DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9PI6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00299

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245495**
2.STATE VENDOR OR MEDICAID NO.
(L2) **606318700**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE EMERALDS AT GRAND RAPIDS LLC**
(L4) **2801 SOUTH HIGHWAY 169**
(L5) **GRAND RAPIDS, MN** (L6) **55744**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2019**

6. DATE OF SURVEY **01/14/2022** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **93** (L18)
13.Total Certified Beds **93** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel ___ 6. Scope of Services Limit
___ 3. 24 Hour RN ___ 7. Medical Director
___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size
___ 5. Life Safety Code ___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	93			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Christine Bodick-Nord HFE - NE II 01/03/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/27/2022 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
08/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/07/2022
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 10, 2022

CMS Certification Number (CCN): 245495

Administrator
The Emeralds At Grand Rapids Llc
2801 South Highway 169
Grand Rapids, MN 55744

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 4, 2022 the above facility is certified for:

93 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 93 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 10, 2022

Administrator
The Emeralds At Grand Rapids Llc
2801 South Highway 169
Grand Rapids, MN 55744

RE: CCN: 245495
Cycle Start Date: December 9, 2021

Dear Administrator:

On January 13, 2022, we notified you a remedy was imposed. On January 14, 2022 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 4, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 9, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 21, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 9, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 4, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 9PI6

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(L4) **2801 SOUTH HIGHWAY 169**
(L5) **GRAND RAPIDS, MN** (L6) **55744**

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3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2019**

6. DATE OF SURVEY **12/09/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
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FISCAL YEAR ENDING DATE: (L35)
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And/Or Approved Waivers Of The Following Requirements:
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___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

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18 SNF	18/19 SNF	19 SNF	ICF	IID
	93			
(L37)	(L38)	(L39)	(L42)	(L43)

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17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE - NE II 01/03/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/27/2022 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

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(L27)

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A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
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03-Risk of Involuntary Termination
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INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
December 21, 2021

Administrator
The Emeralds At Grand Rapids Llc
2801 South Highway 169
Grand Rapids, MN 55744

RE: CCN: 245495
Cycle Start Date: December 9, 2021

Dear Administrator:

On December 9, 2021, 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 March 9, 2022 (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 June 9, 2022 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 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
E 000	Initial Comments On 12/6/21, through 12/9/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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.	E 000		
F 000	INITIAL COMMENTS On 12/6/21, through 12/9/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT IN compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5495127C (MN74740), with a deficiencies cited at F677 and F725; H5495128C (MN74739), with a deficiency cited at F677 and F725; H5495119C (MN71211) with a related deficiency cited at 677; H5495121C (MN74738) with a related deficiency cited at F677; and H5495122C (MN71639) with a related citation at F677. The following complaints were found to be SUBSTANTIATED:	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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F 000	Continued From page 1 H5495118C (MN70947), however NO deficiencies were cited due to actions implemented by the facility prior to survey: AND The following complaints were found to be UNSUBSTANTIATED: H5495120C (MN78539); H5495123C(MN71901); H5495124C (MN73313); H5495125C (MN73811); H5495126C (MN74649); H5495129C (MN78309); and H5495130C (MN78545). 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 has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		12/31/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 12/09/2021

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F 550	Continued From page 2 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and document review, the facility failed to ensure elopement risks and wander guard assessments were updated to promote dignity for 1 of 1 residents	F 550	Immediate Corrective Action: Elopement assessment completed for R49 to determine if wander guard is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 3 (R49) reviewed for elopement risk and wander guard use. Findings include: R49's electronic medical record (EMR), indicated R49 had diagnoses that included legal blindness and alcohol-induced persisting dementia. R49's elopement risk evaluation dated 3/14/19, indicated R49 was not at risk for elopement and scored 0 to 14 per direction of the document. An elopement risk assessment dated 11/5/20, indicated R49 was at risk for elopement, however, the form had no determination (score) if the resident was high or low risk for elopement. The document indicated "...Resident had a past elopement from facility. He continues to be at an increased risk for an elopement related to past history. He currently has a wander guard in place. Resident has not had any other elopements however will continue with current plan of care for resident safety. Will continue to reassess as needed..." An elopement risk assessment dated 5/03/21, indicated R49 scored high risk for elopement with a unit of measurement of 15 or higher. R49's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 11/5/21, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R49 was cognitively intact and exhibited no behaviors, such as wandering and/or elopement. R49 was noted to be responsible for himself and made his own decisions. R49's Care Plan dated 11/16/21, directed staff to attach a wander guard to the resident's	F 550	necessary. Care plan updated to reflect the assessment. Resident updated on current elopement assessment results. Corrective Action as it applies to others: The Quality of Life-Dignity Policy was reviewed and remains current. All current residents with wander guards will have an elopement assessment completed to assess the need for continued use. All licensed nurses responsible for ongoing resident assessment of a Wander Guard will receive education on the need to reassess the Wander guard use quarterly and prn. Recurrence will be prevented by: Audits of all residents with wander guards will be reviewed to ensure elopement assessment was completed and continued Wander guard use was re-evaluated weekly x4 weeks then monthly for 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Director of Nursing/ Nurse Managers/Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 12/09/2021

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THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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wheelchair. The care plan indicated "...Resident will not leave the facility without someone accompanying me..."

During an observation on 12/7/21, at 1:05 p.m. R49 exited the facility to the outside smoking area and the wander guard alarm sounded. At 1:08 p.m. R49 was observed to return into the facility after the completion of smoking his cigarette. The wander guard alarm system rang during this observation and no staff were observed to address the sound of the wander guard.

During an interview on 12/7/21, at 6:07 p.m. R49 stated he did not remember anyone speaking to him about wearing a wander guard.

During an interview on 12/7/21, at 5:38 p.m. licensed practical nurse (LPN)-C stated she had worked at the facility for the past year and stated R49 only left the facility to go out to smoke.

During an interview on 12/7/21, at 6:15 p.m. nursing assistant (NA)-D stated she had never seen R49 attempt to leave the facility.

During an interview on 12/8/21, at 7:15 p.m., LPN-B stated she had worked at the facility on the night shift for the past month. LPN-B stated she had never seen R49 elope and stated the resident remained in his room during the night shift.

During an interview on 12/8/21 at 9:08 a.m., the interim Director of Nursing (DON) stated the last time R49 eloped from the facility was in 2016. The interim DON stated she was unaware that R49 had no current attempts of elopement and stated the facility was addressing this issue.

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F 550	Continued From page 5 During an interview on 12/8/21 at 9:14 a.m., R49 stated he was aware the wander guard alarm would go off when he left the facility to go outside to smoke. R49 stated he was not aware the wander guard was concealed on his wheelchair. R49 stated he was very upset about the wander guard and stated he was not treated in a dignified manner. R49 stated there was an incident in the past and he did not realize he needed to sign out, but that incident happened a few years ago. During an interview on 12/8/21 at 9:37 a.m., the interim DON confirmed the facility did not have a consent for the use of a wander guard for R49. During an interview on 12/8/21 at 9:49 a.m., LPN-A (Care Coordinator for the facility) stated she reviews the care plans and confirmed R49 had no elopements since 2016. LPN-A stated dignity was the resident's right to make decisions about their care. During an interview on 12/9/21 at 12:35 p.m., the interim DON stated she was unaware the wander guard was hidden in R49's wheelchair. Review of a policy provided by the facility titled "Quality of Life-Dignity," dated August 2009, indicated "...Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality...Residents shall be assisted in attending the activities of their choice, including activities outside the facility..."	F 550		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		12/31/21

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F 657	Continued From page 6 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and document review, the facility failed to ensure a resident's Care Plan was revised for one of 32 residents (R49) which accurately reflected the resident's elopement history and use of a wander guard (a mobile device attached to the resident or wheelchair to alert staff if the resident exited the building without adequate supervision). The facility also failed to ensure R9's representative was invited to care plan meetings and failed to ensure quarterly care meetings were conducted	F 657	Immediate Corrective Action: R9□s family was contacted to attend a care conference. Care conference form and notes completed at time of care conference. R49s care plan was reviewed and revised to reflect current needs. Corrective Action as it applies to others:	

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F 657	Continued From page 7 after each annual and quarterly assessment for R9. Findings include: R49's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 11/5/21, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R49 was cognitively intact and exhibited no behaviors, such as wandering and/or elopement. R49's Care Plan dated 11/16/21, indicated R49 was at risk for elopement related to a diagnosis of dementia and a wander guard was placed on his wheelchair. During an observation on 12/7/21 at 1:05 p.m., R49 exited the main dining room to the outside designated smoking area. The wander guard alarm system rang. At 1:08 p.m., R49 re-entered the main dining room from the outside. No staff came to check on the status of this resident during this observation. During an interview on 12/7/21 at 6:15 p.m., nursing assistant (NA)-D entered R49's room and confirmed the resident did not have a wander guard on his wheelchair or on his ankle. NA-D stated she had never seen R49 leave the facility on his own. During an interview on 12/8/21 at 9:00 a.m. NA-B stated the wander guard band was hidden in R49's wheelchair since the resident had a history of cutting the band off. NA-D then pulled the resident's wheelchair around and pointed to a pocket attached to the back of the wheelchair. NA-D stated she had never seen R49 wander	F 657	The Care Planning Policy was reviewed and remains current. All residents assessed for care conference completion within the last 90 days. Any resident who has not had a care conference documented in the last 90 days will be scheduled to have one completed. Family and resident will be invited to each care conference. All residents with wander guards will have care plans reviewed to reflect current needs. Education provided to Social Service Director and Designee on care conference regulations and requirements. All licensed nurses responsible for ongoing resident assessment of a Wander Guard will receive education on the need to reassess the Wander guard use quarterly and prn and to update care plan accordingly. Recurrence will be prevented by: Audit 5 residents to ensure care conference was completed quarterly with family and resident being offered to attend, documentation for care conference was completed weekly x4 weeks then monthly for 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit.	

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F 657	Continued From page 8 from the facility and said the resident had in the past. During an interview on 12/8/21 at 9:14 a.m., R49 stated a few years ago he went to a store with another resident and failed to alert the facility that he was planning to leave on an outing. During an interview on 12/8/21 at 9:08 a.m., the interim director of nursing (DON) stated R49's last elopement was in 2016. The interim DON stated her expectation for the care plan was to reflect the resident's current status. Review of a facility policy titled "Care Plan," undated indicated "...In accordance with state and federal regulations, each resident will have a person-centered care plan developed by the interdisciplinary team for the purpose of meeting the resident's individual medical, physical, psychosocial and functional needs..." R9's quarterly MDS with an ARD of 9/24/21, indicated a BIMS score of seven out of 15 which indicated R9 was severely cognitively impaired. R9's EMR failed to indicate if R9, and/or her representative were invited to quarterly care conference meetings or that the facility conducted quarterly meetings for the past year for R9. During an interview on 12/6/21, at 10:04 a.m., R9 stated she did not remember being invited to a care conference meeting. During an interview on 12/9/21 at 8:49 a.m., the social worker (SW) stated R9's daughter was invited to participate in the care conferences but	F 657	Audits of all residents with wander guards will be reviewed to ensure elopement assessment is completed and care plan is updated weekly x4 weeks then monthly for 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Social Service Director or designee.	

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F 657	Continued From page 9 did not attend. SW stated the invitations to the resident representative was typically documented in the progress notes as well as the quarterly meetings that were held. A request for the past year of documentation was requested during this interview from the SW. During an interview on 12/9/21 at 10:38 a.m., the SW confirmed there were no care conferences held and there were no invitations to R9's representative available for the past year. The SW stated there were no policies for inviting a resident and/or their representative to care plan meetings nor were there policies on conducting quarterly care conferences. The SW stated the facility follows the regulations. During an interview on 12/9/21 at 12:40 p.m., the interim DON stated care conferences needed to be held on a quarterly basis and residents and/or family members need to be invited to participate in their care conferences.	F 657		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure facial hair was removed for 2 of 2 residents (R20 and R30) who required assistance with hygiene, and were reviewed for activities of daily living (ADLS). In addition, the facility failed to ensure nail care was completed for 1 of 2 residents (R30) dependent	F 677	Immediate Corrective Action: R20□s face was shaved. R30□s face was shaved and fingernails clipped.	12/31/21

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F 677	Continued From page 10 on staff for ADLS. Furthermore, the facility failed to ensure baths were offered for 1 of 3 residents (R39) who required staff assistance for bathing. Findings include: R20's face sheet printed 12/9/21, indicated R20's diagnoses included muscle weakness and nonpsychotic mental disorder. R20's admission Minimum Data Set (MDS) dated 10/13/21, indicated R20 had moderately cognitively impaired, and required limited to extensive assistance of one staff with ADLS. R20's ADL care area assessment (CAA), dated 10/20/21, required limited assistance with personal hygiene. R20's care plan revised 12/8/21, identified R20 required assistance to complete ADLS, however displayed rejection of care. The care plan indicated staff were to monitor behavior, encourage R20 to vent feelings and provide one assist with dressing, bathing and personal hygiene. The Pocket Care Plan: Side B (undated) did not indicated hygiene needs other than bowel/bladder care and oral care. During observation on 12/6/21, at 10:46 a.m. R20 was observed to have multiple chin hairs (approximately 1/4 - 1/2 inches in length) and a darker fine mustache. In a interview on 12/6/21, at 10:46 a.m. R20 was unaware of her facial hair, and was unable to express if she approved of having facial hair. During a telephone interview on 12/7/21, 1:45	F 677	R39 was showered. Corrective Action as it applies to others: The ADL Assistance per Care Plan Policy was reviewed and remains current. All residents who need assistance with ADLs will have updated pocket care plans and care plans to reflect the residents' current needs and preferences regarding showers, nails, and facial hair. All nurses, TMAs, and CNAs will be re-educated on ADL Assistance per Care Plan Policy with focus on completing showers, nail care, and facial hair removal per preferences noted on pocket care plans. Recurrence will be prevented by: Audit 5 residents to ensure their showers, nail care, and facial hair removal is completed per their preference weekly x4 weeks then monthly for 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Director of Nursing or designee	

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p.m. R20's family member (FM)-A stated R20 would have been "mortified" to know she had facial hair. FM-A stated last Christmas, R20 asked to have a electric razor as a gift for her grooming needs. FM-A stated she thought R20's razor was brought to the facility when R20 was admitted, but could not remember if that was so.

In further observations on 12/7/21, at 12:14 p.m. and 12/8/21, at 7:10 a.m. R20 was observed to still have facial hair.

In an interview on 12/8/21, at 1:01 p.m. nursing assistant (NA)-C stated that she had provided R20 with her morning cares. NA-C stated she had not noticed R20's facial hair. NA-C stated when staff notice facial hair they should offer to shave them if they require assistance with personal hygiene needs.

In an interview on 12/8/21, at 1:32 p.m. licensed practical nurse (LPN)-D stated she was unaware that R20 ever had an electric razor. LPN-D stated shortly after admission LPN-D had attempted shaving R20, but R20 pushed and swung out. LPN-D stated she and until staff would attempt assisting R20 with shaving this evening.

During an observation on the morning of 12/9/21, at 8:30 a.m. R20 was observed to be cleanly shaved.

A review of R20's progress notes from 12/8/2021, at 2:09 p.m documented the following: "Resident has been pleasant. No behaviors noted. No concerns noted. No complaints of pain. Resident did talk off and on about nonsensical things. Resident did allow LPN to shave hair on her upper lip and chin. She did need to be cued on

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not pulling back and to sit very still but did allow it to be done."

In an interview on 12/9/21, at 1:49 p.m. the director of nursing (DON) stated that the facility staff, when they notice any resident who requires shaving needs, should offer to assist that resident.

R30's face sheet, printed 12/9/21, indicated R30's diagnoses included encephalopathy, and acute respiratory failure with tracheostomy.

R30's quarterly Minimum Data Set (MDS) dated 10/22/21, indicated R30 was severely cognitively impaired, and required extensive assistance of 1-2 staff for all ADLS.

A review of R30's Care Plan, last revised 12/1/21, indicated R30 was totally dependent on staff for all ADLs and dressing. A review of R30's Pocket Care Plan: Side A (undated) directed the staff "to be dressed in personal clothing daily" and "staff to get resident up in his wheelchair two times a day."

During observation on 12/6/21, at 10:00 a.m. R30 was noted to have not been shaved and had long finger nails, with the both thumbs being approximately 1/4 inches in length. R30 was noted to only be wearing a hospital gown under the top sheet of his bed.

In a telephone interview on 12/6/21, at 2:11 p.m family member (FM)-B stated R30 always took pride in his appearance, was always clean shaven and never had long nails. FM-B stated since R30's admission, FM-B has only once ever seen resident not wearing a hospital gown. FM-B

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stated family had bought a package of three V-Neck tee shirts to dress R30 in. However, a month later, they were still in the original package in his closet. FM-B stated the facility should be getting R30 out of bed as well, and feels that was not occurring when FM-B was not visiting.

Further non-consecutive observations on 12/7/21, between 1:30 p.m. - 7:00 p.m. and 12/8/21, between 8:05 a.m. - 1:53 p.m. R30 continued to be observed with an unshaven face and long finger nails. R30 remained dressed only in a hospital gown, and in bed only.

During an interview on 12/8/21 at 12:41 p.m. nursing assistant (NA)-C stated she assisted with R30's morning cares, and did not shave resident nor notice R30's long finger nails. NA-C was unaware that staff should be dressing R30 in his personal clothes daily. NA-C further stated due to R30 requiring two staff for Hoyer transfers, placing R30 in his wheelchair was not always done.

During an interview and observation on 12/8/21, at 1:53 p.m., registered nurse (RN)-A stated R30 had not been in his wheelchair and she noted the wheelchair the facility provided had caused pressure areas on his lower back, which were now healed. RN-A stated that the local pharmacy and medical supply providers would not accept R30's insurance for a new wheelchair. They were able to obtain service through one medical supply company; however, that company was unable to come out to measure R30 until yesterday, as the company required at least two residents in need before they would come to the facility. In regards to R30's shaving, nails and being dressed in his personal clothing, RN-A stated this all should

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have been performed by the assigned floor staff.

In an interview on 12/9/21, at 1:49 p.m. the director of nursing (DON) stated the floor staff should not only be implementing each resident's care plan, but also follow the Pocket Care Plans that are provided to the floor staff for resident needs and preferences.

R39's Face Sheet (undated), indicated R39's diagnoses included chronic respiratory failure, quadriplegia, traumatic brain injury and anxiety disorder.

R39's annual Minimum Data Set (MDS) dated 10/29/21, indicated R39 was cognitively intact, and required extensive assistance of 1-2 staff with all ADL needs.

R39's ADL care area assessment (CAA), dated 11/12/21, indicated R39 was totally dependent on the facility staff for all grooming, hygiene and bathing needs.

During interview on 12/7/21, at 12:33 p.m. R39 stated this was the fifth day without a shower being offered. R39 stated "they wash me up but it is not the same as having a shower. I sweat a lot."

R39's Care Plan, last revised 12/8/21, indicated R30 was totally dependent on staff for all ADLs, dressing and bathing. The care plan indicated that once in R39's wheelchair he is independent and is able to go into the community independently. R39's care plan further indicated R39 displayed behavior of "Resident will refuse showers if the staff member that he wants is not

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working". A review of R30's Pocket Care Plan: Side A (undated) documented "resident is very specific about how he wants things done." The care sheet further documented R39's refusal to be repositioned every 2 hours and prefers showers.

R39's electronic bath record, from November 2021 and December 1-8, 2021, indicated that in November 2021 only four shower attempts were documented with three entries being refusals. From December 1-8, there was no documentation of any showers being offered.

During interview on 12/8/21, at 1:01 p.m. nursing assistant (NA)-C stated R39 rarely accepted a shower when it was offered by facility staff. However, when R39 requested a shower, R39 expected facility staff to drop everything and do the shower right then. If R39 felt it took took long to organize help, R39 sometimes then refused assistance. NA-C further stated R39 was very particular about how all portions of care provision were to be provided, with the shower process, from getting out of bed, to shower and back to bed taking at times two hours.

In an interview on 12/9/21, at 1:49 p.m. the director of nursing (DON) discussed R39's behaviors, his refusals, and his acceptance of only certain staff, as well as the staff time it took due to his specific personal requirements during the showering process. The DON stated the facility did have ongoing conversation with R39 to try to meet his needs, but R39 was not always receptive.

In review of the facility policy, entitled: Quality of Life: Resident Self Determination and

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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F 677	Continued From page 16 Participation (revised December 2016) indicated: "Our facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life." This policy further indicated: 1. Each resident is allowed to choose activities, schedules and health care that are consistent with his or her interests, values, assessments and plans of care, including: a. Daily routine, such as sleeping and waking, eating, exercise and bathing schedules; b. Personal care needs, such as bathing methods, grooming styles and dress; c. Health care scheduling, such as times of day for therapies and certain treatments; d. Providers of healthcare services; e. Activities, hobbies and interests; and f. Religious affiliation and worship preferences.	F 677		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and	F 688		12/31/21

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F 688	Continued From page 17 assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure care planned range of motion (ROM) exercises were consistently implemented to prevent decline and reduce the risk of contractures for 4 of 4 residents (R8, R12, R9 and R30) reviewed for restorative programs. Findings include: R8's electronic medical record (EMR), undated, indicated R8 had a diagnosis of congenital deformities. R8's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/16/21, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R8 was cognitively intact. Review of the assessment indicated R8 was totally dependent of one staff member for bed mobility and totally dependent with two staff members for transfers. The assessment indicated the resident was totally dependent on staff for all activities of daily living, such as eating, personal hygiene, and toilet use. Review of R8's Care Plan dated 9/27/21, indicated R8 was to received ROM to upper and lower extremities and bilateral hip range of motion twice a week. R8's restorative nursing document dated 12/28/20, indicated skilled therapy referred R8 to restorative nursing to receive bilateral upper extremity and bi-lateral hip range of motion	F 688	Immediate Corrective Action: R8 is getting AROM to BUE, BLE, and bilateral hips twice weekly; pocket care plans and comprehensive care plans updated to reflect restorative needs. R9 is getting AROM to BUE and BLE and stretching twice weekly; pocket care plans and comprehensive care plans updated to reflect restorative needs. R12 is getting AROM to BUE to all planes with a TheraBand twice weekly; pocket care plans and comprehensive care plan updated to reflect restorative needs. R30 is getting AROM to bilateral hands/wrist and PROM to elbow and shoulder twice weekly; pocket care plans and comprehensive care plans updated to reflect restorative needs. Corrective Action as it applies to others: The Restorative Nursing Services was reviewed and remains current. All residents that currently have recommendations for restorative services from therapy will be reviewed to determine the need for continuing restorative services. Pocket care plans and comprehensive care plans will be updated	

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F 688	Continued From page 18 (ROM) twice a week. ROM was to specifically address shoulders and elbow planes. Review of the Unit 2 Restorative Treatment Record document indicated R8 received restorative services on: -The week of 9/27/21, restorative nursing was provided on 9/30/21. There was no evidence R8 received a second day of restorative nursing that week. -The weeks of 10/4/21 and 10/11/21, there was no evidence to indicate R8 received restorative nursing. -The week of 10/18/21, restorative nursing was provided to R8 on 10/21/21 There was no evidence R8 received a second day of restorative nursing that week. -The week of 10/25/21, there was no evidence R8 received restorative nursing. -There were no documents to show R8 received restorative nursing for the month of November 2021,- through 12/06/21. R12's EMR, undated, indicated R12 had a diagnosis of cardiovascular disease affecting the left side of body (stroke). R12's restorative nursing document dated 12/11/20, indicated skilled therapy referred R12 to restorative nursing to receive bi-lateral upper extremity in all planes with medium resistive TheraBand. Review of R12's MDS with an ARD of 10/1/21, indicated a BIMS score of 15 out of 15 which indicated R12 was cognitively intact. Review of the assessment indicated R12 was extensive assistance of one for bed mobility and the	F 688	to reflect that resident requires restorative services. All nurses, TMAs, and CNAs will be educated on need to complete restorative services per pocket care plans. Recurrence will be prevented by: Audit 5 residents to ensure their restorative needs are being completed per therapy recommendations and care plan/pocket care plan reflect these needs weekly x4 weeks then monthly for 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Director of Nursing or designee	

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F 688	Continued From page 19	F 688		

required the assistance of two for transfers.

Review of R12's Care Plan dated 10/11/21, indicated R12's goal was to maintain upper and lower body strength to assist in his self-care. The intervention was to provide R12 with ROM twice a week.

The facility's Unit 2 Restorative Treatment Record indicated R12 received restorative services on:
-The week of 9/27/21, there was no evidence R12 received restorative nursing.
-The weeks of 10/4/21, and 10/11/21, there was no evidence to show R12 received restorative nursing.
-The week of 10/18/21, there was no evidence to show R12 received restorative nursing; the section next to R12's name was blank.
-The week of 10/25/21, there was no evidence R12 received restorative nursing.
-There were no documents to show R12 received restorative nursing for the month of November 2021, through 12/6/21.

R9's EMR, undated, indicated R9 had a diagnosis of adult failure to thrive.

R9's restorative Nursing document dated 7/14/21, indicated skilled therapy referred R12 to restorative nursing to receive bi-lateral extremity ROM and stretching twice a week

R9's MDS with an ARD of 9/24/21, indicated a BIMS score of seven out of 15 which indicated R9 was severely cognitively impaired. The MDS also indicated R9 required extensive assistance of one for bed mobility and was totally dependent for transfers with two staff members.

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R9's Care Plan dated 9/29/21, indicated R9's restorative nursing was to be provided twice a week. The intervention was to provide R9 with bi-lateral ROM and stretching twice a week.

THe facility's Unit 2 Restorative Treatment Record indicated R9 received restorative services on:
-The week of 9/27/21, restorative nursing was provided to R9 on 9/30/21. There was no evidence to show R9 received restorative nursing the second time that week.
-The weeks of 10/4/21, 10/11/21, and 10/18/21, were missing documents to show R9 received restorative nursing during these weeks.
-The week of 10/25/21, there was no evidence R9 received restorative nursing.
-There were no documents to show R9 received restorative nursing for the month of November 2021, through 12/6/21.

During an interview on 12/8/21, at 12:36 p.m., NA-C stated she had worked as a restorative aide for the past seven years. NA-C stated the director of rehabilitation made the referrals to nursing and she received her assignments to perform ROM for residents. NA-C stated the purpose of restorative nursing was not to allow the residents' muscles to stiffen and to get them moving. NA-C stated it was in September 2021, that she began to be pulled from the restorative program and work as a NA. NA-C confirmed residents did not receive restorative nursing in November and December 2021.

During an interview on 12/08/21 at 2:43 p.m., the director of rehabilitation (DOR) stated he would make referrals to nursing to do restorative

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nursing once a resident had been discharged from skilled services. The DOR stated he received alerts from nursing if a resident sustained any decline. The DOR stated R8 or R12 had not sustained decline in their functional status. The DOR stated R8 has lifelong physical limitations and R12 had a status change in early 2020 when R12 had COVID-19 and has not been fully active since.

During an interview on 12/09/21 at 12:31 p.m., the interim director of nursing (DON) stated she and the administrator have pulled NA-C from restorative to meet the needs of the residents. The interim DON stated all NAs were trained to perform restorative nursing and they were looking at restructuring the restorative program. The interim DON confirmed she never directed NAs to perform restorative nursing.

A subsequent interview was conducted on 12/9/21, at 12:16 p.m., with the DOR . The DOR stated R9 has had a slow decline over the years due to her dementia and there has been no recent significant decline identified.

During an interview on 12/9/21, at 12:54 p.m., the interim DON confirmed there were no documents for restorative nursing for the months of December and November 2021.

The facility's Restorative Nursing Services policy undated, indicated "...Residents will receive restorative nursing care as needed to help promote optimal safety and independence...Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's [sic] plan of care..."
R30's Face Sheet printed 12/9/21, indicated

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R30's diagnoses included encephalopathy and acute respiratory failure with tracheostomy.

R30's quarterly Minimum Data Set (MDS) dated 10/22/21, indicated R30 was severely cognitively impaired, and required extensive assistance of 1-2 staff for all ADLS.

R30's care plan last revised 12/1/21, identified R30's need for restorative rehab nursing to include "[active assistive range of motion] AAROM to bilateral hands/wrist, [passive range of motion] PROM to elbow and shoulder. Complete two times a week." A review of R30's Pocket Care Plan: Side A (undated) did not document nursing rehab as part of the the daily care to provide.

R30's functional rehabilitation plan (FMP), undated, but initialed on 7/14/21, by "BS", documented R30's - "Restorative Nursing Plan: AAROM to [both hands / wrist, PROM to elbows, shoulders."

In review of R30's nursing rehab records, only the following was provided by the facility:
August 9th - 13th, 2021 = 0 attempts documented
September 20 - 24th, 2021 = 1 of 2 sessions (Thursday)
September 27th - October 1st, 2021 = 1 of 2 sessions (Thursday)
October 20th - 22nd, 2021 = 0 attempts documented

During interview on 12/8/21, at 12:41 p.m., nursing assistant (NA)-C stated she was normally scheduled as the nursing rehab nursing assistant, however, she was frequently pulled to the floor to perform direct care for the residents. NA-C stated after checking in each morning, she would check

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the staff schedule and find that she had been changed to direct care. NA-C stated during November 2021, she was out due to testing positive for COVID-19 for 10-12 days, and could not speak to who had performed restorative nursing during that time. NA-C stated no other staff have been trained for restorative nursing. NA-C stated she had asked in the past, and was told there was no need. NA-C was uncertain if any residents received restorative nursing in November and December 2021, when she was not pulled to direct care. NA-C stated she started getting pulled to the floor for direct care back in September 2021. Finally, NA-C stated when scheduled to direct care, NA-C stated she attempted to do some restorative with the residents assigned her group if time allowed.

During an interview on 12/8/21, at 2:43 p.m. occupational therapist (DOR/OT) stated once a resident no longer received therapy but could still benefit from ongoing nursing rehab, therapy would fill out a functional maintenance program (FMP) and train the rehab nursing assistant to each resident's needs. DOR/OT stated R30 was still receiving speech therapy, and occupational therapy three days prior as R30's right pinky appeared a little stiff. DOR/OT stated after an assessment of R30, the resident still had functional range of motion (the required range of motions for individuals to maintain maximal independence) and should be be able to care for himself.

In an interview on 12/9/21 at 1:49 p.m. the interim DON stated the facility was struggling with obtaining nursing staff, however, the facility should have looked at ways of providing R30's and other residents nursing rehab needs. The

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F 688	Continued From page 24 DON stated the facility was looking at options for the provision of nursing rehab, but have not finalized that process. The facility policy, entitled: Restorative Nursing Services (last revised July 2017) indicated: "Resident's will receive restorative nursing care as needed to help promote optimal safety and independence." This policy further indicated in section 5: "Restorative goals may include, but are not limited to supporting and assisting the resident in: a. Adjusting and adapting to changes in ability; b. Developing, maintaining and strengthening his/her physiological and psychological resources; c. Maintaining his/her dignity, independence and self-esteem; and d. Participating in the development and implementation of his/her plan of care."	F 688		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following	F 725		12/31/21

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F 725	Continued From page 25 types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and document reviews, the facility failed to provide staffing at levels to ensure baths were routinely provided as scheduled and per resident preferences for 1 of 3 residents (R39) reviewed for bathing; failed to ensure sufficient staffing to provide routine assistance with activities of daily living (ADL's) of grooming, personal hygiene and dressing for 2 of 4 residents (R20, R30) who required assistance and were dependent on staff for ADL's. Finally, the facility failed to ensure sufficient staff to restorative nursing services for 4 of 4 residents (R8, R) reviewed for nursing rehab services. This deficient practice had the potential to affect all 59 residents who resided in the facility. Findings include: Based on observation, interview, and record review, the facility failed to have sufficient nursing staff to provide nursing and related services to assure and attain or maintain the highest practicable physical, mental, and psychological well-being of each resident related to sufficient staffing. Specifically, the facility failed to ensure	F 725	Immediate Corrective Action: R8 is getting AROM to BUE, BLE, and bilateral hips twice weekly; pocket care plans and comprehensive care plans updated to reflect restorative needs. R9 is getting AROM to BUE and BLE and stretching twice weekly; pocket care plans and comprehensive care plans updated to reflect restorative needs. R12 is getting AROM to BUE to all planes with a TheraBand twice weekly; pocket care plans and comprehensive care plan updated to reflect restorative needs. R20□s face was shaved. R30 is getting AROM to bilateral hands/wrist and PROM to elbow and shoulder twice weekly; pocket care plans and comprehensive care plans updated to reflect restorative needs. R30□s face was shaved and fingernails clipped. R30	

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four (Residents (R)8, R12, R9, and R30), out of four reviewed for restorative were provided restorative nursing services.

Findings include:

1.Review of R8's electronic medical record (EMR) Admission Record, undated, indicated R8 was admitted to the facility on 12/7/20.

2. Review of R12's EMR Admission Record undated, indicated R12 was admitted to the facility on 8/2/13.

3. Review of R9's EMR Admission Record, undated, indicated R9 was admitted to the facility on 7/26/18.

A review of documents provided by the facility titled "Nursing," for Nursing Assistant (NA-C) for the months of September, October, November, and December 2021 was completed. For the month of September 2021, indicated NA-C was pulled from her specific duties of restorative nursing for four days during the month. For the month of October 2021, the schedule indicated NA-C was pulled from restorative nursing for nine days of the month. For the month of November, the schedule indicated NA-C was pulled from restorative nursing eight days of the month. The November 2021 schedule indicated NA-C was on medical leave for nine days during this month. The December 2021, schedule indicated NA-C was pulled from restorative for seven days.

Review of documents provided by the facility titled "Unit 2 Restorative Treatment Record" for R8, R12, R9, and R30 failed to indicate all four residents were provided restorative nursing care

gets up into his w/c at least twice daily.

R39 was showered.

Corrective Action as it applies to others:

The Staffing Policy was reviewed and remains current.

All residents that currently have recommendations for restorative services from therapy will be reviewed to determine the need for continuing restorative services. Pocket care plans and comprehensive care plans will be updated to reflect that resident requires restorative services.

All residents who need assistance with ADLs will have updated pocket care plans and care plans to reflect the residents' current needs and preferences regarding showers, nails, and facial hair.

All nurses, TMAs, and CNAs will be re-educated on ADL Assistance per Care Plan Policy with focus on completing showers, nail care, and facial hair removal per preferences noted on pocket care plans.

All nurses, TMAs, and CNAs will be educated on need to complete restorative services per pocket care plans.

Recurrence will be prevented by:

Audit 5 residents to ensure their

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F 725	Continued From page 27 twice a week as directed per the residents' "Plan of Care." During an interview on 12/8/21 at 12:07 p.m., the interim director of nursing (DON) stated she had to pull NA-C from restorative to work as a NA on the floor. During an interview on 12/8/21, at 12:36 p.m., NA-C confirmed she has worked as the restorative aide for the past seven years. NA-C stated she received direction from the Director of Rehabilitation (DOR) regarding which resident(s) require restorative nursing. NA-C stated the goal for restorative nursing was to prevent those residents from going back into skilled therapies, to keep each resident moving and to prevent their muscles from stiffening. NA-C stated she started to be pulled from restorative to work as a NA on the floor in September 2021. NA-C stated she was off on medical leave for 12 days in November 2021. NA-C stated no resident received restorative therapies during the month of November or early part of December 2021. During an interview on 12/8/21 at 2:43 p.m., the DOR stated restorative nursing services were not being provided since staffing has been thin and the restorative aide has been pulled from restorative duties to work the floor. During an interview on 12/9/21 at 12:31 p.m., the interim DON confirmed there was no nursing scheduler. The DON stated both she and the administrator made the decisions on how to staff based on resident and census needs. The DON stated both she and the administrator were looking at restructuring the restorative program since NAs were already trained to walk residents	F 725	restorative needs are being completed per therapy recommendations and care plan/ pocket care plan reflect these needs weekly x4 weeks then monthly for 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Audit 5 residents to ensure their showers, nail care, and facial hair removal is completed per their preference weekly x4 weeks then monthly for 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Director of Nursing or Designee	

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and to provide active and passive range of motion. The DON confirmed she never directed NAs to implement restorative nursing services.

Review of a policy provided by the facility titled "Staffing," dated October 2017 indicated, ". . .Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. . .Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. . ."

R39's Face Sheet, undated, indicated R39's diagnoses included chronic respiratory failure, quadriplegia, traumatic brain injury and anxiety disorder.

R39's annual Minimum Data Set (MDS) dated 10/29/21, indicated R39 was cognitively intact, and required extensive assistance of 1-2 staff with all ADL needs.

R39's ADL Care Area Assessment (CAA), dated 11/12/21, indicated R39 was totally on the facility staff for all grooming, hygiene and bathing needs.

During interview on 12/7/21, at 12:33 p.m. R39 stated this was the fifth day without a shower being offered. R39 stated "they wash me up but it is not the same as having a shower. I sweat a lot."

R39's Care Plan, last revised 12/8/21, indicated R30 was totally dependent on staff for all ADLs, dressing and bathing. The care plan indicated that once in R39's wheelchair he was

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independent and was able to go into the community independently. R39's care plan further indicated R39 displayed behavior of "Resident will refuse showers if the staff member that he wants is not working". A review of R30's Pocket Care Plan: Side A (undated) documented "resident is very specific about how he wants things done." The care sheet further documented R39's refusal to be repositioned every two hours and his preference for showers.

A review R39's electronic bath record, from November 2021, and December 1-8, 2021, indicated that in November 2021 only four shower attempts were documented with three entries being refusals. December 1-8, lacked any documentation of any showers being offered.

During interview on 12/8/21, at 1:01 p.m. nursing assistant (NA)-C stated R39 rarely accepted a shower when it was offered by facility staff. However, when R39 requested a shower, R39 expected facility staff to drop everything and do the shower right then. If R39 felt it took too long to organize help, R39 sometimes then refused assistance. NA-C further stated R39 was very particular about how all portions of care provision are to be provided, with the shower process, from getting out of bed, to shower and back to bed taking at times two hours.

In an interview on 12/9/21, at 1:49 p.m. the director of nursing (DON) discussed R39's behaviors and his refusal of acceptance of only certain staff, as well as the staff time it took due to his specific personal requirements during the showering process. DON stated the facility did have ongoing conversation with R39 to try to meet his needs, but was not always receptive.

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R20's Face Sheet printed12/9/21, indicated R20's diagnoses included muscle weakness and nonpsychotic mental disorder.

R20's admission Minimum Data Set (MDS) dated 10/13/21, indicated R20 had moderately cognitively impaired, and required limited to extensive assistance of one staff with ADLS.

R20's ADL Care Area Assessment (CAA), dated 10/20/21, required limited assistance with personal hygiene.

R20's care plan revised 12/8/21, identified R20 identified R20 required assistance to complete ADLS, however displayed rejection of care. The care plan indicated staff were to monitor behavior, encourage R20 to vent feelings and provide one assist with dressing, bathing and personal hygiene. The Pocket Care Plan: Side B (undated) did not indicated hygiene needs other than bowel/bladder care and oral care.

During observation on 12/6/21, at 10:46 a.m. R20 was observed to have multiple chin hairs (approximately 1/4 - 1/2 inches in length) and a darker fine mustache.

In a interview on 12/6/21, at 10:46 a.m. R20 was unaware of her facial hair, but was unable to express if she approved of having facial hair.

During a telephone interview on 12/7/21, 1:45 p.m. R20's family member (FM)-A stated R20 would have been "mortified" to know she had facial hair. FM-A stated last Christmas R20 asked to have a electric razor as a gift for her grooming needs. FM-A stated she thought R20's razor was

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brought to the facility when R20 was admitted, but could not remember if that was so.

In a further observations on 12/7/21, at 12:14 p.m. and 12/8/21, at 7:10 a.m. R20 was observed to still have facial hair.

In an interview on 12/8/21, at 1:01 p.m. nursing assistant (NA)-C stated that she had provided R20 with her morning cares. NA-C stated she had not noticed R20's facial hair. NA-C stated when staff notice facial hair they should offer to shave them if they require assistance with personal hygiene needs.

In an interview on 12/9/21, at 1:49 p.m. the director of nursing (DON) stated that the facility staff, when they notice any resident who requires shaving needs, should offer to assist that resident.

R30's Face Sheet printed 12/9/21, indicated R30's diagnoses included encephalopathy, and acute respiratory failure with tracheostomy. R30's quarterly Minimum Data Set (MDS) dated 10/22/21, indicated R30 was severely cognitively impaired, and required extensive assistance of 1-2 staff for all ADLS.

During observation on 12/6/21, at 10:00 a.m. R30 was noted to have not been shaved and had long finger nails, with the both thumbs being approximately 1/4 inches in length. R30 was noted to only be wearing a hospital gown under the top sheet of his bed.

In a telephone interview on 12/6/21, at 2:11 p.m family member (FM)-B stated R30 always took pride in his appearance, was always clean

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shaven and never had long nails. FM-B stated since R30's admission, FM-B has only once ever seen resident not wearing a hospital gown. FM-B stated family had bought a package of three V-Neck tee shirts to dress R30 in. However, a month later, they were still in the original package in his closet. FM-B stated the facility should be getting R30 out of bed as well, and feels that was not occurring when FM-B was not visiting

Further non-consecutive observations on 12/7/21, between 1:30 p.m. - 7:00 p.m. and 12/8/21, between 8:05 a.m. - 1:53 p.m. R30 continued to be observed with an unshaven face and long finger nails. R30 remained dressed only in a hospital gown, and in bed only.

A review of R30's Care Plan, last revised 12/1/21, indicated R30 was totally dependent on staff for all ADLs and dressing. A review of R30's Pocket Care Plan: Side A (undated) directed the staff "to be dressed in personal clothing daily" and "staff to get resident up in his wheelchair two times a day."

During an interview on 12/8/21, at 12:41 p.m. nursing assistant (NA)-C stated she assisted with R30's morning cares, and did not shave resident nor noted R30's long finger nails. NA-C was unaware that staff should be dressing R30 in his personal clothes daily. NA-C further stated due to R30 requiring 2 staff for hoyer transfers, placing R30 in his wheelchair was not always done.

During an interview and observation on 12/8/21, at 1:53 p.m., registered nurse (RN)-A stated R30 had not been in his wheelchair and she noted the wheelchair the facility provided was causing pressure areas on his lower back, which were now healed. RN-A stated that the local pharmacy

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and medical supply providers would not accept R30's insurance for a new wheelchair. They were able to obtain service through one supplier, however, only yesterday, would they come out to measure R30 becuase they required at least two residents in need. In regards to R30's shaving, nails and being dressed in his personal clothing, RN-A stated this all should have been performed by the assigned floor staff.

Furthermore, R30 was also assessed to require ongoing nursing restorative services.

R30's care plan (last revised 12/1/21) identified R30's needs for Restorative Rehab Nursing documented R30 receive "[active assistive range of motion] AAROM to bilateral hands/wrist, [passive range of motion] PROM to elbow and shoulder. Complete two times a week." A review of R30's Pocket Care Plan: Side A (undated) did not document nursing rehab as part of the the daily care to provide.

A review of R30's functional rehabilitation plan (FMP), undated but initialed off on 7/14/21 by "BS", documented R30's - "Restorative Nursing Plan: AAROM to [both hands / wrist, PROM to elbows, shoulders."

In review of R30's nursing rehab records, only the following was provided by the facility:
August 9th - 13th, 2021 = 0 attempts documented
September 20 - 24th, 2021 = 1 of 2 sessions (Thursday)
September 27th - October 1st, 2021 = 1 of 2 sessions (Thursday)
October 20th - 22nd, 2021 = 0 attempts documented

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During interview on 12/8/21, at 12:41 p.m., nursing assistant (NA)-C stated she was normally scheduled as the nursing rehab nursing assistant, however, she was frequently pulled to the floor to perform direct care for the residents. NA-C stated after checking in each morning, she would check the staff schedule and find that she had been changed to direct care. NA-C stated that during November 2021, she was out due to testing positive for COVID-19 for 10-12 days, and could not speak to who had performed restorative nursing during that time. NA-C stated no other staff have been trained for restorative nursing and NA-C had asked in the past, and was told there was no need. NA-C was uncertain if any residents received restorative nursing in November and December 2021 when she was not pulled to direct care. NA-C stated she started getting pulled to the floor for direct care back in September 2021. Finally, NA-C stated when scheduled to direct care, NA-C stated she attempted to do some restorative with the residents assigned her group if time allowed.

During an interview on 12/8/21, at 2:43 p.m. occupational therapist (DOR/OT) stated once a resident no longer receives therapy but could still benefit from ongoing nursing rehab, therapy filled out a functional maintenance program (FMP) and trained the rehab nursing assistant to each resident's needs. DOR/OT stated R30 was still receiving speech therapy, and occupational therapy three days prior due to R30's right pinky appeared a little stiff. DOR/OT stated after an assessment of R30, resident still had functional range of motion (the required range of motions for individuals to maintain maximal independence) should be be able to care for himself.

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F 725	Continued From page 35 In an interview on 12/9/21 at 1:49 p.m. the director of nursing (DON) stated the facility was struggling with obtaining nursing staff, however, the facility should have been looking at ways of providing R30's and other residents nursing rehab needs. The DON stated the facility was looking at options for the provision of nursing rehab, but have not finalized that process. In an interview on 12/9/21, at 1:49 p.m. director of nursing (DON) stated the floor staff should not only be implementing each resident's care plan, but also follow the Pocket Care Plans that are provided to the floor staff for resident needs and preferences.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		12/31/21

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F 755	Continued From page 36 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure rinsing of mouth per physician orders, following administration of an inhaler 2 of 2 residents (R56 and R164) observed for inhaler administration. Findings include: R56 R56's Admission Record printed 12/9/21, indicated R56's diagnoses included chronic obstructive pulmonary disease (COPD or emphysema). R56's Order Summary Report dated 12/9/21, indicated R56's physician orders included an order for Advair Diskus Aerosol (inhaled steroid and long acting bronchodilator that treat inflammation and open airways) Powder Breath Activated 250-50 micrograms (mcg)/dose, one inhalation inhale orally every 12 hours, with directives to rinse mouth after each use. R56's Medication Administration Record (MAR)	F 755	Immediate Corrective Action: R56 will have mouth rinsed after each administration of inhaler. R164 will have mouth rinsed after each administration of inhaler. Corrective Action as it applies to others: All residents that have inhalers ordered will be reviewed to ensure that their orders are updated to direct nurse/TMA to rinse mouth as directed/appropriate by manufacturer recommendations of specific inhaler. All TMA and licensed nurses will be educated to follow manufacturer recommendations to rinse mouth after specific inhalers. Recurrence will be prevented by: Audit 5 nurses administering inhalers that	

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F 755	Continued From page 37 for 12/1/21 through 12/31/21, directed R56's mouth to be rinsed following each administration of Advair Diskus Aerosol Powder Breath Activated 250-50 mcg/dose one inhalation every 12 hours. R56's MAR indicated R56 received the inhaler on 12/6/21, during the evening medication pass. The pharmacy label on R56's Advair Diskus inhaler medication directed R56's mouth to be rinsed after each use. On 12/7/21, at 7:22 p.m. licensed practical nurse (LPN)-6 prepared R56's medications for administration, including Advair Diskus inhaler, and brought them into R56's room. LPN-6 handed R56 her Advair Diskus inhaler and inhaled the medication, then took her oral medications, taking a sip of water following her oral medications. R56 did not rinse her mouth following the inhaler and was not cued to rinse her mouth by LPN-6. Upon exiting R56's room, when interviewed, LPN-6 verified he did not have R56 rinse her mouth following administration of the inhaler per physician orders. R164 R164's Admission Record printed 12/9/21, indicated R164's diagnoses included COPD. R164's Order Summary Report dated 12/9/21, indicated R164's physician orders included an order for budesonide-formoterol fumarate aerosol (inhaled steroid and long-acting bronchodilator) 160-4.5 mcg/actuation (ACT)2 puffs inhaled orally two times a day, with directives to rinse mouth after each use. R164's Medication Administration Record (MAR)	F 755	require mouth to be rinsed after administration will be completed weekly x4 weeks then monthly for 2 months to ensure they are following manufacturer recommendations. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Director of Nursing and Designee	

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for 12/1/21, through 12/31/21, directed R164's mouth to be rinsed following each administration of budesonide-formoterol fumarate aerosol 2 puffs inhaled orally two times a day, and directed R164's mouth to be rinsed after each use. R164's MAR indicated R164 received the inhaler on 12/7/21, during the morning medication pass.

The pharmacy label on R64's Budesonide formoterol fumarate inhaler lacked directives to rinse R164's mouth following each use.

On 12/8/21, at 7:44 a.m. LPN-7 prepared R164's medications for administration, including R164's budesonide formoterol fumarate inhaler, and brought them to R164's room. R164 administered another inhaler, had his blood sugar checked, took his oral medications, and then administered 2 puffs of his budesonide-formoterol fumarate inhaler after LPN-7 handed it to him.

On 12/8/21, at 8:07 a.m. LPN-7 verified R164 had not rinsed his mouth following administration of the budosenide-formoterol fumarate inhaler, and she had not cued him to rinse his mouth, but should have.

On 12/9/21, at 3:21 p.m. LPN care coordinator-1 verified residents needed to rinse their mouth after inhalers. LPN-1 stated she puts the physician orders into the electronic medical record, including the MAR with directives to rinse resident's mouth after each use. LPN-1 further verified the directives to rinse mouth following inhaler use should also be included on the pharmacy label.

On 12/9/21, at 4:12 p.m. the director of nursing (DON) verified the nursing staff who administers

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F 755	Continued From page 39 medications should ensure the resident's mouth got rinsed following each use, as directed. A facility policy and procedure for administration of inhalers was requested, but not provided.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		12/31/21

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THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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F 756	Continued From page 40 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consultant pharmacist recommendations were addressed within the directed time frame for 2 of 5 residents (R4 and R36) reviewed for unnecessary medications. Findings include: R4 R4's Admission Record printed 12/9/21, indicated R4's diagnoses included dementia with behavioral disturbance, Alzheimer's disease, anxiety disorder, schizoaffective disorder depressive type, major depressive disorder, osteoarthritis, and hypothyroidism. R4's consultant pharmacist monthly reviews indicated there were irregularities with recommendations to be addressed by R4's physician or nursing within a specific time frame in 2/21, 7/21, 8/21, and 10/21. The consultant pharmacist recommendation for 2/21, was addressed timely, but the recommendations for 7/21, 8/21, and 10/21 were not found in R4's medical record and had not been addressed. The consultant pharmacist recommendations for R4 were as follows: -7/6/21: Hydrocortisone (steroid medication used	F 756	Immediate Corrective Action: R4□s consultant pharmacy reviews were addressed and up to date. R36□s consultant pharmacy reviews were addressed and up to date. Corrective Action as it applies to others: The Medication Management Review Policy was reviewed and remains current. Current unaddressed pharmacy recommendations will be addressed within the time frame specified on each paper document for all residents residing at the facility. Nursing management will be educated on pharmacy recommendations, where they are located, and what needs to be done once they have been emailed to facility by Pharmacist. Recurrence will be prevented by: Audit 5 residents to ensure their consultant pharmacist□s medication review are completed weekly x4 weeks	

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F 756	Continued From page 41 to treat allergies, inflammatory or some auto-immune conditions) should be given with food. Please add instructions to the MAR to "Give with Food," to be completed as soon as possible, but no later than 30 days. -8/4/21: recommendation from 7/21, was repeated. -10/8/21: Paroxetine (antidepressant) is on the Beers list (potentially inappropriate medications for geriatric people) due to effects such as increased confusion and fall risk, and R4 had a recent fall and increased behaviors. The recommendation was to consider change of Paroxetine to another antidepressant medication, as soon as possible but no later than 60 days. R36 R36's Admission Record printed 12/9/21, indicated R36's diagnoses include diabetes, adjustment disorder with mixed anxiety and depressed mood, acute kidney disorder, and emphysema. R36's consultant pharmacist monthly reviews indicated there were irregularities with recommendations to be addressed by R36's physician or nursing within a specific time frame in 1/21, 2/21, 3/21, 6/21, and 10/21. The consultant pharmacist recommendation for 1/21, 2/21, 3/21 were addressed timely, but the recommendations for 6/21, and 10/21 had not been addressed or had not been addressed within the recommended time. The consultant pharmacist recommendations not addressed for R36 were as follows:	F 756	then monthly for 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Director of Nursing or Designee	

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F 756	Continued From page 42 -6/5/21, Atorvastatin (for high cholesterol): Diltiazem may increase the blood level of atorvastatin, increasing the side effects such as liver damage or rhabdomyolysis (breakdown of muscle tissue that releases a damaging protein into the blood); be sure to report any unexplained muscle pain, tenderness or weakness. More frequent evaluation may need to be done to ensure resident is at lowest effective dose. Nursing need to address as soon as possible but no later than 30 days. Follow up was signed 8/23/21. -10/10/21, If a dose reduction is not appropriate for nortriptyline (antidepressant and nerve pain medication) at this time, detailed clinical rationale is needed for continuing the current dose of 50 mg at bedtime. On 12/9/21, at 12:58 p.m. the director of nursing (DON) verified the consultant pharmacist recommendations had not consistently been addressed and should have been addressed within the recommended time frame. The facility policy and procedure for Medication Regimen Review revised 5/19, directed if the physician does not provide a timely or adequate response to the consultant pharmacist's recommendation, or if the consultant pharmacist identifies that no action had been taken, the medical director would be contacted.	F 756		
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what	F 838		12/31/21

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F 838	Continued From page 43	F 838		

resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:

§483.70(e)(1) The facility's resident population, including, but not limited to,
(i) Both the number of residents and the facility's resident capacity;
(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;

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F 838	Continued From page 44 (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based oninterview and document review, the facility failed to conduct and document a comprehensive facility-wide assessment to determine what resources were necessary to care for its residents during day-to-day operations. The lack of an adequate facility assessment had the potential for some of the needs of all 60 residents of the facility to go unmet. Findings include: The facility's comprehensive Facility Assessment Tool, dated 9/13/21, indicated the comprehensive Facility Assessment failed to address pertinent characteristics affecting day-to-day operations: 1. The facility's Facility Assessment Tool was copied and pasted into the facility's assessment from an on-line source from	F 838	Immediate Corrective Action: Facility assessment was reviewed and updated to ensure the assessment was comprehensive and specific to the facility. Corrective Action as it applies to others: Administrator was educated on facility assessment and need for assessment to be facility specific. Recurrence will be prevented by: Facility assessment will be reviewed quarterly and brought to QAPI for the next 6 months. Corrections will be monitored by:	

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F 838	Continued From page 45 https://qioprogram.org/facility-assessment-tool retrieved on 12/7/21. This document included directions to complete the "Facility Assessment Tool" but was not specific to the characteristics of the facility. 2. The Facility Assessment Tool failed to address the specialized training and competencies of the staff who worked in the facility including the infection control preventionist and/or other clinical specialties/services routinely provided for the residents. 3. The Facility Assessment Tool failed to identify the facility was a smoking campus. 4. The Facility Assessment Tool did not address staff access to electronic medical records. 5. The Facility Assessment Tool did not address that the facility had the services of an Infection Control Preventionist and the facility implemented an antibiotic stewardship program. During an interview on 12/9/21 at 9:25 a.m., the administrator confirmed there was no information in the Facility Assessment that reflected the therapy department was a contracted service. The administrator stated the Facility Assessment did not identify the facility was a smoking campus. The administrator stated the Facility Assessment Tool failed to show the use of an Infection Control Preventionist and that the facility adhered to an antibiotic stewardship program.	F 838	Administrator or designee	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/31/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. 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	K 000		

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K 000	Continued From page 2 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 system and in all sleeping rooms that is monitored for automatic fire department notification. The facility has a capacity of 93 beds and had a census of 60 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of	K 222		1/14/22

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K 222	Continued From page 3 locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in	K 222		

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K 222	Continued From page 4 accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain an accessible means of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.5.6.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/08/2021 at 1:00 PM, observation revealed that a steam table in the kitchen was obstructing the exit access to the corridor. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 222	Immediate Corrective Action: The steam table in the kitchen will be moved so it no longer obstructs the exit access to corridor. Corrective Action as it applies to others: Education will be provided to the culinary director and Environmental Services director to ensure that exit access to the corridor is not obstructed. Recurrence will be prevented by: Audits will be conducted on kitchen doors to ensure there is nothing obstructing access to the corridor. Audits will be completed weekly for 3 weeks, and then monthly for 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Environmental Services Director or Designee	
K 341 SS=E	Fire Alarm System - Installation	K 341		2/28/22

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K 341	Continued From page 5 CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install smoke detectors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1 and 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm Code, section 17.7.4.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 12/08/2021 at 1130 AM, it was revealed by observation a smoke detector in activities room 300 A and resident rooms 314, 316, and room 317 were within 36" of the HVAC supply, which is close enough for airflow to prevent operation. An interview with the Director of Environmental	K 341	Immediate Corrective Action: Smoke detector in activities room 300A, and resident rooms 316, 314, and 317 will be moved to be more than 36" away from HVAC supply. A contractor has been contacted and we are waiting for work to be completed. Corrective Action as it applies to others: Education will be provided to environmental services director to ensure Smoke detectors are not within 36 of HVAC supply. The Environmental Services Director has completed an audit of the building to identify any other smore	

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	245495	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/08/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	**2801 SOUTH HIGHWAY 169** **GRAND RAPIDS, MN 55744**

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K 341	Continued From page 6 Services verified these deficient findings at the time of discovery.	K 341	detectors within 36 inches of HVAC supply. Recurrence will be prevented by: Audits will be completed monthly x3 months to ensure smoke detectors are more than 36 away from HVAC supply. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Environmental Services Director or Designee	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.	K 351		3/4/22

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K 351	Continued From page 7 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1, 19.3.5.10, 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.15.8.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 12/08/2021 at 12:15 PM, observation revealed that the closets in patient rooms 310, 313, 402, and 406 are not sprinkler protected. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 351	Immediate Corrective Action: An audit of the building has been completed to determine what closets are not sprinkled. Doors will be removed from affected closets or replaced with a wardrobe. Corrective Action as it applies to others: Education will be provided to Environmental Services director to ensure resident closets are in compliance with NFPA 101 sections 19.3.5.1, 19.3.5.10, 9.7.1.1, and NFPA 13. Recurrence will be prevented by: Audits of patient rooms closets to ensure they are in compliance with NFPA 101 sections 19.3.5.1, 19.3.5.10, 9.7.1.1, and NFPA 13 will be conducted monthly x 3 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Environmental Services Director or Designee	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101	K 355		1/3/22

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K 355	Continued From page 8 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect the K-Class portable extinguisher per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.4.1 and NFPA 10, (2010 edition), Standard for Portable Fire Extinguisher, sections 7.2.1.2, and 7.2.4 through 7.2.4.5. These deficient findings could have an isolated impact on the residents within the facility. FINDINGS INCLUDE: On 12/08/2021, between 11:30 AM to 1:30 PM, it was revealed by observation that the K-Class portable extinguisher in the kitchen was not documented as inspected on the tag from July through November. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 355	Immediate Corrective Action: K class extinguisher in kitchen was inspected on 12/31/21. Corrective Action as it applies to others: Environmental Services Director and Assistants were educated on the frequency on extinguisher inspection. Recurrence will be prevented by: Audits will be completed monthly on extinguishers in the building to ensure monthly extinguisher inspections are completed. Audits will be completed monthly x3 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Environmental Services Director or Designee	
K 751 SS=F	Draperies, Curtains, and Loosely Hanging Fabr CFR(s): NFPA 101	K 751		1/31/22

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K 751	Continued From page 9 Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the flame retardant for loosely hanging privacy curtains per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.5.1 and 10.3.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 12/08/2021 between 10:00 AM and 1:30 PM, it was revealed by observation that resident room privacy curtains in rooms 310, 321, 322, and multiple rooms on the 200 Wing did not have the proper NFPA 701 tag on them. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 751	Immediate Corrective Action: All privacy curtains without NFPA 701 tag will be removed from the building. Corrective Action as it applies to others: The environmental services director will be educated on NFPA 101 Life Safety Sections 19.7.5.1, 10.3.1, and not using privacy curtains without NFPA 701 tag, Recurrence will be prevented by: Audits of privacy curtains ensuring NFPA 701 tag will be completed weekly X3 weeks and monthly x 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Environmental Services Director or Designee	

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