitary environment and prevent the development and transmission of communicable diseases and	07/16/2026

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F0880 SS = F	Continued from page 2 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to keep linen carts covered that were in the communal hallways. The facility also failed to offer hand hygiene to the residents prior to meal service. Lastly the facility failed to identify and investigate a foodborne pathogen that was diagnosed in a resident. This had the potential to affect all residents in the facility. Findings include: Linen: During an observation on 6/14/26 at 2:05 p.m., the hallway clean linen cart on 300 hallway was not covered. During an observation on 6/15/26 at 9:47 a.m., the 300 hallway extra linen cart was again not covered. the green flap that should cover the cart was flipped all the way backwards and was covered with Kleenex and gloves so the flap could not be flipped forward to a closed and covered position. During an interview on 6/15/26 at 9:50 a.m., nursing assistant (NA)-A stated all carts that hold clean	F0880	Continued from page 2 infections. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON or Designee	07/16/2026

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F0880 SS = F	Continued from page 3 linens for resident use should be covered unless staff are actively at the cart removing items to use for resident care. NA-A looked at the 300-hallway cart and confirmed it had been left uncovered and no staff had been around it for several minutes. During an observation on 6/16/26 at 1:12 p.m., the 300-hallway linen cart was again uncovered. During an interview on 6/17/26 at 9:48 a.m., the director of nursing/infection preventionist (DON/IP) stated clean linen carts in the resident hallways should be covered at all times to assist decreasing contamination and possible spread of infection that might be in the facility. Hand Hygiene: During an observation on 6/14/26 at 4:59 p.m., in the main dining room, several staff were lined up outside the kitchen and take the meals plate by plate to the residents seated at tables. Residents were observed being assisted to put on clothing covers, but there were no hand cleaning wipes being offered. During an observation on 6/15/26 at 11:39 a.m., in the main dining room with several staff assisting residents to cover their clothing, bring their lunch plates, and assist some of the residents to eat their meals. Hand hygiene was not offered to any of the residents. During a continuous observation on 6/16/26 beginning at 7:13 a.m., in the main dining room it was noted there were no hand sanitizing wipes or solutions located in the work area by the entrance of the kitchen or on the dining tables where residents ate. R5 wheeled themselves into the dining room and to a table. A kitchen staff member cleared dishes from the table R5 had selected, wiped the table down, and took R5's order. Hand sanitization was not offered to R5. -At 7:25 a.m., a staff member delivered R5's food. R5 was not offered hand sanitization at that time. -At 7:28 a.m., a female resident wheeled self into dining room and to a table. Dining staff removed dirty dishes from the table and wiped the surface down. The female resident was not offered hand sanitization on arrival or when food was delivered. -At 7:32 a.m., staff wheeled in a female resident and parked resident at a table. R35 wheeled themselves	F0880		07/16/2026

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F0880 SS = F	Continued from page 4 in from the outside smoking area and parked themselves at a table. The female resident and R35's breakfast was delivered at 7:36 a.m. Neither resident was offered hand sanitization prior to eating breakfast. -At 7:49 a.m., a male staff wheeled a male resident in a Broda chair up to a table in the back of the dining room. Two other residents who had wheeled themselves into the dining area were moved to a table by the resident in the Broda chair. The male staff then washed their hands at the sink in the dining area and placed clothing protectors on the 3 residents. No hand sanitization was provided to the three residents before they ate their breakfast. R4: R4's significant change Minimum Data Set (MDS) dated 4/8/26, indicated R4 was cognitively intact. R4's Admission Record (also known as face sheet) dated 6/17/26, identified a diagnosis of Enteritis due to Yersinia Enterocolitica with onset date 6/2/26. Additional diagnoses included: neuromuscular dysfunction of bladder, enterocolitis due to clostridium difficile, congestive heart failure, stage IV pressure ulcer, osteomyelitis, and paraplegia. R4's care plan identified the review start date as 4/8/26. The care plan identified R4 was on contact precautions, had a foley catheter, an ostomy, and stage IV sacral pressure ulcer. R4's Grand Itasca emergency department note dated 6/1/26, identified R4's Enteric panel had tested positive for Yersinia enterocolitica. R4 had copious amounts of output from rectal stump with proctitis and sigmoid colitis that appeared infectious/inflammatory on CT imaging. The identified plan was to administer seven days of Bactrim. R4's Grand Itaska discharge documentation dated 6/2/26, indicated R4 had been hospitalized from 5/30/26 to 6/2/26, with the primary diagnosis of Colitis due to Yersinia enterocolitica. Follow-up appointments were scheduled for an ultrasound and surgeon visit. Additional recommendations included primary care follow-up at the facility and to ensure R4 had an infectious disease appointment. The CDC website Yersinia Infection Clinical Overview of Yersiniosis dated March 3, 2026, indicated yersinia enterocolitica was the most common form of yersiniosis with an incubation period of 4 to 6 days	F0880		07/16/2026

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F0880 SS = F	Continued from page 5 which could range from 1 to 14 days. Common clinical presentation included abdominal pain, diarrhea (can be bloody and persistent for several weeks), pain that mimics appendicitis, and sore throat. The Minnesota Department of Health Yersiniosis (Yersinia enterocolitica) fact sheet dated June 2007, indicated Yersinia enterocolitica was found in wild and domestic animals. Especially pigs, but it could also be found in birds, reptiles, rodents, rabbits, sheep, cattle, horses and dogs. Human infections usually resulted from: eating contaminated food, especially raw or under cooked pork products, contact with farm animals or pets, consuming unpasteurized milk or contaminated water, touching contaminated surfaces and then touching mouth, or eating food prepared by someone infected with yersinia who did not sanitize hands properly. The facility symptom tracking log provided by the facility IP included R4 and four other residents who did not have gastrointestinal symptoms. R4's documented symptoms included lethargy, malaise, increased BMs, and fever with an onset date of 5/29/26. R4 had stool sampled and received Sulfamethoxazole/trimethoprim for 7 days. The June log did not include any other residents with gastrointestinal symptoms or a positive Yersinia result for R4. The Bowel Movement report dated 5/15/26 to 5/30/26, included documentation of BM date, time, and consistency for all residents at the facility. The BM consistency of resident BM's was predominately documented as "not required" which made it difficult to ascertain accurate resident diarrhea rates. Other consistency descriptions included: formed/normal, putty like and loose/diarrhea-report to nurse ASAP! (as soon as possible). Report documentation identified the following residents as having had two or more loose/diarrhea stools during the report time period: R2, R11, R13, R14, R4, R15, R16, R5, R6, R21, R22, R26, R29, R33, R36, R37, and R3. During an observation on 6/14/26 at 5:10 p.m., R4's door had a contact isolation sign on the door. On 6/15/26 at 3:32 p.m., contact isolation signage remained on R4's door. On 6/16/26 at 1:24 p.m., contact isolation signage remained on R4's door. On 6/17/26 at 10:00 a.m., contact isolation signage	F0880		07/16/2026

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F0880 SS = F	Continued from page 6 remained on R4's door. During an interview on 6/15/26 at 2:41 p.m., the Minnesota Department of Health Infection Control Assessment and Response (ICAR) Program nurse specialist (PNS) stated Yersinia enterocolitica should be looked at as a foodborne illness. Illness often resulted from undercooked meat, or cross contamination during preparation of raw meat in the kitchen. Raw meat would be the most likely source, especially raw or improperly handled pork. However, there are other sources from outside of the facility that could have caused the yersinia. PNS stated they would expect the facilities infection prevention to work their review process when a resident was identified with a known foodborne illness. During an interview on 6/15/26 at 3:32 p.m., R4 stated they had been in the hospital so many times for different infections, that they couldn't recall what they had been told about what infection, they thought their significant other would know more. R4 stated "they all just ran together." Contact was attempted, but R4's significant other was not available for interview on 6/16/26. On 6/16/26, and 6/17/26, R4's nurse manager was not available for interview. On 6/17/26 at 9:38 a.m., the director of nursing DON and infection preventionist stated the facility performed real time symptom tracking on staff and residents. In addition, the antibiotic stewardship program also tracked symptoms, diagnostic testing and treatments. Resident symptoms such as diarrhea should be reported to the nurse, and then to IP so systems and status changes can be tracked and reviewed. The goal is to identify and detect outbreaks or illnesses like c-diff early. The DON showed symptom mapping done in May and June, each symptom was color coded. Diarrhea fell into the category described as other. Two residents were coded as other. Any resident who has experienced two or more episodes of diarrhea, should be reported to IP along with associated symptoms. The May staff log showed one non-direct care staff member had experienced diarrhea and probable norovirus (based on confirmed norovirus in their household). The facility had performed contract tracing in response to the staff illness. Resident paperwork should be reviewed by the receiving nurse when a resident is admitted or has returned to the facility after an appointment, ER visit, or hospitalization. Any infection prevention/control concerns like assessment findings, new antibiotics, lab results, or diagnoses, should then be reported to	F0880		07/16/2026

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F0880 SS = F	Continued from page 7 the IP for further review and tracking. R4's yersinia diagnosis should have been reported to IP when R4 returned from the hospital. Had the yersinia been identified and reported, a comprehensive review would have been completed. The dietary area would have been reviewed to see if there were any opportunities for education, BM logs would have been reviewed for possible correlations. Any needed follow-up would have been reviewed and acted upon. During an interview on 6/17/26 at 11:11 a.m., the culinary director stated most facility foods, especially the proteins and meats were raw. Raw foods went directly into the freezer and did not get pulled out until 3 days prior to them being served to allow them to thaw the correct way. When raw meat is being prepared to cook, the meat is placed in a lipped container. Only the raw meat can be on the prep table when it is being prepared. A review of the facility menu cycles on 6/17/26, showed that the facility regularly served pork products. The facility Handwashing Policy dated 2/2024, instructed to prevent the spread of infection hand washing should occur before, during and after preparing food, before eating, and after caring for someone who is sick, after using the toilet, after changing incontinent products, after touching animal or animal waste, after handling pet food or treats and after handling garbage. The facility Infection Prevention and Control Program dated 11/2024, identified the program mission was to maintain an infection prevention and control program to ensure a safe, sanitary, environment and to help prevent the development and transmission of communicable diseases and infections. The program addressed residents and staff IP and control. Key components identified included: surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection and employee health. Coordination and oversight included committee review to ensure information about culture results or antibiotic resistance was transmitted accurately and in a timely fashion and whether there was appropriate follow-up of acute infections. Culture reports, sensitivity data, and antibiotic usage reviews were to be included in surveillance activities. Prevention of infection activities included identifying possible infections or potential complications of existing infections and instituting measures to avoid complications or spreading. Monitoring Employee health included	F0880		07/16/2026

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F0880 SS = F	Continued from page 8 policies and procedures that included reporting infections including, but not limited to draining wounds, respiratory infection/symptoms, and frequent loose stools. The Prevention of infection section identified the IP program included identifying possible infections, instituting measures to avoid complications, and enhancing screening for possible significant pathogens. Resident and staff symptom tracking policies were requested but not received. Resident symptom tracking for May and June were requested in addition to the antibiotic stewardship logs but not received.	F0880		07/16/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints	F0605	Immediate Corrective Action: Hospice provider discontinued R34's prn olanzapine order on 6/16/26. Corrective Action as it applies to others: Audit was completed on all current residents who have prn psychotropics to ensure they have a stop date and have been seen by a provider to establish appropriateness prior to prn extension. Date of Compliance: 7/16/26 Recurrence will be prevented by: Audits of prn psychotropics for 5 residents will be completed weekly x4 weeks, then monthly x2 months. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON or Designee	07/16/2026

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F0605 SS = D	Continued from page 9 imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs	F0605		07/16/2026

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F0605 SS = D	Continued from page 10 receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to have a new order and a face-to-face provider visit every 14 days performed prior to renewing an as needed antipsychotic medication. This affected 1 of 5 (R34) residents reviewed for unnecessary medications. Findings include: R34's significant change Minimum Data Set dated 4/13/26, indicated R34 had significant cognitive impairment. Diagnoses included dementia with agitation and anxiety disorder. R34's care plan dated 3/2/26, indicated an alteration in behavior due to severe dementia with agitation, major depressive disorder, and anxiety disorder. Interventions included administer medications as ordered, monitoring for potential side effects. R34's care plan dated 4/3/26, also indicated on hospice cares related to Alzheimer's dementia with interventions that included medications as needed. R34's Order Summary Report dated 5/5/26 through 6/17/26, indicated an order for Olanzapine (antipsychotic medication) 2.5 milligrams (mg) by mouth every 6 hours (hr) as needed (PRN) for 14 days. This order had been reordered every 14 days through the listed time frame. R34's electronic medical record (EMR) dated 5/5/26, indicated	F0605		07/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245495	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0605 SS = D	Continued from page 11 hospice wrote the last order for Olanzapine 2.5mg by mouth every 6 hr PRN for 90 days. R34's EMR lacked documentation related to new orders for Olanzapine PRN written every 14 days as entered into the Order Summary Report since 5/5/26. R34's EMR also lacked documentation the provider did a face-to-face visit with the resident and justified the continued need for the antipsychotic prior to a new order being entered.During an interview on 6/15/26 at 11:25 a.m., registered nurse (RN)-B stated when a resident is on hospice and has behavior concerns, the hospice organization will order prn antipsychotics for the facility to utilize to assist in keeping the client non-behavioral and comfortable. RN-B was not sure how long the prn antipsychotic orders were good for or who made sure all of the required information is gathered prior to a new order is received. During an interview on 6/15/26 at 3:44 p.m., RN-C-cares stated hospice took care of writing and monitoring the prn medications for comfort such as pain medications and antipsychotics like Olanzapine. When hospice would write the orders for prn antipsychotics, the orders would usually be written for at least 90 days so the provider did not have to write the orders so often. The provider would only come on site and do actual face to face visits every 90 days for recertification visits. The provider never comes to the facility just for a medication renewal. The medication renewals were based on what the hospice staff reported to the provider. RN-C reviewed R34's EMR and confirmed hospice was responsible for renewing the Olanzapine 2.5mg every 6 hrs as needed order and the last written order was on 5/5/26. During an interview on 6/15/26 at 4:19 p.m., the director of nursing (DON) stated PRN antipsychotic orders were only good for 14 days, then there had to be a request made for a new order. The DON stated she was not sure of what else was required prior to getting a new order for PRN antipsychotics. There was an expectation the staff followed the policies related to medications and medication orders. Facility policy Psychotropic Medication Use dated 5/25, indicated prn orders for antipsychotics would be limited to 14 days, and not be renewed unless the provider evaluated the resident for appropriateness of the medication. The policy lacked information explaining if the evaluated needed to occur face to face or not.	F0605		07/16/2026

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F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the use of thromboembolism-deterrent stockings (TEDs) as ordered for edema care. This affected 1 of 1 (R45) resident reviewed for edema. Findings include: R45's 5-day Minimum Data Set (MDS) dated 6/2/26, indicated R45 was moderately cognitively impaired. Diagnoses included left lower leg closed fracture, hypertension, and arthritis. R45's provider orders dated 6/10/26, included TEDs stockings right leg on in a.m., off in p.m. every morning and at bedtime. R45's care plan reviewed 6/15/26, did not include right pedal edema or the prescribed intervention of TEDs. R45's treatment administration record (TAR) dated 6/2026, included TEDs stockings to right leg on in a.m., off in p.m. every morning and at bedtime, start date 6/10/26. During an observation on 6/14/26 at 3:31 p.m., R45 was sitting in bed with legs elevated, right foot noted to be edematous with no TEDs stocking. R45 stated they were concerned about their swollen right foot, and their provider told them to keep it elevated. During an observation on 6/15/26 at 12:57 p.m., R45 was in their wheelchair with feet elevated on bed, non-slip sock on right foot, no TEDs stocking. During an observation on 6/16/26 at 10:46 a.m., R45 was in their wheelchair in the dining room. R45 stated their right leg felt tight and lifted their pant leg to rub on right shin and calf. Right leg noted to	F0684	Immediate Corrective Action: R45's TED sock was applied to RLE. Corrective Action as it applies to others: Medication and treatment policy reviewed with licensed nurses and TMAs. Education was provided to licensed nurses, TMAs, and NARs regarding the need to follow MD orders for appropriate wear of TED socks. Date of Compliance: 7/16/26 Recurrence will be prevented by: Audits of appropriate wear of TED socks for 5 residents will be completed weekly x4 weeks, then monthly x2 months. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON or Designee	07/16/2026

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F0684 SS = D	Continued from page 13 be edematous into calf, with a sock and shoe on the right foot, no TEDs stocking. R45 stated they were going to physical therapy. During an interview on 6/15/26 at 2:08 p.m., nursing assistant (NA)-B stated when TEDs are ordered, day shift puts them on the resident and evening shift removes them at bedtime. NA-B stated R45 had an ACE wrap on the left foot and stated they were not aware R45 was to wear TEDs on the right leg. During an interview on 6/15/26 at 2:09 p.m., licensed practical nurse (LPN)-A stated the aides put TEDs stockings on residents when ordered. LPN-A stated R45 was new to them. After reviewing R45's orders, LPN-A confirmed R45 had an order for TEDs to the right leg, and stated the TEDs were important for treating R45's edema. During an interview on 6/16/26 at 12:31 p.m., director of nursing (DON) confirmed R45 had orders for TEDs to the right leg. DON reviewed TAR documentation and stated the nursing staff charted the TEDs application and removal for the last few days. During an interview on 6/16/26 at 1:33 p.m., other staff (O)-C stated R45 came to their therapy appointment around 11 a.m., with a sock and shoe on the right foot, and O-C applied TEDs to R45's right leg during the therapy appointment. O-C stated R45 had right foot and lower leg edema. Medication and Treatment Orders policy dated 2/2024, instructed orders for medications and treatments will be transcribed accurately and in a timely manner.	F0684		07/16/2026
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide monitoring to a dialysis site following a dialysis treatment for 1 of 1 resident (R9) reviewed for dialysis care.	F0698	Immediate Corrective Action: R9's dialysis site was observed for bleeding, and fistula was checked for bruit and thrill. Corrective Action as it applies to others: Hemodialysis policy was reviewed and remains current. Education was provided to licensed nurses on hemodialysis policy, monitoring dialysis site in a timely manner following dialysis run, and assessment of bruit and thrill of dialysis fistula.	07/16/2026

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F0698 SS = D	Continued from page 14 Findings include: R9's quarterly minimum data set (MDS) dated 6/10/26, identified intact cognition and diagnoses of end-stage renal failure, and anemia in chronic kidney disease. The MDS also reflected R9 had dialysis treatments while a resident. R9's provider orders dated 8/27/25, identified to offer rest and a snack after dialysis, to take and record vital signs after dialysis, to monitor fistula (a surgically created connection between an artery and a vein to provide access for dialysis treatment) for bruit (a whooshing sound heard with a stethoscope) and thrill (a powerful pulse felt at the top of the fistula) every shift and to notify provider if these were not found, and to monitor dialysis site every shift for bleeding and to call 911 if bleeding was noted. R9's care plan dated 9/25/24, identified a focus statement for alteration in blood formation and coagulation related to use of anticoagulant medication and included interventions to give anticoagulant medication as ordered, to monitor and notify provider of bleeding. On 6/18/25, a focus statement for risk for complications related to dialysis and included interventions to call 911 for uncontrolled bleeding at fistula, dialysis on Mondays, Wednesdays, and Fridays, to provide treatment and dressings to dialysis site per provider order, send communication folder to dialysis with each run, and fluid restrictions per provider order. During observations and interview on 6/15/26 at 4:04 p.m., R9 was sitting in her wheelchair at the counter in the activity area eating. R9 stated she had just returned from dialysis and the nurse had not seen her yet, normally they take her blood sugar and blood pressure. At 4:07 p.m., R9 was at the nurse's station and registered nurse (RN)-A was checking her vital signs, R9 was observed to be wearing a long-sleeve sweatshirt and RN-A asked her if the left arm was ok for blood pressures and R9 said "yes". RN-A remarked her blood pressure was a little high and was recording the value on a clipboard. R9 headed to her room, then came back down the hall at 4:15 p.m. with some coloring materials and went outside to the smoking area. At 4:21 p.m. RN-A stated the first thing they should do was to check vitals, check the thing in their arm, and give them their meal. RN-A confirmed she had not looked at R9's fistula yet. During an interview on 6/17/26 at 8:25 a.m., dialysis	F0698	Continued from page 14 Date of Compliance: 7/16/26 Recurrence will be prevented by: Audits of dialysis site monitoring and bruit and thrill assessment for 3 residents following dialysis will be completed weekly x4 weeks, then monthly x2 months. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON or Designee	07/16/2026

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F0698 SS = D	Continued from page 15 clinical manager (CM)-A stated it was important they were checking her fistula site once a shift, but it should be visualized and monitored right after she returns from the dialysis run because the resident would be at risk for bleeding or complications. During an interview on 6/17/26 at 10:36 a.m., the director of nursing (DON) stated her expectation was after a dialysis run, making sure to check the site any excessive bleeding, doing the vitals and any follow up with the communication they send back and forth. A policy, Hemodialysis dated 11/22/19, identified the facility will ensure that residents who require dialysis, receive such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Ongoing assessment and evaluation of the resident's condition and monitoring for complications should occur before and after dialysis treatments (i.e. infection and patency of fistula or graft).	F0698		07/16/2026
F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides.	F0732	Immediate Corrective Action: The weekend staffing sheets were reviewed, revised if needed, and posted by the charge nurse each weekend day. Corrective Action as it applies to others: Nursing staff were educated on reviewing, revising, and posting the daily staffing sheets every weekend day. Date of Compliance: 7/16/26 Recurrence will be prevented by: Audits will be completed weekly x4 weeks, then monthly x2 months to ensure daily staffing sheets are posted accurately each weekend day. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by:	07/16/2026

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F0732 SS = C	Continued from page 16 (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure daily staffing data was posted over the weekend. This deficient practice had the potential to affect any resident, family member, or visitor who wished to view the posting. Findings include: During an observation on 6/14/26 (Sunday) at 1:30 p.m., the facility staffing data sheet was posted in the main entrance. The documented read Day of week: Friday, Today's Date: 6/12/26. During an observation on 6/14/26 at 6:57 p.m., it was noted the 6/12/26 posted staffing data sheet had been taken down and replaced with a staffing data sheet for Sunday, 6/14/26. During an interview on 6/17/26 at 12:36 p.m., The administrator stated staffing sheets should be posted each morning and indicated it was the night staff's responsibility to review, make changes if needed, and then post. The administrator confirmed	F0732	Continued from page 16 Administrator or Designee	07/16/2026

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F0732 SS = C	Continued from page 17 Saturday and Sunday staffing sheets had not been posted in the morning as expected.	F0732		07/16/2026

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	245495	A. BUILDING **01 - MAIN BUILD...** B. WING	**06/16/2026**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/16/2026. At the time of this survey, The Emeralds At Grand Rapids LLC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		07/02/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245495	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/16/2026**

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. The Emeralds At Grand Rapids is a 1-story building with a partial basement and was constructed at 4 different times. The original building was constructed in 1963, is 1 story with a partial basement, and was determined to be of Type II(111) construction. In 1968 a one story addition, without a basement, was constructed south and west of the original building, and was determined to be of Type II (111) construction. In 1980 a one story addition was constructed to the north of the original building, was determined to be a type V (111) construction, and is separated with a 2-hour fire barrier. This building is no longer used by residents and is staff only. In 2001 two other one story additions were built, one north of the west wing (a chapel) and one south of the west wing (special cares unit) which were determined to be Type II (111) construction and separated with 2-hour fire barriers. The building is divided into 8 smoke compartments by 30-minute and 2-hour fire barriers. The facility is fully sprinkler protected and has a fire alarm system with smoke detection in the corridor	K0000		07/02/2026

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K0000 Bldg. 01	Continued from page 2 system and in all sleeping rooms that is monitored for automatic fire department notification. The facility has a capacity of 95 beds and had a census of 80 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		07/02/2026
K0541 SS = F Bldg. 01	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to secure the laundry chute door per NFPA 101 (2012 edition), Life Safety Code section 19.5.4.1. These deficient findings could have a widespread impact on the residents within the facility. On 06/16/2026 at 1218pm, it was revealed by observation that the laundry chute did not have a self closing door located on lower level. This device is required to close laundry chute in the event of a fire at bottom of chute.	K0541	Immediate Corrective Action: Self closing door on laundry chute was installed on lower level, ensuring that door self closes completely to ensure proper fire safety. Corrective Action as it applies to others: All other laundry chutes were inspected to ensure that there is a properly functioning self closing door to ensure proper fire safety. Date of Compliance: 7/30/2026 Recurrence will be prevented by: Regional Maintenance director or Administrator in Training will audit all laundry chute doors in the facility once weekly for four weeks to ensure doors latch and close. Corrections will be monitored by: Administrator or designee	07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245495	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/16/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emeralds at Grand Rapids LLC	**2801 SOUTH HIGHWAY 169 , GRAND RAPIDS, Minnesota, 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0541 SS = F Bldg. 01	Continued from page 3 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0541		07/30/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.17. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/16/2026, at 3:54pm, it was revealed by observation that the Emergency Generator Alarm	K0918	Immediate Corrective Action: The emergency generator remote annunciator panel was moved to a staffed nursing station. Corrective Action as it applies to others: After emergency generator remote annunciator panel was installed, Administrator in Training and Regional Maintenance director confirmed that panel was operational. Date of Compliance: 8/23/2026 Recurrence will be prevented by: The emergency generator remote annunciator panel will remain located at a staffed nursing station. This will be audited once weekly for four weeks to ensure that emergency generator remote annunciator panel is at a staffed Nursing Station. Corrections will be monitored by: Administrator or designee	08/23/2026

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K0918 SS = F Bldg. 01	Continued from page 4 Annunciator Panel was not located location readily observed by operating personnel at a regular work station. The panel is currently located in the main dining room where the former nurses station was located. This area is not staffed 24 hours as required by code. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0918		08/23/2026
K0920 SS = E Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/16/2026, the following times, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following	K0920	Immediate Corrective Action: Additional outlets were installed in kitchen office to ensure that Portable Air Conditioner, Microwave, and Fridge are being plugged directly into outlet and not into Power Strip or Extension Cord. Corrective Action as it applies to others: All administrative offices were audited for improper usage of extension cords and power strips. Any improper usage was corrected immediately. Date of Compliance: 7/30/2026 Recurrence will be prevented by: Administrative offices will be audited for compliance in relation to extension cord and power strip usage once weekly for 4 weeks. Corrections will be monitored by: Administrator or designee	07/30/2026

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K0920 SS = E Bldg. 01	Continued from page 5 areas; 1) at 2:47pm, Power-strip in Kitchen Office with air conditioner plugged in. 2) at 3:24pm, Power-strip in cabinet with refrigerator and microwave plugged in. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0920		07/30/2026
K0223 SS = D Bldg. 01	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure that the doors to high hazard room would close and latch with power of self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 06/16/2026, at 3:34pm, it was revealed by observation that the door at the soiled utility room by room 319 did not close and latch when tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0223	Immediate Corrective Action: Room 319's door and latch were adjusted to ensure that door closes completely. Corrective Action as it applies to others: All resident room doors were inspected to verify they close completely. Date of Compliance: 7/30/2026 Recurrence will be prevented by: Four Resident doors will be audited weekly for 4 weeks. Corrections will be monitored by: Administrator or designee	07/30/2026

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K0353 SS = D Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Section 8.6.5.3.2. These deficient findings could an isolated impact on the residents within the facility. Findings include: On 06/16/2026, at 3:21pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in infection control room. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353	Immediate Corrective Action: Infection Control room was rearranged to ensure no objects were within 18 inches of sprinkler heads. Corrective Action as it applies to others: All storage rooms with sprinkler heads were audited to ensure that objects were not within 18 inches of sprinkler heads Date of Compliance: 7/30/2026 Recurrence will be prevented by: Storage room will be audited once weekly to ensure compliance. Corrections will be monitored by: Administrator or designee	07/30/2026