



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 16, 2026

Administrator
GRAND VILLAGE
923 HALE LAKE POINTE
GRAND RAPIDS, MN 55744

RE: CCN:245368
Cycle Start Date: July 7, 2026

Dear Administrator:

On July 7, 2026, a survey was completed at your facility by the Minnesota Departments 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:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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 October 7, 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 January 7, 2027 (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,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245368		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/07/2026	
NAME OF PROVIDER OR SUPPLIER GRAND VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE , 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 7/6/26-7/7/26, 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			
F0000	INITIAL COMMENTS On 7/6/26-7/7/26, a federal recertification survey (S5368039-0) was conducted using the Risk-Based Survey (RBS) process at your facility. Your facility was in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The facility is enrolled in ePOC, 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, the facility must acknowledge receipt of the electronic documents.			F0000			

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 4, 2026

Administrator
GRAND VILLAGE
923 HALE LAKE POINTE
GRAND RAPIDS, MN 55744

RE: CCN: 245368
Cycle Start Date: September 3, 2026

Dear Administrator:

On September 3, 2026, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245368		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SUB ACUTE B. WING		(X3) DATE SURVEY COMPLETED 07/07/2026	
NAME OF PROVIDER OR SUPPLIER GRAND VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE , GRAND RAPIDS, Minnesota, 55744			
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K0000 Bldg. 02	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/07/2026. At the time of this survey, Grand Village 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			08/24/2026

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: 245368		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SUB ACUTE B. WING		(X3) DATE SURVEY COMPLETED 07/07/2026	
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K0000 Bldg. 02	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. Grand Village was built in 5 different stages. The original building was built in the early 1900's of which only a small 1-story portion remains. It is Type II (222) construction and is separated from all other additions by at least 2-hour fire rated barriers. In 1972 a 1-story addition, without a basement, was constructed to the south of the existing building and was determined to be Type II (000) construction. In 1992, two 1-story additions, without basements, were constructed. One to the south of the 1972 building's west wing and one to the west of the 1972 building. Both additions were determined to be Type II (000) construction. The upper levels of the 1900's building were no longer used for healthcare. The 1992 west addition is separated from the rest of the building with 2-hour fire barriers. In 2000 the laundry/kitchen addition was constructed in between the original building and the 1992 west addition. It is 1-story, without a basement and is Type II (111) construction. In 2004 the Sub-acute building was constructed to the north of the original building with the majority of the 1900's original building raised. It is 1-story, without a basement, was determined to be Type V (111) construction and is separated by 2-hour fire rated barriers. In 2011 a connecting link between the 1992 additions was created. The building is divided into 12 smoke zones with 1/2 hour and 1 hour fire			K0000			08/24/2026

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K0000 Bldg. 02	Continued from page 2 rated barriers.			K0000			08/24/2026
K0353 SS = F Bldg. 02	The facility has a capacity of 119 beds and had a census of 99 at the time of the survey.			K0353			08/24/2026
	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:						
	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101				A report of the fourth quarter sprinkler system test was obtained and filed in the testing binder.		
	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.				Items stored above the 18 inch clearance area under sprinkler heads in the Nurses Supply Office Storage Room and the Moose Wing Medical Storage Room were removed and stored appropriately.		
	a) Date sprinkler system last checked _____				All storage rooms were audited to ensure proper storage.		
	b) Who provided system test _____				All staff were educated to not store items within the 18 inch clearance area below sprinkler heads at any time.		
	c) Water system supply source _____				Audits will be conducted by the Environmental Services Director or designee of facility storage rooms to ensure the 18 inch clearance rule is filed. These audits will be conducted weekly for 4 weeks and monthly for 2 months.		
	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 the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, 4.6.12 and 9.7.5. NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2 and 5.2.1.2. These deficient findings could have a widespread impact on the residents within the facility.				Results of these audits will be reviewed at monthly QAPI meetings and plan will be adjusted if needed.		
	Findings include: 1) On 07/07/2026, at 11:15am, it was revealed by a review of available documentation the facility failed to perform the fourth quarter sprinkler system						

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K0353 SS = F Bldg. 02	Continued from page 3 testing. 2) On 07/07/2026, at 1:00pm, in the Nurses Supply Office Storage Room 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. 3) On 07/07/2026, at 1:57pm, in the Moose Wing Medical Storage Room 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. An interview with Maintenance Director verified these deficient findings at the time of discovery.			K0353			08/24/2026
K0521 SS = F Bldg. 02	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/07/202, at 12:22pm, it was revealed by a review of available documentation that the facility could not provide a fire damper inspection report. An interview with Maintenance Director verified this deficient finding at the time of discovery.			K0521	A fire damper inspection was scheduled, completed and documentation placed in the inspection binder. Administrator or designee will audit annually that the fire damper inspection is complete. This audit will be reviewed at the appropriate QAPI meeting.		08/24/2026
K0918 SS = F Bldg. 02	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System			K0918	The annual generator inspection was scheduled, completed and documentation placed in the inspection binder.		08/24/2026

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K0918 SS = F Bldg. 02	Continued from page 4 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 install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.3.8,8.4.1, 8.4.2.1, 8.4.2.3,8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/07/2026, at 12:35pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing that an annual generator inspection was not performed by a generator technician. An interview with Maintenance Director verified this deficient finding at the time of discovery.			K0918	Continued from page 4 Administrator or designee will audit the completion of the generator inspection annually. Results of this audit will be reviewed at the appropriate monthly QAPI meeting.		08/24/2026

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K0291 SS = E Bldg. 02	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on observation the facility failed to maintain emergency lighting system per NFPA 101 (2012 edition), Life Safety Code sections 19.2.9.1 and 7.9.3.1.1. This deficient practice could have a patterned impact on the residents within the facility. Findings include: On 07/07/2026 at 12:10pm, based on review of available documentation it was revealed that the facility failed to conduct the annual 90 minute required Emergency Lighting test. An interview with Maintenance Director verified this deficient finding at the time of discovery.			K0291	The annual 90 minute Emergency Lighting test was conducted and documented. Audits of these lighting tests will be conducted yearly by the Administrator or designee. Results of this audit will be reviewed during QAPI.		08/24/2026
K0321 SS = E Bldg. 02	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms			K0321	The doors to the TV room that has been converted to a storage room and Mechanical room on Moose Wing were repaired so that the door closes and latches. An audit was conducted by the Environmental Service Director or designee of all fire doors in the building to ensure that they close and latch. Results of this audit will be reviewed at QAPI.		08/24/2026

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K0321 SS = E Bldg. 02	Continued from page 6 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) 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 07/07/2026, At the following times, it was revealed by observation that the following doors did not close and latch when tested in the following areas: 1) At 1:38pm, the TV Room that has been converted to a storage rooms door did not close and latch. 2) At 1:50pm, the Mechanical room door on the Moose Wing did not close and latch An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0321			08/24/2026
K0281 SS = D Bldg. 02	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention.			K0281	Electrician scheduled and proper lighting, ensuring two light sources, was installed at the Birch and Norway exits respectively. An audit was conducted by the Environmental Services Director or designee of all exits on the building to ensure proper lighting is present that meets regulation. Additional fixtures were added if needed.		08/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245368		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SUB ACUTE B. WING		(X3) DATE SURVEY COMPLETED 07/07/2026	
NAME OF PROVIDER OR SUPPLIER GRAND VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE , GRAND RAPIDS, Minnesota, 55744			
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K0281 SS = D Bldg. 02	Continued from page 7 18.2.8, 19.2.8 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview the facility failed to provide the level of lighting as required by the Life Safety Code, (NFPA 101) 2012 edition section 7.8.1.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/07/2026, at the following times, it was revealed by observation that the exterior lights in the following locations of the exit discharges had only one bulb for illumination and/or lighting fixture. Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2.2 lux) in any designated area. 1) At 12:59pm, Exit on the Burch Wing does not have second bulb and/or second lighting source. 2) At 1:11pm, Exit on the Norway Wing does not have a lighting source. An interview with Maintenance Director verified these deficient findings at the time of discovery.			K0281	Continued from page 7 Results of this audit to be reviewed at monthly QAPI.		08/24/2026
K0355 SS = D Bldg. 02	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/07/2026, at 12:10pm, it was revealed by documentation review that the fire extinguishers			K0355	The annual fire extinguisher inspection was scheduled, completed and documentation placed in the inspection binder. Annual audits of the annual fire extinguisher inspection documentation will be completed by the Administrator or designee. Results of this audit will be reviewed at the appropriate QAPI meeting.		08/24/2026

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K0355 SS = D Bldg. 02	Continued from page 8 annual inspection documentation could not be provided.			K0355			08/24/2026
K0363 SS = D Bldg. 02	An interview with Maintenance Director verified this deficient finding at the time of discovery. Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on			K0363	The door for resident room 216 was fixed and now latches. All resident room doors were audited by the Environmental Services Director or designee to ensure that they properly latch and any repairs necessary were made. The results of this audit were reviewed at the monthly QAPI meeting		08/24/2026

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K0363 SS = D Bldg. 02	Continued from page 9 the residents within the facility. Findings include: On 07/07/2026, at 12:57pm, it was revealed by observation that the resident room door 216 does not latch. An interview with Maintenance Director verified this deficient finding at the time of discovery.			K0363			08/24/2026
K0511 SS = D Bldg. 02	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and failed to maintain the Utility System per NFPA 101 (2012 edition), Life Safety Code section 9.1.2 and NFPA 70 (2011 edition), National Electric Code, section 408.20. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/07/2026, at 12:48pm, it was revealed by observation that the electrical panel located in the main corridor was not locked. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.			K0511	The electrical panel in the main corridor was locked. An audit was completed by the Environmental Services Director or designee of all electrical panels in the building to ensure that they were locked. Audits of electrical panels in the building will be completed by the Environmental Services Director or designee to ensure that they are locked weekly for 4 weeks and then monthly for 2 months. Results of these audits will be reviewed at the monthly QAPI meeting.		08/24/2026
K0761 SS = D Bldg. 02	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.			K0761	The proper 13 point inspection was obtained. Environmental Services Director or designee completed the 13 point inspection on all necessary doors. Administrator or designee will audit the completion		08/24/2026

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K0761 SS = D Bldg. 02	Continued from page 10 Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1 and 5.2.4.2. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1) On 07/07/2026, at 12:39pm, it was revealed by review of available documentation the required annual door inspection documentation the facility failed to provide a document showing all 13 points of the required door inspection was completed. 2) On 07/07/2026, at 1:22pm, It was revealed by observation that the fire doors and/or fire door frames were missing door rating tags. on the double doors leading to the Lake River patient care wing. An interview with Maintenance Director verified these deficient findings at the time of discovery.			K0761	Continued from page 10 of the door inspections annually. Results of this audit will be reviewed at the appropriate QAPI meeting.		08/24/2026