Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 14, 2025

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

RE: CCN: 245495
Cycle Start Date: March 27, 2025

Dear Administrator:

On March 27, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Cell: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 27, 2025 (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 September 27, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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 03/27/2025

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 3/24/25 to 3/27/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities 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 3/24/25 to 3/27/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H54951640C(MN00110112). 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	F 000		

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

Electronically Signed | 04/23/2025

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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F 000	Continued From page 1 regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review facility failed to perform a self-administration of medication assessment and obtain provider order to have medication left in room for 2 of 2 (R13 and R29) residents reviewed for self-administration of medication. R13's quarterly Minimum Data Set (MDS) assessment dated 2/12/25, indicated R13 had intact cognition. Diagnoses included heart failure, hypertension and renal insufficiency. During an observation of R13's room on 3/24/25 at 3:17 p.m., a box with a tube of diclofenac cream was noted on the shelf to the right of the bed. During an interview on 3/24/25 at 3:17 p.m., R13 stated the staff utilize the diclofenac cream on her back and just leave it on the shelf so it would be available when they needed it. During a second observation of R13's room on 3/25/25 at 2:06 p.m., a box with a tube of diclofenac cream was again noted on the shelf to the right of the bed. R29's quarterly MDS dated 3/4/25, indicated R29	F 554	Immediate Corrective Action: R13 and R29 have had self-administration of medication assessments completed, and care planned as indicated. Corrective Action as it applies to others: All residents will be reviewed to identify if a self-administration of medication assessments needs to be completed and care planned. Education will be provided to Nurses and TMAs on self-administration of medications policy, and that medications cannot be left in a resident room if a resident is not deemed appropriate to self-administer their medication. Self-administration of medications policy reviewed and remains current. Recurrence will be prevented by: 5 med passes will be audited weekly x3 weeks then monthly x2 months to identify that medications are not being left in resident rooms, unless resident has been	5/2/25

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F 554	Continued From page 2 was cognitively intact. Diagnoses included anxiety, depression and post traumatic stress disorder. R29's Medication Admin Audit Report dated 3/27/25, indicated R29 had orders for Ipratopium-albuterol inhalation solution 0.5-2.5mg inhaled 4 times a day. On 3/26/25, a dose had been set up at 11:38 a.m. During an observation on 3/24/25 at 6:40 p.m., a nebulizer canister was observed full of a liquid substance, not running, and no medical staff were in the room with the resident. During a second observation on 3/26/25 at 12:53 p.m., again a nebulizer canister was observed full of liquid substance, not running, and no medical staff with him. At that time R29 turned on the nebulizer machine and started administering the liquid in the nebulizer canister. During an interview on 3/25/25 at 2:10 p.m. licensed practical nurse (LPN)-B stated prior to a medication left at bedside there must be a self-administration of medication (SAM) form completed, which showed resident was safe to leave medication at bedside and that resident wanted to have medication left at bedside. After that an order would be obtained from the provider to leave medication at bedside. LPN-B entered R13's room and confirmed a tube of Diclofenac cream had been left at R13's bedside shelf. LPN-B then reviewed R13's medical record and indicated there was no SAM or order to keep any medication at bedside. During a second interview on 3/26/25 at 12:56 p.m., LPN-B entered R29's room and confirmed	F 554	deemed capable of self-administration of medications. 5 residents will be audited weekly x3 weeks then monthly x2 months for Self Administration of Medication Assessments completion and care plan updated. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Director of Nursing or Designee.	

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F 554	Continued From page 3 R29 had a full canister of liquid in the canister he was administering medication with. LPN-B reviewed R29's medication administration record (MAR) and stated the last documented administration of inhaled nebulizer medication was done at 11:38 a.m., and not at the current time. LPN-B stated based on the amount of liquid in the canister R29 had just started the nebulizer at the current time and not at 11:38 a.m., as documented. R29 did not have a SAM or provider order to keep medication of any kind at bedside, so the staff member should have made sure the nebulizer had been utilized at 11:38 a.m., when documented as administered. During an interview on 3/27/25 at 1:54 p.m., the director of nursing (DON) stated if the resident did not have a SAM assessment or provider order to leave medication at bedside. Staff should not leave at bedside and should stay with the resident while they took the medication. The facility Self-Administration of Medications policy last revised 2/24 indicated the facility would deem if a resident was safe to self administer medication through assessment forms and provider orders.	F 554		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical	F 578		5/2/25

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F 578	Continued From page 4 services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure advanced directives for emergency care and treatment were accurately reflected in all areas of the medical chart to ensure resident wishes would be implemented correctly in an emergent situation for 1 of 16	F 578	Immediate Corrective Action: R200 Code Status order was updated to match resident POLST. Corrective Action as it applies to others:	

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F 578	Continued From page 5 residents (R200) reviewed for advanced directives. Findings include: R200's admission Minimum Data Set (MDS) dated 2/19/25, indicated R200 was cognitively intact with the diagnoses of congestive heart failure, diabetes, and respiratory failure. R200's careplan initiated on 2/18/25, included the focus area Current Code Status: see current POLST [Physician Orders for Life Sustaining Treatment]. Interventions included review advanced directives per resident and or family request and arrange for MD consult as necessary. During record review on 3/24/25 at 4:48 p.m., R200's scanned in POLST dated 3/18/25, signed by the provider on 3/20/25, directed do not resuscitate (DNR). However, the order entered in the chart on 3/18/25, was for Cardiopulmonary resuscitation (CPR) and R200's banner also instructed CPR. During an interview on 3/24/25 at 6:27 p.m., R200 stated they had been asked if they had a living will when they returned to the facility. R200 stated they had told staff they didn't want CPR at the facility, they only wanted to die once. R200 indicated they had family members that had broken ribs and didn't do good after CPR. R200 stated they didn't want brain damage or to be worse off after. They would be a full code if they were having a procedure done at the hospital but otherwise they wanted to be DNR. During an interview on 3/24/25 at 6:04 p.m., RN-A	F 578	All residents POLST were audited to identify POLST matched code status order in Electronic Medical Record. Management Nurses, and Health Information will be educated on POLST documentation policy and that POLST and code status orders in Electronic Medical Record need to match. POLST documentation policy reviewed and remains current. Recurrence will be prevented by: All resident POLSTs will be audited weekly x3 weeks, then monthly x2 months to ensure POLST and code status in Electronic Medical Record match. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Director of Nursing or Designee.	

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F 578	Continued From page 6	F 578		

stated for an un-responsive resident they would go to the electronic medical record and look at the code status there to know what to do. RN-A opened R200's EMR and stated R200's POLST was DNR, but the banner and order were for CPR. RN-A stated they would have done CPR on R200 based on the banner, so in that instance the wrong things would have happened because the order and the banner were entered incorrectly based on the POLST.

During an interview on 3/24/25 at 6:11 p.m., LPN-A stated to determine a resident code status they would look at the facesheet and if it was not there they would look at the banner because it was quickest. LPN-A opened R200's chart and stated based on the banner they would start CPR on R200 if they found R200 unresponsive. LPN-A confirmed R200's banner and chart did not match and stated they would contact the provider or supervisor to determine what action to take when the POLST and banner did not match.

During an interview on 3/24/25 at 6:02 p.m., LPN-C stated they always went to the main EMR screen to determine a resident's code status. LPN-C opened a EMR record and pointed to the banner and code status location. LPN-C stated they only went to the POLST to look at code status if the banner status was empty.

During an interview on 3/24/25 at 6:03 p.m., LPN-B stated on admit the POLST reviewed with the resident and once the resident signed the POLST their status was entered on the EMR banner. It then went to the HUC so it could be signed by the provider and scanned in. The POLST and the order/banner should match. If a resident stopped breathing, staff can go to the

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F 578	Continued From page 7 banner for the code status. During an interview on 3/24/25 at 6:56 p.m., the director of nursing (DON) stated as a health care professional it is a number one priority to make sure residents are safe and that their wishes are respected and honored. The DON stated the facility had a process in place to honor resident's wishes and ensure their code status was correctly documented. The banner is a quick place for nurses to identify if CPR should be implemented. In R200's situation because the banner did not match the order, if R200 had coded and received CPR, R200's wishes would not have honored. CPR could have also resulted in negative consequences for R200. With CPR, R200's medical condition could have potentially been worsened after CPR resulting in a lower quality of life for R200 post CPR. During an interview on 3/24/25 at 7:17 p.m., RN-B stated they corrected R200's order and banner to reflect R200's POLST which showed R200 wanted to be a DNR. RN-B stated they expected staff to look at the EMR banner for a resident's code status. RN-B confirmed R200 would have likely received CPR if they had coded prior to the banner and order being corrected. RN-B explained performing CPR on a resident who did not want it could be bad for the resident depending on the outcome. CPR could result in pain, broken ribs, and possibly medical deficits that were not there prior to CPR. During an interview on 3/24/25 at 7:27 p.m., the administrator stated respecting the wishes of the resident was very important and indicated the team had corrected R200's code status as soon as they had been made aware of the error. The	F 578		

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F 578	Continued From page 8 administrator indicated the facility had a process in place to get the resident's wishes regarding code status at the time of admission and then an order and banner status in place so that resident wishes could be honored as soon as they were known, while waiting for the final POLST to be completed. The administrator indicated that their HUC completed weekly audits on code status for all residents, however they had just completed an audit on all residents in the building due to the error on R200's code status. They had fixed R200's code status as soon as they were made aware of the discrepancy, had audited code status for the whole building, and had began staff education. On 3/24/25 at 7:38 p.m., R200's banner and orders were reviewed and indicated R200's code status was now listed as DNR. On 3/25/25 at 9:00 a.m., the HUC stated they were responsible for scanning the POLST into the chart, they did not update the banner, nurses did that. The HUC indicated they had started to do code status audits weekly at the facility on the second week of February 2025. Their process was to go through every resident. They started with review of the code status on the banner and then made sure the POLST was signed, correctly completed and matched the banner and order. The HUC's audit book showed several completed weekly audits. The audit completed on 3/18/25, listed R200 as being in the hospital. The HUC indicated they had not completed their audit for this week yet, but if there was a discrepancy it would be found during the audit. During a follow-up interview on 3/25/25 at 8:54 a.m., RN-A stated they had notified the social	F 578		

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F 578	Continued From page 9 worker R200's code status and POLST did not match once they had been made aware of it. RN-A stated they had checked R200's chart at shift start this a.m. and R200's code status had been fixed. The facility policy POLST documentation dated 12/2024, indicated the purpose of the POLST was to identify and document the code status consistent with the resident wishes so that staff know immediately what action to take or not take when an emergency arises. The policy identified a process for managing code status orders and the POLST and indicated routine audits of the POLST documentation should be conducted.	F 578		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services	F 582		5/2/25

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F 582	Continued From page 10 available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS-10055) to 1 of 3 residents (R54) reviewed whose Medicare Part A coverage ended while in the facility.	F 582	Immediate Corrective Action: R54 is discharged from facility. Corrective Action as it applies to others: Medicare discharges in the last 30 days	

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F 582	Continued From page 11 Findings included: R54's Notice of Medicare Non-Coverage (CMS-10123) dated 10/15/24, indicated R54's last day of skilled services was on 10/15/24 due to going on hospice services. The form was signed by R54 and dated 10/15/24. In addition, R54's medical record lacked evidence the required CMS-10055 had been reviewed and/or provided to R54 prior to their Medicare Part A coverage ending. R54's Census List indicated a payer change occurred on 10/16/24, to hospice private pay. R54's progress notes from 10/9/24 to 10/17/24, indicated R54 was a resident of the facility until discharge on 10/17/24. During an interview on 3/27/25 at 8:01 a.m., the business office manager (BOM) stated she was responsible to give the residents the CMS 10123 and 10055 forms to the residents 3 days prior to discharge from Medicare-A services. The CMS-10055 was also known as the daily rate form so the resident would be aware of the approximate daily rate bill if they had to pay out of pocket. The BOM reviewed R54's record and acknowledged the 10055 had not been issued to R54, but R54 had remained in the facility after the last day of Medicare A coverage stopped. The BOM stated even though R54 was only in the facility for 1 day after the discontinuation of Medicare A coverage, a 10055 form should have been issued so R54 was aware of what each day of stay would cost. During an interview on 3/27/25 at 8:14 a.m., the administrator stated any resident that stayed at	F 582	will be audited to identify if ABN and NOMNC have been completed as indicated by ABN/NOMNC policy. Business Office Manager and Director of Social Services will be educated on ABN/NOMNC policy. ABN/NOMNC policy reviewed and remains current. Recurrence will be prevented by: All residents with Medicare discharges will be audited monthly x3 months to identify if SNF ABN forms were completed per facility policy. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Administrator or Designee	

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F 582	Continued From page 12 the facility after Medicare part A coverage stopped coverage needed to have the 10055 form given to them so they were aware of what a daily rate might be for their stay. The facility's policy titled ABN/NOMNC Policy and Procedure dated 2/20/23, indicated any resident that stayed in the facility after Medicare part A coverage ended would be issued a SNFABN: CMS-10055.	F 582		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to notify the provider as ordered for a weight increase of 3 pounds (lb.) or more in 24 hours for 1of 2 residents (R27). The facility also failed to follow fluid restrictions as ordered for 2 of 2 residents (R27, R28). The facility also failed to address elevated blood glucose levels for 1 of 1 resident (R16). The facility also failed to have a resident assessed for usage of a walker for 1 of 1 resident (R12) reviewed for provider orders. Findings include: R27:	F 684	Immediate Corrective Action: R27 weight increase was made known to provider. R27 and R28 fluid restrictions were updated in orders. R16 elevated blood glucose levels were made known to provider. R12 had orders obtained for PT was evaluated for walker usage.	5/2/25

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F 684	Continued From page 13 R27's annual Minimum Data Set (MDS) assessment dated 12/20/24, indicated intact cognition. Diagnoses included anemia, coronary artery disease and renal failure. R27's care plan dated 9/25/24, indicated a risk for complications related to dialysis. Interventions included fluid restriction per order. R27's Order Summary Report (OSR) dated 2/4/25, indicated R27 was on an IDDSI level 7 regular texture diet with a 1500 milliliter (ml) fluid restriction. R27's OSR as indicated on 12/7/24 R27 was placed on a 2000 ml fluid restriction. Review of R27's MAR from 2/25 and 3/25 indicated the following: - During 2/25 R27 received more than 1500ml of fluid 2 times and lacked documented fluid amounts for at least one shift 10 days. - During 3/25 R27 received more than 1500 ml of fluid 2 times and lacked documented amounts for at least one shift 7 days. R28's quarterly MDS assessment dated 3/19/25, indicated intact cognition. Diagnoses included heart failure, hypertension and post kidney transplant. R28's care plan dated 3/19/25 indicated a potential for altered nutrition status with interventions of weekly weights and offer adequate fluids at and between meals. The care plan lacked information related to daily weights or fluid restrictions. R28's OSR dated 1/27/25, indicated a heart healthy diet with a 2000 ml fluid restriction. The	F 684	Corrective Action as it applies to others: All residents with weight parameter notifications will be reviewed to ensure proper notification to provider as ordered. All residents with fluid restrictions were reviewed and orders updated to reflect breakdown of fluids between nursing and dietary. All residents that receive blood sugar checks will be reviewed to ensure they have parameters in their orders for when to notify a provider and reviewed to ensure proper notification to provider has been completed as ordered. All residents will be reviewed for if they have a preference to be using a walker, if not already using, and if so, will obtain a PT order to assess and treat to ability to use. Recurrence will be prevented by: 5 residents will be audited to ensure the provider was notified if weight outside of parameters weekly x3 weeks and then monthly x2 months. 5 residents will be audited to ensure residents on a fluid restriction have orders in place and proper documentation of fluid intake weekly x3 weeks and then monthly x2 months. 5 residents will be audited to ensure the provider was notified if blood sugar was outside of parameters per their orders weekly x3 weeks and then monthly x2 months. 5 residents will be audited to	

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F 684	Continued From page 14 OSR also indicated on 12/20/24, orders were placed to weigh daily and notify the provider with a weight gain of 3 lbs in 24 hours or 5lbs in 1 week. Review of R28's MAR and Treatment Administration Record (TAR) from 1/25 through 3/25 indicated a lack documentation the fluid restriction was being monitored as ordered. Review of R28's MAR and TAR from 1/25 through 3/25, indicated the following: - A 24 hr 4 lb weight gain on 2/11/25, and a 4.6 lb weight gain on 2/13/25. Daily weights were missed 3 times. - A 24hr 6lb weight gain on 3/10/25. Daily weights were missed 6 times. R28's medical record for 1/25 through 3/25, lacked documentation the weights over 3lbs in 24 hrs or missed recieved a provider notification.. During an interview on 3/25/25 at 2:48 p.m., nurse assistant (NA)-C stated daily weight would be obtained by the NA's usually on day shift and then given to the nurse to enter into the medical record. For residents on a fluid restriction, the nursing staff would keep track how much fluid the resident took in during meals and throughout the day, minus fluids given with medications, and that would be given to the nurse to enter into the medical record and keep track of. During an interview on 3/27/25 at 12:48 p.m., registered nurse (RN)-B stated she was not sure how documentation would be done to show weights were called to provider or fluid restrictions were followed but did believe there was some documentation that went into the	F 684	ensure their walker preferences have been identified weekly x3 weeks and then monthly x2 months. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Director of Nursing Or Designee.	

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F 684	Continued From page 15 medical record to show it was completed. RN-B reviewed R27's and R28's medical record and indicated there was no documentation related to fluid restriction orders or weight orders being followed or that the provider was notified when needed. During an interview on 3/27/25 at 1:58 p.m., the director of Nursing (DON) stated staff should follow provider orders and follow the policy related to provider notifications. R16: R16's quarterly Minimum Data Set (MDS) dated 3/11/25, indicated R16 was cognitively intact and received insulin injections daily. R16's Diagnosis Report dated 3/27/25, included diagnoses of multiple myeloma, coronary artery bypass, diabetes type II with chronic kidney disease, diabetic neuropathy, heart failure, and hypertension. R16'a Careplan last reviewed on 3/19/25, included the following: Potential for alteration in blood sugar related to diagnosis of diabetes. Goal: resident will be free from hyper/hypo glycemic episodes with the following interventions: -Encourage diabetic HS snack. -Labs per MD order -Monitor resident for signs/symptoms of hyper and hypoglycemia. -Monitor residents blood sugar as ordered. -Administer scheduled and sliding scale insulin as ordered. -Administer medication as ordered. -Diet as ordered. Encourage resident to follow prescribed diet.	F 684		

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F 684	Continued From page 16 R16's Order Summary Report for 2/1/25 to 2/28/25, included an order, dexamethasone oral tablet 4mg give 5 tablets by mouth one time a day every seven days for cancer treatment. Start date 3/2/25. R16's Order Summary Report Active orders as of 3/27/25, included the following orders: -consistent carbohydrate diet -blood sugar monitoring via finger stick 4 times a day -monitor for s/s of hyper/hypoglycemia including but not limited to lethargy, sweating, weakness, confusion, pale, vomiting, and excessive thirst every shift -Lantus subcutaneous solution pen-injector. Inject 12 units subcutaneously at bedtime related to diabetes type 2 -Lantus subcutaneous solution pen-injector. Starting 3/27/25, inject 15 units subcutaneously at bedtime related to type two diabetes. -Novolog flex pen solution pen-injector. Inject 4 units subcutaneously three times a day related to diabetes type 2 R16's careplan and current orders lacked parameters for provider notification and instruction on actions to be taken in the event R16 became hyperglycemic or hypoglycemic. R16's careplan did not identify R16 was receiving steroids, nor did it include a focus area with goals and interventions for steroid use/monitoring. Prior to 3/24/25, R16's most current in-person provider encounter at the facility was documented as 1/23/25. R16's nursing notes included the following:	F 684		

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F 684	Continued From page 17 -A note on 3/23/25 indicated the on-call provider had been notified of a blood sugar reading of 485. The provider did not give any orders. -A note on 3/24/25, indicated the on-call provider had been notified of a blood sugar reading of 598. A one-time order for NovoLog 4 units was received and would be administered to R16. R16's medical record lacked evidence of provider notification for blood sugar values greater than 400 on 3/26/25, 3/21/25, 3/20/25, 3/13/25, or 3/6/25, In addition the chart lacked evidence a provider had been notified R16's blood sugars had been trending up. R16's Essentia Health Lab Report result for a hemoglobin A1C drawn on 1/14/25, showed that R16's A1C was 6.4 which meant that R16 had an estimated average blood glucose of 137mg/dl. The blood glucose values listed on the Weights and vitals Summary effective 1/1/25 to 3/31/25, were reviewed. Summarized documented blood glucose values between 3/1/25 and 3/27/25, showed R16 had had 8 blood glucose readings greater than 400 mg/dl, 20 readings greater than 300 mg/dl, 17 blood glucose readings below 200 mg/dl, with all other values falling between 200 and 299 mg/dl during the time period reviewed (R16 blood glucose testing was ordered four times a day). During an interview on 3/24/25 at 3:00 p.m., R16 stated they had had a high blood sugar, and the doctor never treated it with insulin. R16 stated they knew the high sugars were not good for them, but the nurse had said the doctor didn't want to treat it. R16 indicated they had requested to talk to a doctor about their high blood sugars.	F 684		

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F 684	Continued From page 18 During an interview on 3/27/25 at 8:16 a.m., R16 stated they continued to worry about their blood sugar values, and explained they could go into a diabetic coma if their blood sugars got to high. R16 also worried about their eye sight getting worse because of their blood sugars. R16 stated they had told staff they were very concerned about their blood sugars and had also asked to be seen by a provider, but nobody had seem them since January. R16 indicated their blood sugars had been better before they started steroids, usually below 200 and rarely over 300, but now they were high all the time and they knew they needed more than a one time dose of insulin to take care of it. During an interview on 3/27/25 at 12:34 p.m., the director of nursing (DON) pulled up and reviewed R16's blood sugar record in the EMR. The DON confirmed R16's blood sugars had been consistently high and stated R16 frequently ate high carb take meals. R16's prescribed steroids would also elevate blood sugars. The DON stated they would expect nurses to notify the provider when blood sugars were in the 400-500s. In addition, they expected the provider would be notified if a resident was trending with high blood sugars. Registered nurse consultant (RNC-D) was present at the interview and stated they did not see a note that indicated R16 had been seen by a provider in February or March. Nor did they see nursing documentation that a provider had been notified of trending blood sugars or greater than 400 values other than on 3/23 and 3/24/25. RNC-D reviewed R16's A1C lab results and stated R16's A1C had been good in January. The DON stated R16 was medically complicated with	F 684		

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F 684	Continued From page 19 several chronic diseases including cardiac issues which could be negatively impacted by higher blood sugars. R16's organs would have to work harder and R16 was at risk for hospitalization and DNK [diabetes ketoacidosis, a life threatening condition where the body does not have enough insulin, the body then makes ketones, which leads to the blood becoming too acidic] due to the high sugars. During an interview on 3/27/25 at 12:59 p.m., R16's nurse practitioner (NP-E) stated they had been contacted for a high blood sugar, and had ordered insulin coverage however, they had not been informed R16's blood sugars had been trending high. NP-E stated they would expect a call immediately for a blood sugar over 400 so the blood sugar(s) could be addressed. In addition, they expected it would be communicated to them if a resident's blood sugar started trending up averaging in the 200s to 300s. NP-E explained trending high blood sugars could result in further amputations, kidney issues, changes in vision, organ stress or complications like DNK for R16. If it had been communicated to them that R16's blood sugars were averaging greater than 200 with values around or greater than 400, R16's insulin would have been adjusted to address those values in addition to treatment of the reported high value. All polices and protocols related to blood glucose monitoring and management were requested. RN-D indicated the facility did not have a specific glucose management policy and indicated they would reference the Med and TX order policy for following provider orders. The Medication and Treatment Orders policy	F 684		

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F 684	Continued From page 20 dated 2/2024, was reviewed. The policy did not address or instruct staff on diabetes management, nor did it provide actions/intervention to take or instruct when to notify the provider in the event a resident experienced hyper/hypoglycemia. R12: R12's annual minimum data set (MDS) dated 2/5/25, identified R12 was cognitively intact and diagnosed with arthritis, depression, schizophrenia, spondylosis in lower back (degenerative condition of spinal discs and joints causing pain and stiffness), and sciatica on the right side (pressure in the lumbar spine which causes radiating pain from the buttocks down the leg). MDS further identified R12 uses a wheelchair and requires partial to moderate assistance (worker does less than half of the effort) to transfer from a sitting to standing and standing to sitting position. R12's care plan reviewed on 3/25/25, identified R12 required the assist of 1 with toileting and used a bedpan. R12 had alteration in mobility related to increased weakness and the need for assistance with mobility. R12 will move safely within the environment, used a wheelchair for locomotion, and required moderate assist of 1 for wheelchair to toilet transfers. R12's active orders dated 3/5/25, identified physical therapy (PT) and occupational therapy (OT) to evaluate and treat for mobility. R12's progress note dated 3/16/25, identified R12 had requested to be seen again by PT. No	F 684		

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	245495	A. BUILDING _____ B. WING _____	C 03/27/2025

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F 684	Continued From page 21 additional progress notes were made from 3/16/25 to 3/25/25. R12's medical recorded lacked a risk versus benefit form related to the use of a walker completed prior to 3/25/25. During interview and observation on 3/24/25 at 3:36 p.m., R12 stated she would like to use a walker to assist with bathroom transfers instead of using a bedpan. R12 identified over the past several weeks she has reported this to nursing staff, requested to be provided with a walker, and to be seen by PT but no action had been taken. Approximately two weeks ago R12's father purchased her a walker and had it delivered to the facility. R12 stated after the walker was delivered, she was assured maintenance would assist with assembly, but no action had been taken. An unopened box identified as containing a 4-wheeled walker was noted in R12's closet. During interview and observation on 3/25/25 at 1:29 p.m., R12 reported a housekeeper put in a maintenance request to have her walker assembled. Maintenance worker was observed removing the box which contained the walker from the R12's room. During interview on 3/25/25 at 1:32 p.m., licensed practical nurse (LPN)-E confirmed R12 had requested to be seen by PT. LPN-E identified R12 made this request approximately 2 weeks ago. LPN-E reported the request to the director of nursing (DON) and documented it in R12's progress notes. During interview on 3/25/25 at 1:49 p.m., occupation therapist (OT)-B explained any	F 684		

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F 684	Continued From page 22 resident who was provided with or obtained a walker must be assessed prior to its use to assure the walker was the correct type, height, and safe to use. Assessment prior to the use of a walker was a standard of care. (OT)-B reviewed R12's therapy documents and confirmed R12's did not have a current PT/OT referral and R12's medical record did not contain any therapy related documents (progress notes, screenings, or plan of care) which occurred in the past 30 days. During observation on 3/26/25 at 10:38 a.m., R12 had an assembled 4-wheeled walker at the foot of her bed. During interview on 3/27/25 at 9:45 a.m., R12 explained maintenance had returned the assembled 4-wheeled walker on 3/25/25. R12 reports she has been using the walker for the past 2 days and was not assessed or provided with education from nursing or PT/OT staff prior its use. R12 identified feeling a little scared and shaky while using the walker because it moves faster than she had expected. During interview on 3/27/25 at 10:42 a.m., DON expects nursing leadership be made aware of a resident's request for a walker. Nursing leadership will notify the provider who will, if warranted, order a PT/OT evaluation. PT/OT will be made aware of the order no later than the following day. The timeframe in which a resident will to be evaluated by PT/OT was in the facility policy. If a resident brings a walker into the facility DON identifed immediate action needs to be taken to evaluate the resident for safety. Depending on the resident this may include PT/OT evaluation, resident education, or the	F 684		

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F 684	Continued From page 23 completion of a risk verse benefit form. A policy for PT/OT evaluation and treatment was requested but not provided.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to perform prescribed dressing changes to a pressure ulcer as ordered for 1 of 3 residents (R27) reviewed for pressure ulcers. Findings include: R27's annual Minimum Data Set (MDS) assessment dated 12/20/24, indicated intact cognition. Diagnoses included anemia, coronary artery disease and renal failure. R27 was at risk for pressure ulcers and had an unhealed unstageable pressure ulcer. R27's Medication Administration Record (MAR)	F 686	Immediate Corrective Action: R27 current dressing change order was completed per order. Corrective Action as it applies to others: All residents will be audited to identify if they have wound care orders, and if dressing changes are being completed. Licensed Nurses will be educated on Skin Assessment & Wound Management policy, and completion of treatments per physician order. Skin Assessment &	5/2/25

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F 686	Continued From page 24 dated 3/25, indicated orders were present from 3/7/25 to 3/20/25 to cleanse pressure ulcer with vashe. Loosely fill wound with vashe damped packing strip, ensure filling in tunnel and undermining. Leave out tail for easy removal. Cover with bordered foam dressing. Change twice daily and as needed. R27's MAR dated 3/25 lacked documentation dressing changes were completed on the following days: - Day shift 3/9/25, 3/13/25, 3/14/25, 3/16/25 through 3/18/25, and 3/20/25 - Evening shift 3/8/25 through 3/10/25, 3/14/25 through 3/16/25 R/27's progress notes were reviewed from 3/8/25 through 3/20/25. Progress notes lacked documentation as to why scheduled dressing changes were missed or passed on to the next shift to make sure they were done. During an interview on 3/24/25 at 7:05 p.m., R27 stated there was a pressure ulcer on her coccyx region that nursing was doing dressing changes on. The staff would miss several of the dressing changes since the wound appeared. During an interview on 3/26/25 at 5:08 p.m., trained mediation aide (TMA)-B stated that either the nurse manager or a nurse from 200 hallway would do all of the dressing changes for 100 hallway when a nurse was not assigned. I know everybody is really busy, so I never know when they are done or not done. During an interview on 3/26/25 at 5:19 p.m., licensed practical nurse (LPN)-C stated the nurse	F 686	Wound Management policy reviewed and remains current. Trained Medication Assistants will be educated on needing to notify licensed nurse if treatments need to be completed. Recurrence will be prevented by: Wound Care Completion will be audited on 5 residents weekly x 3 weeks, then monthly x2 months. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Director of Nursing or Designee.	

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F 686	Continued From page 25 on either 200 or 300 hallways would assist 100 hallway with dressing changes when there was not a nurse assigned to 100 hallway. We usually find time to run over to 100 hallway to get the dressing changes done. I can't think of any specific times, but I know there have been times when evening shift has not been able to get 100 hallway dressing changes done. When that would happen, we would report off to the next shift to get the dressing changes done and document in progress report why it was not done. After the next shift completed the dressing change, they would go into the MAR and document the completed dressing change. During an interview on 3/27/25 at 12:48 p.m., registered nurse (RN)-B reviewed R27's MAR and acknowledge several dressing changes were not documented on. Based on the documentation, there is no way to know if the dressing changes were completed. During an interview on 3/27/25 at 1:58 p.m. the director of nursing (DON) stated dressing changes needed to be done as ordered and documented on in the MAR. Facility policy Skin Assessment and Wound Management last revised 2/25 indicated ongoing treatments would be followed as ordered by the provider.	F 686		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the	F 698		5/2/25

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F 698	Continued From page 26 comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to consistently monitor dialysis access site for 1 of 1 resident (R27) reviewed for dialysis care. Findings include: R27's annual Minimum Data Set (MDS) dated 12/20/24, indicated intact cognition. Diagnoses included anemia, end stage renal disease and diabetes. The MDS indicated R27 was on dialysis. R27's care plan dated 9/25/24, indicated R27 had a dialysis port to the right chest. The care plan lacked information related to R27's arteriovenous dialysis fistula in the right arm. R27's Order Summary report dated 2/6/24, indicated orders which included dialysis-monitor chest port post dialysis, dialysis-no IV. Blood draws, blood pressures on right arm. Fistula incision care and monitor dialysis site for bleeding. The order summary lacked to monitor the fistula "bruit and thrill" (swish sound coming from fistula indicating normal function) from fistula. Provider progress note dated 2/18/25, indicated R27 had right upper extremity fistula placed for dialysis on 2/13/25. During an interview on 11/16/25 at 1:24 p.m., licensed practical nurse (LPN)-E stated R32's access site got assessed for bruit, bleeding, and	F 698	Immediate Corrective Action: R27 has active order for dialysis monitoring in Treatment Orders and bruit and thrill were then assessed. Corrective Action as it applies to others: All dialysis residents will be audited to identify if they have dialysis monitoring orders in place and are being assessed for bruit and thrill. Licensed Nurses will be educated on Hemodialysis policy, in regards to monitoring resident dialysis access site for bruit and thrill. Trained Medication Assistants will be educated on notifying a licensed nurse to assess bruit and thrill. Recurrence will be prevented by: Dialysis access site monitoring for bruit and thrill will be audited weekly x3 weeks, and then monthly x2 months for monitoring completion. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Director of Nursing or designee.	

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F 698	Continued From page 27 infection on the day shift but often not on dialysis days because R32 left the facility during the night shift at 5:30 a.m., and often did not return until later in the evening shift. During an interview on 3/27/25 at 9:41 a.m., the dialysis clinical manager (DCM) confirmed R27 had a AV fistula placed on 2/13/25, and was used by the dialysis team for dialysis treatments. The DCM stated the facility should start monitoring the fistula for the bruit and thrill at least daily right after the fistula is placed. Monitoring was important because there would be early warning signs of a potential bigger issue. During an interview on 3/27/25 at 9:57 a.m. trained medication aide (TMA)-A indicated R27 had a new fistula that the dialysis center just started using. TMA-A did not believe the nurse would evaluate the fistula at all. During an interview on 3/27/25 at 12:48 p.m. registered nurse (RN)-B stated staff had not started monitoring R27's fistula for bruit and thrill since the fistula was placed. RN-B was unsure how often the fistula should be monitored. During an interview on 3/27/25 at 1:58 p.m. the director of nursing indicated the bruit and thrill should be monitored per facility policy. The facility dialysis policy was not received.	F 698		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to	F 726		5/2/25

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F 726	Continued From page 28 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 §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure licensed staff were educated and competent in the administration of intravenous medications (IV) and/or the management and care of peripherally inserted central catheters (PICC) [a long thin tube inserted into a vein on the inside of the upper arm that extends into a larger vein leading to the heart for medication, blood, and nutrition administration] for 1 of 1 residents (R200)	F 726	Immediate Corrective Action: R200 had her PICC lumen cap replaced and provider updated on missing lumen cap and air that was found in PICC line during blood draw. Corrective Action as it applies to others: All residents with PICC lines will be	

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F 726	Continued From page 29 reviewed for PICC line care and management. This deficient practice had the potential to impact all residents at the facility who had IV/PICC access and/or received medications through IV/PICC access. Findings include: R200's admission Minimum Data Set (MDS) dated 2/19/25, indicated R200 was cognitively intact with the diagnoses of congestive heart failure, diabetes, and respiratory failure. R200's careplan initiated on 2/18/25, did not include R200's PICC line nor did it include goals and interventions for care of R200's PICC line. The Order Summary Current Orders as of 3/24/25, included the following orders: -PICC/Midline-Change cap (needless access device) weekly with dressing change q wed in am -Vancomycin HCl Intravenous Solution (Vancomycin HCl) use 1500 mg intravenously every 24 hours related to methicillin resistant staphylococcus aureus infection as the cause of disease classified elsewhere (B95.62) for 20 Days. Inject 1500mg in NS over 90 minutes into the vein every 24 hours for 20 days. -PICC/Midline Change dressing location_____(blank) using sterile technique weekly and as needed. Document in progress notes description of care and resident's response to procedure every Wed -PICC/Midline-Measure arm circumference 3 inches above insertion site weekly with dressing change in the morning every Wed -PICC/Midline-Measure total catheter length on dressing change. Location_____(blank) in morning.	F 726	audited to ensure PICC line maintenance has been completed per policy. Flushing Midline and Central Line IV Catheter Policy, Obtaining Blood Specimen From a Venous Catheter Policy and Central Venous Catheter Dressing Policy were reviewed and remain current. LPNs and RNs will be educated on PICC lines including general maintenance and blood draws and will have PICC competencies completed. Recurrence will be prevented by: New hire nurse PICC line competency completion will be audited monthly x3 months. Residents with PICC lines will be audited weekly x3 weeks, then monthly x2 months to identify PICC line maintenance has been completed per policy. Audits and findings will be reported to QAPI committee for further recommendations.¿ Corrections will be monitored by: Director of Nursing or Designee	

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F 726	Continued From page 30 -PICC Line monitor for complaints of unusual sounds near the neck ear or the affected site every shift -PICC/Midline monitor site location_____(blank) every shift for s/s of infection and infiltration every shift During an observation on 3/26/25 at 11:28 a.m., R200's PICC line was covered with a transparent dressing. The end or R200's PICC line did not have a lumen cap on it. R200 stated they had been told it was okay to not have the cap on the PICC line. R200 thought it had been that way for a couple of days. R200 also stated she had had a blood draw yesterday and the nurse had removed about 6 big syringes of air from their PICC line and they were afraid something bad might happen because of all that air. After an observation on 3/26/25 at 11:46 a.m., registered nurse RN-B confirmed R200's PICC line was missing the lumen cap attachment and indicated the missing cap was a concern for infection. RN-B opened the electronic medical record (EMR), and stated R200's cap was changed before R200's antibiotic was started on 3/25/25 at 1:15 p.m. RN-B indicated the cap would have likely been off sometime between the time the antibiotic was discontinued on 3/25/25, and now. During an interview on 3/26/25 at 11:51 a.m., the director of nursing (DON) stated the PICC line should have the lumen cap on the end of the PICC line as it is an infection prevention issue for it to be capless. The DON confirmed R200 was correct, five 10cc syringes of air had been pulled off of R200 PICC line during R200's blood draw completed on 3/25/25. The PICC line gets	F 726		

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F 726	Continued From page 31	F 726		

clamped so they were not sure how the air got in R200's line. The DON indicated the order instructed to flush, and didn't say anything to pull back before the flush, and indicated air could have entered the PICC line with flushing. The DON stated they thought they may need to do some PICC line education with staff. The DON confirmed the air had not been documented or a note made to indicate the provider had been notified of the air in R200's PICC line on 3/26/25.

During an interview on 3/26/25 at 2:51 p.m., the DON stated they had a call out to infectious disease and had notified R200's provider that R200's lumen cap had been off. The DON indicated that it was possible the lumen could have been accidently removed during a flush or something and indicated R200's PICC like should have a lumen cap at the end of it at all times to prevent infection. The DON stated another resident had told the them that R200 was concerned about dying because of the air in their PICC line. They were also concerned about the air as well because of the risk for air embolism. The DON indicated they had updated the provider about the air in R200 line on 3/25/25 and indicated R200 had a follow-up appointment tomorrow, so R200 would see the provider then.

During an interview on 3/26/25 at 3:08 p.m., R200 stated when they first got back from the hospital there was a green cap on the end of the PICC line but the facility didn't use that cap any longer. R200 stated they thought the clear cap (lumen cap) had been missing from their PICC line for a couple of days. R200 stated one day they sent a staff in that said they didn't know about PICC lines but they said they were told to do it anyway. R200 stated they were afraid they were going to

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F 726	Continued From page 32 get killed here with all that air in their line. During an interview on 3/26/25 at 5:12 p.m., RN-A stated when they hooked up R200's antibiotic yesterday, the clear lumen had been attached to R200's PICC. The antibiotic didn't get done until after they had left for the day so another staff would have disconnected the antibiotic when it was done. RN-A stated today when they went to hook up R200's antibiotic, the PICC line would flush, but there was no blood return so R200 was being sent to the emergency room for evaluation of their PICC line. RN-A stated they would definitely contact the provider for any air pulled back from a PICC line that was greater than 4cc because there should not be any air in the PICC line. RN-A stated they had not received any hand off report of R200 having had air in their PICC line on 3/25/25. During an interview on 3/26/25 at 5:37 p.m., RN-B stated RN-A had reported R200's PICC line was not properly functioning. RN-B stated they had talked to R200 to see if they would like to go into to have it assessed or if they would like the nurse at the facility to try Cathflo. R200 had chosen to go to the hospital to have it addressed. During an interview on 3/26/25 at 5:59 p.m., RN consultant (RN-G) stated once they had been made aware R200's PICC line was missing the lumen cap they consulted the nurse practitioner who advised the access area be cleansed and re-capped right away followed by a call to infectious disease. RN-G stated they did as advised and had also successfully pulled back and flushed R200's PICC line after they had attached the new cap.	F 726		

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F 726	Continued From page 33 During an interview on 3/27/25 at 9:39 a.m., licensed practical nurse (LPN-D) stated they never received PICC line training or IV medication administration training, or had they ever completed a hands on or any other competency for PICC lines. They did recall watching a PICC line demonstration at one time. LPN-D confirmed as part of their job they administered IV medications and flushes through PICC lines. During an interview on 3/27/25 at 12:07 p.m., the DON stated they had contacted LPN-A who had disconnected R200's antibiotic on 3/26/25. The DON showed a written statement signed by LPN-A which indicated LPN-A could not say for sure if the lumen cap had been removed when they disconnected R200's antibiotic on 3/26/25, or if the cap was in place when they completed the task. The DON stated the LPN would receive follow-up education on PICC lines. The DON stated air pulled from a PICC line was a serious concern because it could mean a resident was at risk for an air embolism. They would expect any nurse that encountered air in a PICC line to notify the provider and document the event in the progress notes. RNC-D and RNC-G were also present. RNC-D stated the facility did not do a competency for intravenous medication administration or IV and PICC line management when RN's or LPN's were hired, nor was there any education specific to PICC lines, however they had done PICC line review at their skills day with a dummy arm. The facility did not have specific education for PICC lines or competencies for blood draws or PICC line dressing changes. The DON confirmed the facility did not have a competency in place to ensure PICC line management competency or IV medication	F 726		

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F 726	Continued From page 34 competency for RN's or LPNs. The DON indicated they did not have a process to make sure that LPN's were competent to administer IV medications through an IV or PICC line. The DON indicated when a nurse was hired, they were asked what they knew how to do. The DON felt the facility did on the spot training if a nurse did not know how to do a skill related to IV or PICC lines they would be taught on the spot. A list of licensed staff who had performed PICC line care and medication administration to R200's PICC line and their PICC line competencies for PICC line management, dressing changes, blood draws and IV mediation competencies specific to LPNs was requested. The facility identified three LPNs including LPN-A and LPN-D. Five RNs were identified. Information provided included: - The New hire LPN/RN Competency Check List provided by the facility did not include intravenous medication administration nor did it include PICC lines. -The Temporary Agency Staff Orientation Checklist dated 2/12/24, was provided for RN-A. The checklist did not include PICC lines or -The Nurse Annual Skill Fair Competency Checklist listed several areas including IV/PICC line and medication administration however no additional documents were included to indicate what nurses were competent to do regarding IV/PICCs and medication administration. A completed check list dated 6/5/24, was provided for LPN-A, and one RN. -Education and or competency documentation was not provided for the other staff who worked with R200's PICC line. The facility policy Flushing Midline and Central	F 726		

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F 726	Continued From page 35 Line IV Catheters dated May 2022, directed staff to aspirate the CVAD catheter for blood return to confirm patency prior to administration of medication and solutions. The section Complications gave instruction if there is resistance or lack of blood return during flushing stop the flush and consult the IV nurse specialist or provider. The documentation and reporting section both instruct staff to notify the provider if there are any complications. The facility policy Obtaining Blood Specimens From a Venous Catheter dated May 2022, directed staff to notify physician, supervisor, and oncoming shift of any problems or inability to get blood sample. Facility Policies Central Venous Catheter Dressing changes dated May 2022, directed staff to document date and time of dressing change, location and description of site, complications and interventions done, and if flushed: positive blood return and whether needleless connection device or extension tubing was changed. None of the facility policies provided specifically addressed cap changes or how to address air in a PICC line.	F 726		
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.	F 756		5/2/25

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F 756	Continued From page 36 §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. §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 make sure pharmacy recommendations were addressed timely for 2 of 5 residents (R28, R33) reviewed for unnecessary medications. Findings include	F 756	Immediate Corrective Action: R28 and R33 pharmacy recommendations addressed. Corrective Action as it applies to others:	

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F 756	Continued From page 37 R28's quarterly Minimum Data Set (MDS) dated 3/19/25, identified intact cognition, and diagnoses included heart failure, hypertension, and renal failure. R28's order summary report dated 12/12/24, indicated R28 was started on Quetiapine Fumarate oral tablet 25 milligrams (mg) one time daily by mouth for a diagnosis of "other specified anxiety disorders." R28's Consultant Pharmacist Medication Regimen (PMR) Review dated 2/13/25, recommended the facility address the diagnosis for Quetiapine Fumarate. The PMR indicated CMS guidance for antipsychotic utilization in nursing facilities required an FDA approved diagnosis in chart to use the medication which "other specified anxiety was not." The form had not been addressed or signed as completed. During interview on 3/27/25 at 10:43 a.m., the consultant pharmacist (CP) explained monthly medication regimen reviews were done monthly on all residents. CP stated medication regimen reviews were tracked over time and provider responses of accepting or rejecting recommendations were noted. CP stated providers had a month to respond and if there was no response from the provider then the recommendation would be sent again. During interview on 3/27/25 at 12:49 p.m., the director of nursing (DON) stated an expectation for provider to respond to pharmacist medication regimen review recommendations with the next visit, but at least within 30 days.	F 756	Pharmacy recommendations from March and April will be audited for recommendation response, and followed up on as indicated. Nursing Management team will be educated on Consultant Pharmacist Services Provider Requirements in regards to pharmacy recommendations. Consultant Pharmacist Services Provider Requirements reviewed and remains current. Recurrence will be prevented by: Pharmacy Recommendations will be audited monthly x3 months for recommendation follow-up. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Director of Nursing or Designee	

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F 756	Continued From page 38 R33's quarterly MDS dated 12/29/24, identified intact cognition, and diagnoses including sequelae of cerebral infarction (aftereffects of a stroke), dyspnea (shortness of breath), post-traumatic stress disorder (PTSD), rib fracture, chronic kidney disease, protein-calorie malnutrition, depression, and psychosis. R33's order summary report dated 3/27/25, included the following order: -polyvinyl alcohol ophthalmic solution 1.4%- instill one drop in both eyes as needed for dry eyes. Order was written 1/15/25. R33's Consultant Pharmacist Medication Regimen Review dated 2/13/25, recommended the provider to "please add frequency (e.g 4 times a day prn dry eyes) to complete order" for polyvinyl alcohol ophthalmic solution. R33's medical record did not contain a provider response to this recommendation. R33's Consultant Pharmacist Medication Regimen Review dated 3/12/25, recommended the provider to "please add frequency (e.g 4 times a day prn dry eyes) to complete order (repeat)" for polyvinyl alcohol ophthalmic solution. R33's medical record did not contain a provider response to this recommendation. During interview on 3/27/25 at 10:43 a.m., consultant pharmacist (CP) explained monthly medication regimen reviews were done monthly on all residents. CP stated medication regimen reviews were tracked over time and provider responses of accepting or rejecting recommendations were noted. CP stated providers had a month to respond and if there was no response from the provider then the	F 756		

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F 756	Continued From page 39 recommendation would be sent again. During interview on 3/27/25 at 12:49 p.m., director of nursing (DON) stated expectation for provider to respond to pharmacist medication regimen review recommendations. Facility policy Consultant Pharmacist Services Provider Requirements policy was requested but not provided.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	F 757	Immediate Corrective Action:	5/2/25

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F 757	Continued From page 40 facility failed to have an appropriate diagnosis for use of medication for 1 of 5 residents (R28) reviewed for unnecessary medications. Findings include R28's quarterly Minimum Data Set (MDS) dated 3/19/25, identified intact cognition, and diagnoses included heart failure, hypertension, renal failure and post kidney transplant. R28's order summary report dated 12/12/24, indicated R28 was on Tacrolimus Oral 1mg capsule, take one by mouth every 12 hours for health maintenance. During interview on 3/27/25 at 10:43 a.m., the consultant pharmacist (CP) stated medications appropriate for a diagnoses of health maintenance included several different vitamins and minerals that a resident took as a preventative or maintenance dosing program. The CP stated Tacrolimus was an antirejection drug for patients who have received a transplant. The CP reviewed R28's chart and indicated R28 had a history of post kidney transplant and post kidney transplant would have been the appropriate diagnoses for that medication. During interview on 3/27/25 at 12:49 p.m., the director of nursing (DON) stated all medications ordered by providers would have appropriate diagnoses assigned to them. Facility medication policy was not provided.	F 757	R28 has appropriate diagnosis for Tacrolimus Oral 1mg capsule. Corrective Action as it applies to others: All residents will have orders reviewed to identify appropriate diagnosis for medications. Licensed Nurses and Health Information Assistant will be educated on medication and treatment orders policy in regards to linking appropriate diagnosis or indication to medication. Medication and treatment orders policy reviewed and remains current. Recurrence will be prevented by: 5 Resident orders will be audited weekly x3 weeks, and then monthly x2 months for appropriate diagnosis or indication with medications. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Director of Nursing or Designee.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		5/2/25

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F 758	Continued From page 41 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their	F 758		

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F 758	Continued From page 42 rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to have an appropriate diagnosis for use of an antipsychotic for 1 of 5 residents (R28) reviewed for unnecessary medications. In addition, the facility failed to complete orthostatic blood pressure (series of blood pressures taken while lying, sitting, and standing) monitoring for an antipsychotic medication for 1 of 1 residents (R33). Findings include R28's quarterly Minimum Data Set (MDS) dated 3/19/25, identified intact cognition, and diagnoses included heart failure, hypertension, and renal failure. R28's order summary report dated 12/12/24, indicated R28 was started on Quetiapine Fumarate oral tablet 25 milligrams (mg) one time daily by mouth for a diagnosis of "other specified anxiety disorders." R28's Consultant Pharmacist Medication Regimen (PMR) Review dated 2/13/25, recommended the facility address the diagnosis for Quetiapine Fumarate. The PMR indicated CMS guidance for antipsychotic utilization in nursing facilities required an FDA approved	F 758	Immediate Corrective Action: R28 has appropriate diagnosis for Quetiapine Fumarate oral tablet 25 milligrams. R33 has orthostatic blood pressure monitoring order for antipsychotic in Medication Administration Record and was completed. Corrective Action as it applies to others: Residents on antipsychotics will be audited to identify they have an appropriate diagnosis for their medications. Residents on antipsychotics will have an orthostatic blood pressure completed monthly or as indicated per provider order. Licensed Nurses and Trained Medication Aides will be educated on Psychotropic Medication Use Policy in regards to appropriate diagnosis for medications, and monitoring for antipsychotics. Licensed Nurses and Trained Medication Aides will be educated on the Psychotropic Medication Use Policy	

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F 758	Continued From page 43 diagnosis in chart to use the medication which "other specified anxiety disorder" was not. During interview on 3/27/25 at 10:43 a.m., the consultant pharmacist (CP) stated appropriate Food and Drug Administration approved diagnoses included behaviors and disorders that included specific negative behaviors such as delirium, Schizophrenia or anxiety with psychosis. During interview on 3/27/25 at 12:49 p.m., the director of nursing (DON) stated all medications ordered by providers would have appropriate diagnoses assigned to them. R33's quarterly Minimum Data Set (MDS) dated 12/29/24, identified intact cognition, and diagnoses including sequelae of cerebral infarction (aftereffects of a stroke), dyspnea (shortness of breath), post-traumatic stress disorder (PTSD), rib fracture, chronic kidney disease, protein-calorie malnutrition, depression, delirium, and psychosis. MDS also indicated R33 received antipsychotic medication on a routine basis. R33's Order Summary Report dated 3/27/25, identified order for haloperidol tablet 5 milligrams (mg) to be given by mouth twice a day for delirium and psychosis. Report also identified order to monitor orthostatic blood pressure monthly on the 4th and 5th of the month while resident is receiving antipsychotic medications. R33's treatment administration records (TAR) reviewed for October 2024 to March 2025, did not have orthostatic blood pressure readings on the 4th or the 5th of any month. During interview on 3/27/25 at 12:49pm, director	F 758	specific to the need to complete monthly orthostatic blood pressures monthly or as ordered for all residents on antipsychotic medications. Psychotropic Medication Use policy reviewed and remains current. Recurrence will be prevented by: 5 residents on antipsychotics will be audited to identify they have an appropriate diagnosis for their medications and audited for monthly orthostatic blood pressures completion or as ordered for residents weekly x3 weeks, then monthly x2 months. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Director of Nursing or designee.	

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F 758	Continued From page 44 of nursing (DON) stated expectation for staff to follow provider's orders. DON also stated expectation for orthostatic blood pressures to be completed monthly for residents taking an antipsychotic. Facility policy Consultant Pharmacist Services policy was requested but not provided.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		5/2/25

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F 761	Continued From page 45 Based on observation, interview, and document review the facility failed to ensure medications were properly labeled with direction for use for 1 of 1 resident (R13). Findings include: R13's quarterly Minimum Data Set (MDS) assessment dated 2/12/25, indicated R13 had intact cognition. Diagnoses included heart failure, hypertension, and renal insufficiency. R13's Order Summary Report dated 3/29/24, indicated R13 had ordered Diclofenac sodium topical gel, apply 2gms topically to shoulders, upper and mid back 4 times a day. During an observation of R13's room on 3/24/25 at 3:17 p.m., a box with a tube of diclofenac cream was noted on the shelf to the right of the bed. The box and the tube lacked any kind of label with resident name, medication dosage or times to administer. During an interview on 3/24/25 at 3:17 p.m., R13 stated the staff utilize the diclofenac cream on her back and just leave it on the shelf so it would be available when they needed it. During a second observation of R13's room on 3/25/25 at 2:06 p.m., a box with a tube of diclofenac cream was again noted on the shelf to the right of the bed. The box and the tube lacked any kind of label with resident name, medication dosage or times to administer. During an interview on 3/25/25 at 2:10 p.m., licensed practical nurse (LPN)-B stated any medication left at the resident's bedside needed	F 761	Immediate Corrective Action: R13 Diclofenac sodium topical gel removed from resident room and disposed of. Resident has a new tube of Diclofenac sodium topical gel which is labeled with resident identifiers and dosage. Corrective Action as it applies to others: Medication carts will be audited to ensure medications are properly labeled with patient name and direction for use. Licensed Nurses and TMAs will be educated on the Medication and Treatment Order Policy and the need to ensure resident medications are properly labeled per order. Medication and Treatment Order Policy reviewed and remains current. Recurrence will be prevented by: 5 residents medications will be audited weekly x3 weeks then monthly x2 months to identify if medications are properly labeled. Audits and findings will be reported to QAPI committee for further recommendations.¿ Corrections will be monitored by: Director of Nursing or Designee.	

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F 761	Continued From page 46 to have a label with the resident's name, dosage of medication to administer, and frequency to administer so everybody was aware of the correct order. LPN-B entered R13's room and observed the box and tube of diclofenac cream in R13's room. She confirmed there was no label on the box or the tube. Since there was no label on the box or the tube, nobody would know the appropriate dosage or if the resident should have the medication. There was an increased risk of a resident getting a medication not ordered or the incorrect dosage. During an interview on 3/27/25 at 1:54 p.m., the director of nursing (DON) stated any medication left at a resident bedside should have at least the name of the resident, the dosage of medication to give and the frequency the medication should be administered. Facility policy Medication and Treatment Orders last revised 2/24, indicated all ordered medications and treatments would include: a. Name and strength of the drug b. Number of doses, start and stop date, and/or specific duration of therapy. c. Dosage and frequency of administration d. Route of administration e. Clinical condition or symptoms for which the medication is prescribed.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		5/2/25

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F 812	Continued From page 47 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain proper food storage temperature in a unit refrigerator containing resident food. Furthermore, the facility failed to ensure refrigerated food items were properly labeled and dated. This deficient practices had the potential to affect all residents and visitors using unit refigerators to store food. Findings include: During observation on 3/26/25 at 10:41 a.m., unit refrigerator on wing 3 was reviewed. Refrigerator temperature read 50 degrees on both thermometers inside fridge. The following items were found: -french onion dip container with expiration date of November 11, 2024. -package of sliced cheese labeled with resident name without opened on date. -package of sliced deli meat labeled with resident name without opened on date. -large bottle of pedialyte beverage labelled with	F 812	Immediate Corrective Action: Unit 3 refrigerator was removed and replaced, perishable food items in refrigerator were disposed of due to unproper food storage temperature. Corrective Action as it applies to others: Unit refrigerators will be audited to identify if temperature log sheets are on refrigerator, and temperatures are within range. Refrigerators will also be audited for proper labeling and dates on food. All staff will be educated on Food Receiving and Storage policy in regards to resident food items needing to be labeled and dated in refrigerator, and refrigerator temperatures needing to be completed daily and if out of range to alert the administrator immediately. Food Receiving and Storage policy reviewed	

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F 812	Continued From page 48 open date of 11/25/24 and name of resident that discharged in December of 2024. During followup observation on 3/26/25 at 3:32 p.m., unit refrigerator on wing 3 was reviewed. Refrigerator temperature read 50 degrees on both thermometers inside fridge. During interview on 3/26/25 at 3:34 p.m., nursing assistant (NA)-B verified both thermometers inside unit refrigerator on wing 3 read 50 degrees. During interview on 3/26/25 at 3:48 p.m., registered nurse (RN)-B verified contents of unit refrigerator on wing 3. RN-B further verified temperature on both internal thermometers read 50 degrees. RN-B stated 50 degrees was too warm for safe food storage and all perishable foods from the fridge would be thrown out. RN-B stated staff should have made a maintenance request to have the fridge looked at due to high temperaure. During observation on 3/27/25 at 7:23 a.m., unit refrigerator on wing 3 had been removed from the unit. During interview on 3/27/25 at 1:04 p.m., administrator stated unit refrigerator from wing 3 had been removed for resident safety. Administrator confirmed 50 degrees to be an unsafe temperature for food storage as it could increase the chances for food-borne illness and adverse effects. Administrator also stated expectation for staff to label resident food with date and resident name. Undated Refrigerators and Freezers policy identified 'acceptable temperature ranges are 35	F 812	and remains current. Recurrence will be prevented by: Unit refrigerators will be audited weekly x3 weeks, and then monthly x2 months to identify if refrigerator temperatures are within range, and resident food items properly dated and labeled. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Culinary Director or designee.	

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F 812	Continued From page 49 degrees to 40 degrees for refrigerators.' Policy stated 'supervisor will take immediate action if temperatures are out of range.' Policy further identified 'all food shall be properly dated.'	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		5/2/25

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F 880	Continued From page 50 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based observation, interview and record review the facility failed to ensure nebulizer equipment was properly washed, dried and stored for 2 of 2 residents (R29, R14); that equipment for tube feeding tube flushes was properly dated, rinsed,	F 880	Immediate Corrective Action: R29, and R14 had nebulizer equipment properly washed, dried and stored.	

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F 880	Continued From page 51 dried and stored for 1 of 1 residents (R16); and the facility failed to ensure proper PICC line cap placement occured for 1 of 1 resident (R200) who were reviewed for infection prevention and control. Findings include: R29: R29's quarterly MDS dated 3/4/25 indicate R29 was cognitively intact. Diagnoses included anxiety, depression and post-traumatic stress disorder. R29's Medication Admin Audit Report dated 3/27/25, indicated R29 had orders for Ipratopium-albuterol inhalation solution 0.5-2.5mg inhaled 4 times a day. On 3/26/25, a dose had been set up at 11:38 a.m. During an observation on 3/24/25 at 6:40 p.m., a nebulizer cannister was observed full of a liquid substance. During a second observation on 3/26/25 at 12:53 p.m., again a nebulizer cannister was observed full of liquid substance, not running, and no medical staff with him. At that time R29 turned on the nebulizer machine and started administering the liquid in the nebulizer cannister. During an interview on 3/26/25 at 12:56 p.m., LPN-B entered R29's room and confirmed R29 had a full canister of liquid in the cannister he was administering medication with. LPN-B reviewed R29's medication administration record (MAR) and stated the last documented administration of inhaled nebulizer medication was done at 11:38	F 880	R16 equipment for tube feeding tube flushes replaced. R200 had her PICC lumen cap replaced and provider updated on missing lumen cap and air that was found in PICC line during blood draw. Corrective Action as it applies to others: All residents will be audited to identify who uses a nebulizer, and their nebulizer equipment will be audited to identify if they are properly washed, dried and stored. All residents will be audited to identify who is currently on a tube feeding and audit equipment for tube flushes to identify if they are properly dated, rinse, dried and stored. All residents with PICC lines will be audited to ensure PICC line maintenance has been completed per policy. Licensed Nurses and Trained Medication Assistants will be educated on Oral Inhalation Administration Policy in regards to how to properly wash, dry, and store nebulizer equipment. Licensed Nurses will be educated on Enteral Tube Feeding via Syringe Policy and how to handle tube feeding equipment when flushing to ensure supplies are properly dated, rinsed, dried, and stored.	

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F 880	Continued From page 52 a.m. and not at the current time. LPN-B stated based on the amount of liquid in the cannister R29 had just started the nebulizer at the current time and not at the 11:38 a.m, which meant fluid had sat in the nebulizer cannister for over an hour, not moving, which increased the risk of infectious disease. During an interview on 3/27/25 at 1:54 p.m., the director of nursing (DON) stated the facility staff should follow the infection control protocols related to nebulizer treatments and cleaning. The facility Oral Inhalation Administration policy dated 5/22, indicated medication should be given right after setup. After medication is given rinse and disinfect the nebulizer equipment according to manufacturer's recommendations, or wash pieces with warm water, rinse with hot water and allow to air dry. R14: R14's Minimum Data Set (MDS) dated 2/5/25, indicated R16 was moderately cognitively impaired with the diagnoses of heart failure, end stage renal disease with dialysis, diabetes and respiratory failure. R14's care plan last reviewed 2/19/25, indicated R14 was at risk for alteration in oxygen/gas exchange due to their respiratory status with the goal of adequate gas exchange: no cyanosis, freedom from shortness of breath, oxygen saturations greater than 90%, and normal respiratory pattern. Interventions included administration of Inhaler per MD order and notification of provider with respiratory changes.	F 880	LPNs and RNs will be educated on PICC lines including general maintenance and blood draws and will have PICC competencies completed. Flushing Midline and Central Line IV Catheter Policy, Obtaining Blood Specimen From a Venous Catheter Policy and Central Venous Catheter Dressing Policy were reviewed and remain current. Recurrence will be prevented by: 5 residents with nebulizers will be audited weekly x3 weeks, then monthly x2 months to ensure they are properly washed, dried and stored. Residents who are tube fed will be audited weekly x3 weeks, then monthly x2 months to ensure tube feeding flushing supplies are properly dated, rinse, dried, and stored. New hire nurse PICC line competency completion will be audited monthly x3 months. Residents with PICC lines will be audited weekly x3 weeks, then monthly x2 months to identify PICC line maintenance has been completed per policy. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Director of Nursing or Designee.	

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F 880	Continued From page 53 R14's Order Summary Report Active orders as of 3/27/25, included the following orders: -Ipratropium-albuterol inhalation solution 0.5-2.5 (3) 3mg/3ml, 3 ml inhale orally via nebulizer (neb) every 4 hours as needed for shortness of breath. -Ipratropium-albuterol inhalation solution 0.5-2.5 (3) 3mg/3ml, 3 ml inhale orally via nebulizer every 4 hours as needed for shortness of breath. Give before dialysis on Monday, Wednesday, and Friday. -Change oxygen tubing and mask weekly every Saturday. -Rinse and dry nebulizer cup after each nebulizer treatment During an observation on 3/24/25 at 3:28 p.m., R14's bed was unmade. R16 pointed to the foot of their bed where there was a nebulizer treatment unit sitting directly on the bed sheet and stated they received neb treatments for breathing. The Neb treatment unit and mask were directly on the bed and the neb cup had liquid and moisture droplets on the sides of the cup. The tubing unit was not dated. During an observation on 3/25/25 at 2:11 p.m., R14's nebulizer treatment unit cord could be seen, the rest of the unit was on the bed with bed covers and a pillow over it. During an observation on 3/25/25 at 3:31 p.m., R14's nebulizer treatment unit and tubing was still at the foot of R14's unmade bed. The medication cup had fluid in it. During an observation on 3/26/25 at 8:24 a.m., R14's nebulizer treatment machine power cord was visible at the foot of the bed, the rest of the unit was covered with bedding.	F 880		

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F 880	Continued From page 54 During an interview at 3/26/25 on 11:19 a.m., R14 stated they had had a neb treatment early in the morning but not recently. R14 lifted up their bed coverings to show the neb treatment unit at the foot of the bed. The medication cup was dated 3/24, and there was liquid in the nebulizer cup. During an observation on 3/27/25 at 7:23 a.m., R14's nebulizer treatment machine was laying at the foot of R14's bed. The medication cup had been removed. There was a short tube connected to the machine and the other end was open to air and laying on R200's mattress at the foot of the bed. During an interview on 3/26/25 at 2:12 p.m., RN-A pulled up R14's MAR and stated R14 had had a nebulizer treatment last on 3/26/25 at 5:48 a.m. RN-A stated there was also an order on the medication administration record to sign off on for cleaning and letting the nebulizer treatment supplies air dry. RN-A went into R14's room and noted R14's nebulizer treatment had liquid in the administration cup. RN-A stated this should have been removed, cleaned and left to air dry and indicated they were going to take care of it. RN-A stated it was important to clean after each use because leaving moisture in the cup created a risk for respiratory infection. During an interview on 3/27/25 at 10:04 a.m., RN-B stated once a nebulizer treatment is done, staff should disconnect the tubing from the machine, rinse the medication cup, and then let it dry. RN-B stated it was important to do this after each use to prevent potential respiratory infections. In a perfect world the nebulizer unit should not be stored at the foot of a resident's	F 880		

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F 880	Continued From page 55 bed. During an interview on 3/27/25 at 12:26 p.m., the DON stated after each nebulizer administration it should be rinsed and left to air dry. This was also one of R14's orders. The DON indicated there are lots of infection risks associated with nebulizer treatments. Lack of cleaning between uses could lead to bacteria growth in the tubing unit which could lead to thrush or growth of other forms of bacteria that could go directly into the lungs when used without cleaning. R14's unit should not be stored on the foot of R14's bed between uses. The facility policy Oral Inhalation Administration dated May 2022, directed staff to rinse and disinfect the nebulizer equipment according to manufacturer recommendation and once equipment was completely dry, store in plastic bag with the resident's name and date on it. R16: R16's quarterly Minimum Data Set (MDS) dated 3/11/25, indicated R16 was cognitively intact with the following diagnoses: multiple myeloma, diabetes with neuropathy, heart disease and end stage renal disease. R'16 careplan last updated 3/19/25, included the following interventions for R16's PEG tube maintenance: -fluid flushes per order -monitor PEG tube site for signs and symptoms of infection -PEG tube cares per protocol -change tube feeding bag and syringe every 24 hours.	F 880		

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F 880	Continued From page 56 R16's Order Summary dated 3/27/25 included: -free water flushes 150 ml [milliliters] for a total of 600 ml of fluid via tube per day -GJ Tube-clean area and cover with split dressing every day. R16' electronic medical record lacked evidence to show the syringe and graduated cylinder used for R16's tube feeding water administration were/had been dated and replaced every 24 hours. During an interview on 3/24/25 at 6:22 p.m., R16 stated the nurses are supposed to change my dressing every day and flush my tube feeding tube a couple times a day. There was an undated graduated cylinder partially filled with water with an undated syringe sitting in it on R16 nightstand. R16 stated they usually had to ask for the dressing to be done unless registered nurse RN-A or licensed practical nurse (LPN-A) were working because they just did it. During an observation on 3/25/25 at 3:31 p.m., R16's graduated cylinder was dated 3/25/25. The cylinder contained water and an undated syringe. During an observation on 3/26/25 at 8:21 a.m., R16's graduated cylinder was dated 3/25/25. The cylinder contained water and an undated syringe. During an observation on 3/26/25 at 2:23 p.m., R16's graduated cylinder was still dated 3/25/25. The cylinder contained water and an undated syringe. During an observation on 3/27/25 at 7:27 a.m., R16's graduated cylinder was dated 3/25/25. The cylinder contained water and an undated syringe. During an interview on 3/27/25 at 8:27 a.m., R16 stated when staff were done putting water in their tube feeding tube staff didn't do anything special	F 880		

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	245495	A. BUILDING _____ B. WING _____	C 03/27/2025

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F 880	Continued From page 57 with the stuff, they just put the water holder (graduated cylinder) back on the nightstand with the syringe in it. During an interview on 3/27/25 at 10:07 a.m., RN-B stated the graduated cylinder, and syringe should be changed out per policy. RN-B stated they would have to review the policy to know how frequently staff should be exchanging the syringe and graduated cylinder, however, staff should not be leaving the syringe siting in water in the graduated cylinder. For infection prevention reasons, the cylinder and syringe should be left to air dry after use, and the policy should be followed. During an observation on 3/27/25 at 12:51 p.m., R16's graduated cylinder was dated 3/25/25. The cylinder contained water and an undated syringe. During an interview on 3/27/25 12:29 p.m., with the director of nursing (DON) and registered nurse consultants (RN-D) and RN-G. RN-D pulled up the facility policy and stated per policy the graduated cylinder should be left to air dry between uses and changed out daily. The DON stated the syringe should be pulled apart and left to air dry after use. It was an expectation staff would follow the policy for resident safety and infection prevention. During an observation on 3/27/25 at 1:50 p.m., R16's graduated cylinder was dated 3/25/25. The cylinder contained water and an undated syringe. The facility policy Enteral Feeding via Syringe (Bolus) dated 3/2024, instructed staff to make bolus syringe was labeled with the resident's name and marked with date and marked with	F 880		

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F 880	Continued From page 58 date and time and if date and time were greater than 24 hours the syringe should be disposed of, and new supplies should be obtained. The syringe should be rinsed with hot water and dried and stored in designated area. R200: R200's admission Minimum Data Set (MDS) dated 2/19/25, indicated R200 was cognitively intact with the diagnoses of congestive heart failure, diabetes, and respiratory failure. R200's Order Summary Current Orders as of 3/24/25, included the following orders: -PICC/Midline-Change cap (needless access device) weekly with dressing change q wed in am -Vancomycin HCl Intravenous Solution (Vancomycin HCl) use 1500 mg intravenously every 24 hours related to methicillin resistant staphylococcus aureus infection as the cause of disease classified elsewhere (B95.62) for 20 Days. Inject 1500mg in NS over 90 minutes into the vein every 24 hours for 20 days. During an observation on 3/26/25 at 11:28 a.m., R200's PICC line was covered with a transparent dressing. The end or R200's PICC line did not have a lumen cap on it. R200 stated they had been told it was okay to not have the cap on the PICC line. R200 thought it had been that way for a couple of days. After an observation on 3/26/25 at 11:46 a.m., registered nurse RN-B confirmed R200's PICC line was missing the lumen cap attachment and indicated the missing cap was a concern for infection. RN-B opened the electronic medical record (EMR), and stated R200's cap was	F 880		

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F 880	Continued From page 59	F 880		

changed before R200's antibiotic was started on 3/25/25 at 1:15 p.m. RN-B indicated the cap would have likely been off sometime between the time the antibiotic was discontinued on 3/25/25, and now.

During an interview on 3/26/25 at 2:51 p.m., the director of nursing (DON) stated they had a call out to infectious disease and had notified R200's provider that R200's lumen cap had been off. The DON indicated that it was possible the lumen could have been accidently removed during a flush or something and indicated R200's PICC like should have a lumen cap at the end of it at all times to prevent infection.

During an interview on 3/26/25 at 3:08 p.m., R200 stated when they first got back from the hospital there was a green cap on the end of the PICC line but the facility didn't use that cap any longer. R200 stated they thought the clear cap (lumen cap) had been missing from their PICC line for a couple of days. R200 stated one day they sent a staff in that said they didn't know about PICC lines but they said they were told to do it anyway. R200 stated they had been worried about their PICC line.

During an interview on 3/26/25 at 5:12 p.m., RN-A stated when they hooked up R200's antibiotic yesterday, the clear lumen had been attached to R200's PICC. The antibiotic didn't get done until after they had left for the day so another staff would have disconnected the antibiotic when it was done.

During an interview on 3/26/25 at 5:59 p.m., RN consultant (RNC-A) stated once they had been made aware R200's PICC line was missing the

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F 880	Continued From page 60 lumen cap they consulted the nurse practitioner who advised the access area be cleansed and re-capped right away followed by a call to infectious disease. RNC-A stated they did as advised and had also successfully pulled back and flushed R200's PICC line after they had attached the new cap. During an interview on 3/27/25 at 9:39 a.m., licensed practical nurse (LPN-D) stated they never received picc line training or iv medication administration training, or had they ever completed a hands on or any other competency for PICC lines, but they did recall watching a PICC line demonstration. LPN-D confirmed as part of their job they administered iv medications and flushes through PICC lines. During an interview on 3/27/25 at 12:07 p.m., the DON stated they had contacted LPN-A who had disconnected R200's antibiotic on 3/26/25. The DON showed a written statement signed by LPN-A which indicated LPN-A could not say for sure if the lumen cap had been removed when they disconnected R200's antibiotic on 3/26/25, or if the cap was in place when they completed the task. The DON stated the LPN would receive follow-up education on PICC lines.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 14, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: ERB311

Dear Administrator:

The above facility was surveyed on March 24, 2025 through March 27, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Cell: 651-279-5375 Office: 218-302-6186

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 03/27/2025

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/24/25 to 3/27/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H54951640C(MN00110112). NO citations were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	2 000		

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2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure licensed staff were educated and competent in the administration of intravenous medications (IV) and/or the management and care of peripherally inserted central catheters (PICC) [a long thin tube inserted into a vein on the inside of the upper arm that extends into a larger vein leading to the heart for medication, blood, and nutrition administration] for 1 of 1 residents (R200) reviewed for PICC line care and management. This deficient practice had the potential to impact all residents at the facility who had IV/PICC access and/or received medications through IV/PICC access. Findings include: R200's admission Minimum Data Set (MDS)	2 300	Corrected.	5/2/25

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2 300	Continued From page 3 dated 2/19/25, indicated R200 was cognitively intact with the diagnoses of congestive heart failure, diabetes, and respiratory failure. R200's careplan initiated on 2/18/25, did not include R200's PICC line nor did it include goals and interventions for care of R200's PICC line. The Order Summary Current Orders as of 3/24/25, included the following orders: -PICC/Midline-Change cap (needless access device) weekly with dressing change q wed in am -Vancomycin HCl Intravenous Solution (Vancomycin HCl) use 1500 mg intravenously every 24 hours related to methicillin resistant staphylococcus aureus infection as the cause of disease classified elsewhere (B95.62) for 20 Days. Inject 1500mg in NS over 90 minutes into the vein every 24 hours for 20 days. -PICC/Midline Change dressing location_____(blank) using sterile technique weekly and as needed. Document in progress notes description of care and resident's response to procedure every Wed -PICC/Midline-Measure arm circumference 3 inches above insertion site weekly with dressing change in the morning every Wed -PICC/Midline-Measure total catheter length on dressing change. Location_____(blank) in morning. -PICC Line monitor for complaints of unusual sounds near the neck ear or the affected site every shift -PICC/Midline monitor site location_____(blank) every shift for s/s of infection and infiltration every shift During an observation on 3/26/25 at 11:28 a.m., R200's PICC line was covered with a transparent dressing. The end or R200's PICC line did not	2 300		

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2 300	Continued From page 4 have a lumen cap on it. R200 stated they had been told it was okay to not have the cap on the PICC line. R200 thought it had been that way for a couple of days. R200 also stated she had had a blood draw yesterday and the nurse had removed about 6 big syringes of air from their PICC line and they were afraid something bad might happen because of all that air. After an observation on 3/26/25 at 11:46 a.m., registered nurse RN-B confirmed R200's PICC line was missing the lumen cap attachment and indicated the missing cap was a concern for infection. RN-B opened the electronic medical record (EMR), and stated R200's cap was changed before R200's antibiotic was started on 3/25/25 at 1:15 p.m. RN-B indicated the cap would have likely been off sometime between the time the antibiotic was discontinued on 3/25/25, and now. During an interview on 3/26/25 at 11:51 a.m., the director of nursing (DON) stated the PICC line should have the lumen cap on the end of the PICC line as it is an infection prevention issue for it to be capless. The DON confirmed R200 was correct, five 10cc syringes of air had been pulled off of R200 PICC line during R200's blood draw completed on 3/25/25. The PICC line gets clamped so they were not sure how the air got in R200's line. The DON indicated the order instructed to flush, and didn't say anything to pull back before the flush, and indicated air could have entered the PICC line with flushing. The DON stated they thought they may need to do some PICC line education with staff. The DON confirmed the air had not been documented or a note made to indicate the provider had been notified of the air in R200's PICC line on 3/26/25.	2 300		

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2 300	Continued From page 5 During an interview on 3/26/25 at 2:51 p.m., the DON stated they had a call out to infectious disease and had notified R200's provider that R200's lumen cap had been off. The DON indicated that it was possible the lumen could have been accidently removed during a flush or something and indicated R200's PICC like should have a lumen cap at the end of it at all times to prevent infection. The DON stated another resident had told the them that R200 was concerned about dying because of the air in their PICC line. They were also concerned about the air as well because of the risk for air embolism. The DON indicated they had updated the provider about the air in R200 line on 3/25/25 and indicated R200 had a follow-up appointment tomorrow, so R200 would see the provider then. During an interview on 3/26/25 at 3:08 p.m., R200 stated when they first got back from the hospital there was a green cap on the end of the PICC line but the facility didn't use that cap any longer. R200 stated they thought the clear cap (lumen cap) had been missing from their PICC line for a couple of days. R200 stated one day they sent a staff in that said they didn't know about PICC lines but they said they were told to do it anyway. R200 stated they were afraid they were going to get killed here with all that air in their line. During an interview on 3/26/25 at 5:12 p.m., RN-A stated when they hooked up R200's antibiotic yesterday, the clear lumen had been attached to R200's PICC. The antibiotic didn't get done until after they had left for the day so another staff would have disconnected the antibiotic when it was done. RN-A stated today when they went to hook up R200's antibiotic, the PICC line would flush, but there was no blood return so R200 was being sent to the emergency room for evaluation	2 300		

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2 300	Continued From page 6 of their PICC line. RN-A stated they would definitely contact the provider for any air pulled back from a PICC line that was greater than 4cc because there should not be any air in the PICC line. RN-A stated they had not received any hand off report of R200 having had air in their PICC line on 3/25/25. During an interview on 3/26/25 at 5:37 p.m., RN-B stated RN-A had reported R200's PICC line was not properly functioning. RN-B stated they had talked to R200 to see if they would like to go into to have it assessed or if they would like the nurse at the facility to try Cathflo. R200 had chosen to go to the hospital to have it addressed. During an interview on 3/26/25 at 5:59 p.m., RN consultant (RN-G) stated once they had been made aware R200's PICC line was missing the lumen cap they consulted the nurse practitioner who advised the access area be cleansed and re-capped right away followed by a call to infectious disease. RN-G stated they did as advised and had also successfully pulled back and flushed R200's PICC line after they had attached the new cap. During an interview on 3/27/25 at 9:39 a.m., licensed practical nurse (LPN-D) stated they never received PICC line training or IV medication administration training, or had they ever completed a hands on or any other competency for PICC lines. They did recall watching a PICC line demonstration at one time. LPN-D confirmed as part of their job they administered IV medications and flushes through PICC lines. During an interview on 3/27/25 at 12:07 p.m., the DON stated they had contacted LPN-A who had	2 300		

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2 300	Continued From page 7 disconnected R200's antibiotic on 3/26/25. The DON showed a written statement signed by LPN-A which indicated LPN-A could not say for sure if the lumen cap had been removed when they disconnected R200's antibiotic on 3/26/25, or if the cap was in place when they completed the task. The DON stated the LPN would receive follow-up education on PICC lines. The DON stated air pulled from a PICC line was a serious concern because it could mean a resident was at risk for an air embolism. They would expect any nurse that encountered air in a PICC line to notify the provider and document the event in the progress notes. RNC-D and RNC-G were also present. RNC-D stated the facility did not do a competency for intravenous medication administration or IV and PICC line management when RN's or LPN's were hired, nor was there any education specific to PICC lines, however they had done PICC line review at their skills day with a dummy arm. The facility did not have specific education for PICC lines or competencies for blood draws or PICC line dressing changes. The DON confirmed the facility did not have a competency in place to ensure PICC line management competency or IV medication competency for RN's or LPNs. The DON indicated they did not have a process to make sure that LPN's were competent to administer IV medications through an IV or PICC line. The DON indicated when a nurse was hired, they were asked what they knew how to do. The DON felt the facility did on the spot training if a nurse did not know how to do a skill related to IV or PICC lines they would be taught on the spot. A list of licensed staff who had performed PICC line care and medication administration to R200's PICC line and their PICC line competencies for PICC line management, dressing changes, blood	2 300		

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2 300	Continued From page 8 draws and IV mediation competencies specific to LPNs was requested. The facility identified three LPNs including LPN-A and LPN-D. Five RNs were identified. Information provided included: - The New hire LPN/RN Competency Check List provided by the facility did not include intravenous medication administration nor did it include PICC lines. -The Temporary Agency Staff Orientation Checklist dated 2/12/24, was provided for RN-A. The checklist did not include PICC lines or -The Nurse Annual Skill Fair Competency Checklist listed several areas including IV/PICC line and medication administration however no additional documents were included to indicate what nurses were competent to do regarding IV/PICCs and medication administration. A completed check list dated 6/5/24, was provided for LPN-A, and one RN. -Education and or competency documentation was not provided for the other staff who worked with R200's PICC line. The facility policy Flushing Midline and Central Line IV Catheters dated May 2022, directed staff to aspirate the CVAD catheter for blood return to confirm patency prior to administration of medication and solutions. The section Complications gave instruction if there is resistance or lack of blood return during flushing stop the flush and consult the IV nurse specialist or provider. The documentation and reporting section both instruct staff to notify the provider if there are any complications. The facility policy Obtaining Blood Specimens From a Venous Catheter dated May 2022, directed staff to notify physician, supervisor, and oncoming shift of any problems or inability to get	2 300		

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2 300	Continued From page 9 blood sample. Facility Policies Central Venous Catheter Dressing changes dated May 2022, directed staff to document date and time of dressing change, location and description of site, complications and interventions done, and if flushed: positive blood return and whether needleless connection device or extension tubing was changed. None of the facility policies provided specifically addressed cap changes or how to address air in a PICC line. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise and implement policies and procedures related to nursing oversight and implement a training program for newly hired nursing staff. The administrator or designee should ensure oversight is provided to ensure appropriate competency and orientation is provided upon hire, yearly, and as needed. The director of nursing or designee, should re-educate staff on the policies and procedures and have a system for evaluating and monitoring consistent implementation of these policies, with results of those audits being brought to the facility's Quality Assurance Committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 300		
2 620	MN Rule 4658.0445 Subp. 4 A-N Clinical Record; Admission Information Subp. 4. Admission information. Identification information must be collected and maintained for	2 620		5/2/25

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2 620	Continued From page 10 each resident upon admission and must include, at a minimum: A. the resident's legal name and preferred name; B. previous address; C. social security number; D. gender; E. marital status; F. date and place of birth; G. date and hour of admission; H. advance directives, & Do Not Resuscitate (DNR) & Do Not Intubate (DNI) status, if any; I. name, address, and telephone number of designated relative or significant other, if any; J. name, address, and telephone number of person to be notified in an emergency; legal representative, designated representative, or representative payee, if any; K. legal representative, designated representative, or representative payee, if any; L. religious affiliation, place of worship, and clergy member; M. hospital preference; and N. name of attending physician. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure advanced directives for emergency care and treatment were accurately reflected in all areas of the medical chart to ensure resident wishes would be implemented correctly in an emergent situation for 1 of 16 residents (R200) reviewed for advanced directives.	2 620	Corrected.	

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2 620	Continued From page 11 Findings include: R200's admission Minimum Data Set (MDS) dated 2/19/25, indicated R200 was cognitively intact with the diagnoses of congestive heart failure, diabetes, and respiratory failure. R200's careplan initiated on 2/18/25, included the focus area Current Code Status: see current POLST [Physician Orders for Life Sustaining Treatment]. Interventions included review advanced directives per resident and or family request and arrange for MD consult as necessary. During record review on 3/24/25 at 4:48 p.m., R200's scanned in POLST dated 3/18/25, signed by the provider on 3/20/25, directed do not resuscitate (DNR). However, the order entered in the chart on 3/18/25, was for Cardiopulmonary resuscitation (CPR) and R200's banner also instructed CPR. During an interview on 3/24/25 at 6:27 p.m., R200 stated they had been asked if they had a living will when they returned to the facility. R200 stated they had told staff they didn't want CPR at the facility, they only wanted to die once. R200 indicated they had family members that had broken ribs and didn't do good after CPR. R200 stated they didn't want brain damage or to be worse off after. They would be a full code if they were having a procedure done at the hospital but otherwise they wanted to be DNR. During an interview on 3/24/25 at 6:04 p.m., RN-A stated for an un-responsive resident they would go to the electronic medical record and look at the code status there to know what to do. RN-A opened R200's EMR and stated R200's POLST	2 620		

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2 620	Continued From page 12 was DNR, but the banner and order were for CPR. RN-A stated they would have done CPR on R200 based on the banner, so in that instance the wrong things would have happened because the order and the banner were entered incorrectly based on the POLST. During an interview on 3/24/25 at 6:11 p.m., LPN-A stated to determine a resident code status they would look at the facesheet and if it was not there they would look at the banner because it was quickest. LPN-A opened R200's chart and stated based on the banner they would start CPR on R200 if they found R200 unresponsive. LPN-A confirmed R200's banner and chart did not match and stated they would contact the provider or supervisor to determine what action to take when the POLST and banner did not match. During an interview on 3/24/25 at 6:02 p.m., LPN-C stated they always went to the main EMR screen to determine a resident's code status. LPN-C opened a EMR record and pointed to the banner and code status location. LPN-C stated they only went to the POLST to look at code status if the banner status was empty. During an interview on 3/24/25 at 6:03 p.m., LPN-B stated on admit the POLST reviewed with the resident and once the resident signed the POLST their status was entered on the EMR banner. It then went to the HUC so it could be signed by the provider and scanned in. The POLST and the order/banner should match. If a resident stopped breathing, staff can go to the banner for the code status. During an interview on 3/24/25 at 6:56 p.m., the director of nursing (DON) stated as a health care professional it is a number one priority to make	2 620		

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2 620	Continued From page 13 sure residents are safe and that their wishes are respected and honored. The DON stated the facility had a process in place to honor resident's wishes and ensure their code status was correctly documented. The banner is a quick place for nurses to identify if CPR should be implemented. In R200's situation because the banner did not match the order, if R200 had coded and received CPR, R200's wishes would not have honored. CPR could have also resulted in negative consequences for R200. With CPR, R200's medical condition could have potentially been worsened after CPR resulting in a lower quality of life for R200 post CPR. During an interview on 3/24/25 at 7:17 p.m., RN-B stated they corrected R200's order and banner to reflect R200's POLST which showed R200 wanted to be a DNR. RN-B stated they expected staff to look at the EMR banner for a resident's code status. RN-B confirmed R200 would have likely received CPR if they had coded prior to the banner and order being corrected. RN-B explained performing CPR on a resident who did not want it could be bad for the resident depending on the outcome. CPR could result in pain, broken ribs, and possibly medical deficits that were not there prior to CPR. During an interview on 3/24/25 at 7:27 p.m., the administrator stated respecting the wishes of the resident was very important and indicated the team had corrected R200's code status as soon as they had been made aware of the error. The administrator indicated the facility had a process in place to get the resident's wishes regarding code status at the time of admission and then an order and banner status in place so that resident wishes could be honored as soon as they were known, while waiting for the final POLST to be	2 620		

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2 620	Continued From page 14 completed. The administrator indicated that their HUC completed weekly audits on code status for all residents, however they had just completed an audit on all residents in the building due to the error on R200's code status. They had fixed R200's code status as soon as they were made aware of the discrepancy, had audited code status for the whole building, and had began staff education. On 3/24/25 at 7:38 p.m., R200's banner and orders were reviewed and indicated R200's code status was now listed as DNR. On 3/25/25 at 9:00 a.m., the HUC stated they were responsible for scanning the POLST into the chart, they did not update the banner, nurses did that. The HUC indicated they had started to do code status audits weekly at the facility on the second week of February 2025. Their process was to go through every resident. They started with review of the code status on the banner and then made sure the POLST was signed, correctly completed and matched the banner and order. The HUC's audit book showed several completed weekly audits. The audit completed on 3/18/25, listed R200 as being in the hospital. The HUC indicated they had not completed their audit for this week yet, but if there was a discrepancy it would be found during the audit. During a follow-up interview on 3/25/25 at 8:54 a.m., RN-A stated they had notified the social worker R200's code status and POLST did not match once they had been made aware of it. RN-A stated they had checked R200's chart at shift start this a.m. and R200's code status had been fixed. The facility policy POLST documentation dated	2 620		

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2 620	Continued From page 15 12/2024, indicated the purpose of the POLST was to identify and document the code status consistent with the resident wishes so that staff know immediately what action to take or not take when an emergency arises. The policy identified a process for managing code status orders and the POLST and indicated routine audits of the POLST documentation should be conducted. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review policies and procedures for advanced directives, physician orders and/or a POLST to ensure records a re consistent and maintained accurate throughout the medical record upon admission, quarterly, and with any significant change such as the election of a hospice benefit. The DON should also ensure a process for inputting this changed data appropriately into the electronic medical record. Staff should be educated on the need to clarify discrepancies in advanced directives, POLST, and/or physician orders. The DON or designee should review the resident affected, and all other current residents to ensure accuracy of code status and audit any newly admitted resident EMR. The results of those audits should go to the Quality Assurance Performance Improvement (QAPI) committee for a specific time until compliance is achieved and maintained to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 620		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers	2 900		5/2/25

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2 900	Continued From page 16 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to perform prescribed dressing changes to a pressure ulcer as ordered for 1 of 3 residents (R27) reviewed for pressure ulcers. Findings include: R27's annual Minimum Data Set (MDS) assessment dated 12/20/24, indicated intact cognition. Diagnoses included anemia, coronary artery disease and renal failure. R27 was at risk for pressure ulcers and had an unhealed unstageable pressure ulcer. R27's Medication Administration Record (MAR) dated 3/25, indicated orders were present from 3/7/25 to 3/20/25 to cleanse pressure ulcer with vashe. Loosely fill wound with vashe damped packing strip, ensure filling in tunnel and undermining. Leave out tail for easy removal.	2 900	Corrected.	

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2 900	Continued From page 17 Cover with bordered foam dressing. Change twice daily and as needed. R27's MAR dated 3/25 lacked documentation dressing changes were completed on the following days: - Day shift 3/9/25, 3/13/25, 3/14/25, 3/16/25 through 3/18/25, and 3/20/25 - Evening shift 3/8/25 through 3/10/25, 3/14/25 through 3/16/25 R/27's progress notes were reviewed from 3/8/25 through 3/20/25. Progress notes lacked documentation as to why scheduled dressing changes were missed or passed on to the next shift to make sure they were done. During an interview on 3/24/25 at 7:05 p.m., R27 stated there was a pressure ulcer on her coccyx region that nursing was doing dressing changes on. The staff would miss several of the dressing changes since the wound appeared. During an interview on 3/26/25 at 5:08 p.m., trained mediation aide (TMA)-B stated that either the nurse manager or a nurse from 200 hallway would do all of the dressing changes for 100 hallway when a nurse was not assigned. I know everybody is really busy, so I never know when they are done or not done. During an interview on 3/26/25 at 5:19 p.m., licensed practical nurse (LPN)-C stated the nurse on either 200 or 300 hallways would assist 100 hallway with dressing changes when there was not a nurse assigned to 100 hallway. We usually find time to run over to 100 hallway to get the dressing changes done. I can't think of any specific times, but I know there have been times	2 900		

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2 900	Continued From page 18 when evening shift has not been able to get 100 hallway dressing changes done. When that would happen, we would report off to the next shift to get the dressing changes done and document in progress report why it was not done. After the next shift completed the dressing change, they would go into the MAR and document the completed dressing change. During an interview on 3/27/25 at 12:48 p.m., registered nurse (RN)-B reviewed R27's MAR and acknowledge several dressing changes were not documented on. Based on the documentation, there is no way to know if the dressing changes were completed. During an interview on 3/27/25 at 1:58 p.m. the director of nursing (DON) stated dressing changes needed to be done as ordered and documented on in the MAR. Facility policy Skin Assessment and Wound Management last revised 2/25 indicated ongoing treatments would be followed as ordered by the provider. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit	2 900		

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2 900	Continued From page 19 information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain proper food storage temperature in a unit refrigerator containing resident food. Furthermore, the facility failed to ensure refrigerated food items were properly labeled and dated. This deficient practices had the potential to affect all residents and visitors using unit refigerators to store food. Findings include: During observation on 3/26/25 at 10:41 a.m., unit refrigerator on wing 3 was reviewed. Refrigerator temperature read 50 degrees on both thermometers inside fridge. The following items were found: -french onion dip container with expiration date of November 11, 2024. -package of sliced cheese labeled with resident name without opened on date.	21100	Corrected.	5/2/25

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21100	Continued From page 20 -package of sliced deli meat labeled with resident name without opened on date. -large bottle of pedialyte beverage labelled with open date of 11/25/24 and name of resident that discharged in December of 2024. During followup observation on 3/26/25 at 3:32 p.m., unit refrigerator on wing 3 was reviewed. Refrigerator temperature read 50 degrees on both thermometers inside fridge. During interview on 3/26/25 at 3:34 p.m., nursing assistant (NA)-B verified both thermometers inside unit refrigerator on wing 3 read 50 degrees. During interview on 3/26/25 at 3:48 p.m., registered nurse (RN)-B verified contents of unit refrigerator on wing 3. RN-B further verified temperature on both internal thermometers read 50 degrees. RN-B stated 50 degrees was too warm for safe food storage and all perishable foods from the fridge would be thrown out. RN-B stated staff should have made a maintenance request to have the fridge looked at due to high temperaure. During observation on 3/27/25 at 7:23 a.m., unit refrigerator on wing 3 had been removed from the unit. During interview on 3/27/25 at 1:04 p.m., administrator stated unit refrigerator from wing 3 had been removed for resident safety. Administrator confirmed 50 degrees to be an unsafe temperature for food storage as it could increase the chances for food-borne illness and adverse effects. Administrator also stated expectation for staff to label resident food with date and resident name.	21100		

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21100	Continued From page 21 Undated Refrigerators and Freezers policy identified 'acceptable temperature ranges are 35 degrees to 40 degrees for refrigerators.' Policy stated 'supervisor will take immediate action if temperatures are out of range.' Policy further identified 'all food shall be properly dated.' SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods are stored and labeled properly to prevent potential degraded food served to residents of the facility. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to food storage and labeling. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items are stored and labeled appropriately. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to	21390		5/2/25

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21390	Continued From page 22 reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based observation, interview and record review the facility failed to ensure nebulizer equipment was properly washed, dried and stored for 2 of 2 residents (R29, R14); that equipment for tube feeding tube flushes was properly dated, rinsed, dried and stored for 1 of 1 residents (R16); and the facility failed to ensure proper PICC line cap placement occured for 1 of 1 resident (R200) who were reviewed for infection prevention and control. Findings include: R29: R29's quarterly MDS dated 3/4/25 indicate R29 was cognitively intact. Diagnoses included	21390	Corrected.	

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21390	Continued From page 23 anxiety, depression and post-traumatic stress disorder. R29's Medication Admin Audit Report dated 3/27/25, indicated R29 had orders for Ipratopium-albuterol inhalation solution 0.5-2.5mg inhaled 4 times a day. On 3/26/25, a dose had been set up at 11:38 a.m. During an observation on 3/24/25 at 6:40 p.m., a nebulizer cannister was observed full of a liquid substance. During a second observation on 3/26/25 at 12:53 p.m., again a nebulizer cannister was observed full of liquid substance, not running, and no medical staff with him. At that time R29 turned on the nebulizer machine and started administering the liquid in the nebulizer cannister. During an interview on 3/26/25 at 12:56 p.m., LPN-B entered R29's room and confirmed R29 had a full canister of liquid in the cannister he was administering medication with. LPN-B reviewed R29's medication administration record (MAR) and stated the last documented administration of inhaled nebulizer medication was done at 11:38 a.m. and not at the current time. LPN-B stated based on the amount of liquid in the cannister R29 had just started the nebulizer at the current time and not at the 11:38 a.m, which meant fluid had sat in the nebulizer cannister for over an hour, not moving, which increased the risk of infectious disease. During an interview on 3/27/25 at 1:54 p.m., the director of nursing (DON) stated the facility staff should follow the infection control protocols related to nebulizer treatments and cleaning.	21390		

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21390	Continued From page 24 The facility Oral Inhalation Administration policy dated 5/22, indicated medication should be given right after setup. After medication is given rinse and disinfect the nebulizer equipment according to manufacturer's recommendations, or wash pieces with warm water, rinse with hot water and allow to air dry. R14: R14's Minimum Data Set (MDS) dated 2/5/25, indicated R16 was moderately cognitively impaired with the diagnoses of heart failure, end stage renal disease with dialysis, diabetes and respiratory failure. R14's care plan last reviewed 2/19/25, indicated R14 was at risk for alteration in oxygen/gas exchange due to their respiratory status with the goal of adequate gas exchange: no cyanosis, freedom from shortness of breath, oxygen saturations greater than 90%, and normal respiratory pattern. Interventions included administration of Inhaler per MD order and notification of provider with respiratory changes. R14's Order Summary Report Active orders as of 3/27/25, included the following orders: -Ipratropium-albuterol inhalation solution 0.5-2.5 (3) 3mg/3ml, 3 ml inhale orally via nebulizer (neb) every 4 hours as needed for shortness of breath. -Ipratropium-albuterol inhalation solution 0.5-2.5 (3) 3mg/3ml, 3 ml inhale orally via nebulizer every 4 hours as needed for shortness of breath. Give before dialysis on Monday, Wednesday, and Friday. -Change oxygen tubing and mask weekly every Saturday. -Rinse and dry nebulizer cup after each nebulizer treatment	21390		

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21390	Continued From page 25 During an observation on 3/24/25 at 3:28 p.m., R14's bed was unmade. R16 pointed to the foot of their bed where there was a nebulizer treatment unit sitting directly on the bed sheet and stated they received neb treatments for breathing. The Neb treatment unit and mask were directly on the bed and the neb cup had liquid and moisture droplets on the sides of the cup. The tubing unit was not dated. During an observation on 3/25/25 at 2:11 p.m., R14's nebulizer treatment unit cord could be seen, the rest of the unit was on the bed with bed covers and a pillow over it. During an observation on 3/25/25 at 3:31 p.m., R14's nebulizer treatment unit and tubing was still at the foot of R14's unmade bed. The medication cup had fluid in it. During an observation on 3/26/25 at 8:24 a.m., R14's nebulizer treatment machine power cord was visible at the foot of the bed, the rest of the unit was covered with bedding. During an interview at 3/26/25 on 11:19 a.m., R14 stated they had had a neb treatment early in the morning but not recently. R14 lifted up their bed coverings to show the neb treatment unit at the foot of the bed. The medication cup was dated 3/24, and there was liquid in the nebulizer cup. During an observation on 3/27/25 at 7:23 a.m., R14's nebulizer treatment machine was laying at the foot of R14's bed. The medication cup had been removed. There was a short tube connected to the machine and the other end was open to air and laying on R200's mattress at the foot of the bed.	21390		

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21390	Continued From page 26 During an interview on 3/26/25 at 2:12 p.m., RN-A pulled up R14's MAR and stated R14 had had a nebulizer treatment last on 3/26/25 at 5:48 a.m. RN-A stated there was also an order on the medication administration record to sign off on for cleaning and letting the nebulizer treatment supplies air dry. RN-A went into R14's room and noted R14's nebulizer treatment had liquid in the administration cup. RN-A stated this should have been removed, cleaned and left to air dry and indicated they were going to take care of it. RN-A stated it was important to clean after each use because leaving moisture in the cup created a risk for respiratory infection. During an interview on 3/27/25 at 10:04 a.m., RN-B stated once a nebulizer treatment is done, staff should disconnect the tubing from the machine, rinse the medication cup, and then let it dry. RN-B stated it was important to do this after each use to prevent potential respiratory infections. In a perfect world the nebulizer unit should not be stored at the foot of a resident's bed. During an interview on 3/27/25 at 12:26 p.m., the DON stated after each nebulizer administration it should be rinsed and left to air dry. This was also one of R14's orders. The DON indicated there are lots of infection risks associated with nebulizer treatments. Lack of cleaning between uses could lead to bacteria growth in the tubing unit which could lead to thrush or growth of other forms of bacteria that could go directly into the lungs when used without cleaning. R14's unit should not be stored on the foot of R14's bed between uses. The facility policy Oral Inhalation Administration dated May 2022, directed staff to rinse and	21390		

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21390	Continued From page 27 disinfect the nebulizer equipment according to manufacturer recommendation and once equipment was completely dry, store in plastic bag with the resident's name and date on it. R16: R16's quarterly Minimum Data Set (MDS) dated 3/11/25, indicated R16 was cognitively intact with the following diagnoses: multiple myeloma, diabetes with neuropathy, heart disease and end stage renal disease. R'16 careplan last updated 3/19/25, included the following interventions for R16's PEG tube maintenance: -fluid flushes per order -monitor PEG tube site for signs and symptoms of infection -PEG tube cares per protocol -change tube feeding bag and syringe every 24 hours. R16's Order Summary dated 3/27/25 included: -free water flushes 150 ml [milliliters] for a total of 600 ml of fluid via tube per day -GJ Tube-clean area and cover with split dressing every day. R16' electronic medical record lacked evidence to show the syringe and graduated cylinder used for R16's tube feeding water administration were/had been dated and replaced every 24 hours. During an interview on 3/24/25 at 6:22 p.m., R16 stated the nurses are supposed to change my dressing every day and flush my tube feeding tube a couple times a day. There was an undated graduated cylinder partially filled with water with an undated syringe sitting in it on R16 nightstand.	21390		

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21390	Continued From page 28 R16 stated they usually had to ask for the dressing to be done unless registered nurse RN-A or licensed practical nurse (LPN-A) were working because they just did it. During an observation on 3/25/25 at 3:31 p.m., R16's graduated cylinder was dated 3/25/25. The cylinder contained water and an undated syringe. During an observation on 3/26/25 at 8:21 a.m., R16's graduated cylinder was dated 3/25/25. The cylinder contained water and an undated syringe. During an observation on 3/26/25 at 2:23 p.m., R16's graduated cylinder was still dated 3/25/25. The cylinder contained water and an undated syringe. During an observation on 3/27/25 at 7:27 a.m., R16's graduated cylinder was dated 3/25/25. The cylinder contained water and an undated syringe. During an interview on 3/27/25 at 8:27 a.m., R16 stated when staff were done putting water in their tube feeding tube staff didn't do anything special with the stuff, they just put the water holder (graduated cylinder) back on the nightstand with the syringe in it. During an interview on 3/27/25 at 10:07 a.m., RN-B stated the graduated cylinder, and syringe should be changed out per policy. RN-B stated they would have to review the policy to know how frequently staff should be exchanging the syringe and graduated cylinder, however, staff should not be leaving the syringe siting in water in the graduated cylinder. For infection prevention reasons, the cylinder and syringe should be left to air dry after use, and the policy should be followed. During an observation on 3/27/25 at 12:51 p.m., R16's graduated cylinder was dated 3/25/25. The	21390		

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21390	Continued From page 29 cylinder contained water and an undated syringe. During an interview on 3/27/25 12:29 p.m., with the director of nursing (DON) and registered nurse consultants (RN-D) and RN-G. RN-D pulled up the facility policy and stated per policy the graduated cylinder should be left to air dry between uses and changed out daily. The DON stated the syringe should be pulled apart and left to air dry after use. It was an expectation staff would follow the policy for resident safety and infection prevention. During an observation on 3/27/25 at 1:50 p.m., R16's graduated cylinder was dated 3/25/25. The cylinder contained water and an undated syringe. The facility policy Enteral Feeding via Syringe (Bolus) dated 3/2024, instructed staff to make bolus syringe was labeled with the resident's name and marked with date and marked with date and time and if date and time were greater than 24 hours the syringe should be disposed of, and new supplies should be obtained. The syringe should be rinsed with hot water and dried and stored in designated area. R200: R200's admission Minimum Data Set (MDS) dated 2/19/25, indicated R200 was cognitively intact with the diagnoses of congestive heart failure, diabetes, and respiratory failure. R200's Order Summary Current Orders as of 3/24/25, included the following orders: -PICC/Midline-Change cap (needless access device) weekly with dressing change q wed in am -Vancomycin HCl Intravenous Solution (Vancomycin HCl) use 1500 mg intravenously	21390		

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21390	Continued From page 30 every 24 hours related to methicillin resistant staphylococcus aureus infection as the cause of disease classified elsewhere (B95.62) for 20 Days. Inject 1500mg in NS over 90 minutes into the vein every 24 hours for 20 days. During an observation on 3/26/25 at 11:28 a.m., R200's PICC line was covered with a transparent dressing. The end or R200's PICC line did not have a lumen cap on it. R200 stated they had been told it was okay to not have the cap on the PICC line. R200 thought it had been that way for a couple of days. After an observation on 3/26/25 at 11:46 a.m., registered nurse RN-B confirmed R200's PICC line was missing the lumen cap attachment and indicated the missing cap was a concern for infection. RN-B opened the electronic medical record (EMR), and stated R200's cap was changed before R200's antibiotic was started on 3/25/25 at 1:15 p.m. RN-B indicated the cap would have likely been off sometime between the time the antibiotic was discontinued on 3/25/25, and now. During an interview on 3/26/25 at 2:51 p.m., the director of nursing (DON) stated they had a call out to infectious disease and had notified R200's provider that R200's lumen cap had been off. The DON indicated that it was possible the lumen could have been accidently removed during a flush or something and indicated R200's PICC like should have a lumen cap at the end of it at all times to prevent infection. During an interview on 3/26/25 at 3:08 p.m., R200 stated when they first got back from the hospital there was a green cap on the end of the PICC line but the facility didn't use that cap any longer.	21390		

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21390	Continued From page 31 R200 stated they thought the clear cap (lumen cap) had been missing from their PICC line for a couple of days. R200 stated one day they sent a staff in that said they didn't know about PICC lines but they said they were told to do it anyway. R200 stated they had been worried about their PICC line. During an interview on 3/26/25 at 5:12 p.m., RN-A stated when they hooked up R200's antibiotic yesterday, the clear lumen had been attached to R200's PICC. The antibiotic didn't get done until after they had left for the day so another staff would have disconnected the antibiotic when it was done. During an interview on 3/26/25 at 5:59 p.m., RN consultant (RNC-A) stated once they had been made aware R200's PICC line was missing the lumen cap they consulted the nurse practitioner who advised the access area be cleansed and re-capped right away followed by a call to infectious disease. RNC-A stated they did as advised and had also successfully pulled back and flushed R200's PICC line after they had attached the new cap. During an interview on 3/27/25 at 9:39 a.m., licensed practical nurse (LPN-D) stated they never received picc line training or iv medication administration training, or had they ever completed a hands on or any other competency for PICC lines, but they did recall watching a PICC line demonstration. LPN-D confirmed as part of their job they administered iv medications and flushes through PICC lines. During an interview on 3/27/25 at 12:07 p.m., the DON stated they had contacted LPN-A who had disconnected R200's antibiotic on 3/26/25. The	21390		

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21390	Continued From page 32 DON showed a written statement signed by LPN-A which indicated LPN-A could not say for sure if the lumen cap had been removed when they disconnected R200's antibiotic on 3/26/25, or if the cap was in place when they completed the task. The DON stated the LPN would receive follow-up education on PICC lines. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21390		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any	21530		5/2/25

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	00299	A. BUILDING: _____ B. WING _____	C 03/27/2025

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21530	Continued From page 33 irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to make sure pharmacy recommendations were addressed timely for 2 of 5 residents (R28, R33) reviewed for unnecessary medications. Findings include R28's quarterly Minimum Data Set (MDS) dated 3/19/25, identified intact cognition, and diagnoses included heart failure, hypertension, and renal	21530	Corrected.	

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21530	Continued From page 34 failure. R28's order summary report dated 12/12/24, indicated R28 was started on Quetiapine Fumarate oral tablet 25 milligrams (mg) one time daily by mouth for a diagnosis of "other specified anxiety disorders." R28's Consultant Pharmacist Medication Regimen (PMR) Review dated 2/13/25, recommended the facility address the diagnosis for Quetiapine Fumarate. The PMR indicated CMS guidance for antipsychotic utilization in nursing facilities required an FDA approved diagnosis in chart to use the medication which "other specified anxiety was not." The form had not been addressed or signed as completed. During interview on 3/27/25 at 10:43 a.m., the consultant pharmacist (CP) explained monthly medication regimen reviews were done monthly on all residents. CP stated medication regimen reviews were tracked over time and provider responses of accepting or rejecting recommendations were noted. CP stated providers had a month to respond and if there was no response from the provider then the recommendation would be sent again. During interview on 3/27/25 at 12:49 p.m., the director of nursing (DON) stated an expectation for provider to respond to pharmacist medication regimen review recommendations with the next visit, but at least within 30 days. R33's quarterly MDS dated 12/29/24, identified intact cognition, and diagnoses including sequelae of cerebral infarction (aftereffects of a stroke), dyspnea (shortness of breath), post-traumatic stress disorder (PTSD), rib fracture, chronic kidney disease, protein-calorie	21530		

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21530	Continued From page 35 malnutrition, depression, and psychosis. R33's order summary report dated 3/27/25, included the following order: -polyvinyl alcohol ophthalmic solution 1.4%- instill one drop in both eyes as needed for dry eyes. Order was written 1/15/25. R33's Consultant Pharmacist Medication Regimen Review dated 2/13/25, recommended the provider to "please add frequency (e.g 4 times a day prn dry eyes) to complete order" for polyvinyl alcohol ophthalmic solution. R33's medical record did not contain a provider response to this recommendation. R33's Consultant Pharmacist Medication Regimen Review dated 3/12/25, recommended the provider to "please add frequency (e.g 4 times a day prn dry eyes) to complete order (repeat)" for polyvinyl alcohol ophthalmic solution. R33's medical record did not contain a provider response to this recommendation. During interview on 3/27/25 at 10:43 a.m., consultant pharmacist (CP) explained monthly medication regimen reviews were done monthly on all residents. CP stated medication regimen reviews were tracked over time and provider responses of accepting or rejecting recommendations were noted. CP stated providers had a month to respond and if there was no response from the provider then the recommendation would be sent again. During interview on 3/27/25 at 12:49 p.m., director of nursing (DON) stated expectation for provider to respond to pharmacist medication regimen review recommendations.	21530		

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21530	Continued From page 36 Facility policy Consultant Pharmacist Services Provider Requirements policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications to ensure recommendations are acted upon. The director of nursing (DON) or designee and the consulting pharmacist should educate physicians and staff on the importance of ensuring recommendations are acted upon ASAP. Audits should be developed to monitor timliness of action from physician, using appropriate timeframes for a specific and measurable amount of time. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the	21540		5/2/25

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21540	Continued From page 37 matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to have an appropriate diagnosis for use of medication for 1 of 5 residents (R28) reviewed for unnecessary medications. Findings include R28's quarterly Minimum Data Set (MDS) dated 3/19/25, identified intact cognition, and diagnoses included heart failure, hypertension, renal failure and post kidney transplant. R28's order summary report dated 12/12/24, indicated R28 was on Tacrolimus Oral 1mg capsule, take one by mouth every 12 hours for health maintenance. During interview on 3/27/25 at 10:43 a.m., the consultant pharmacist (CP) stated medications appropriate for a diagnoses of health maintenance included several different vitamins and minerals that a resident took as a preventative or maintenance dosing program. The CP stated Tacrolimus was an antirejection drug for patients who have received a transplant.	21540	Corrected.	

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21540	Continued From page 38 The CP reviewed R28's chart and indicated R28 had a history of post kidney transplant and post kidney transplant would have been the appropriate diagnoses for that medication. During interview on 3/27/25 at 12:49 p.m., the director of nursing (DON) stated all medications ordered by providers would have appropriate diagnoses assigned to them. Facility medication policy was not provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage and diagnoses for use. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21540		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review facility failed to perform a self-administration of medication assessment and	21565	Corrected.	5/2/25

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21565	Continued From page 39 obtain provider order to have medication left in room for 2 of 2 (R13 and R29) residents reviewed for self-administration of medication. R13's quarterly Minimum Data Set (MDS) assessment dated 2/12/25, indicated R13 had intact cognition. Diagnoses included heart failure, hypertension and renal insufficiency. During an observation of R13's room on 3/24/25 at 3:17 p.m., a box with a tube of diclofenac cream was noted on the shelf to the right of the bed. During an interview on 3/24/25 at 3:17 p.m., R13 stated the staff utilize the diclofenac cream on her back and just leave it on the shelf so it would be available when they needed it. During a second observation of R13's room on 3/25/25 at 2:06 p.m., a box with a tube of diclofenac cream was again noted on the shelf to the right of the bed. R29's quarterly MDS dated 3/4/25, indicated R29 was cognitively intact. Diagnoses included anxiety, depression and post traumatic stress disorder. R29's Medication Admin Audit Report dated 3/27/25, indicated R29 had orders for Ipratopium-albuterol inhalation solution 0.5-2.5mg inhaled 4 times a day. On 3/26/25, a dose had been set up at 11:38 a.m. During an observation on 3/24/25 at 6:40 p.m., a nebulizer canister was observed full of a liquid substance, not running, and no medical staff were in the room with the resident.	21565		

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21565	Continued From page 40 During a second observation on 3/26/25 at 12:53 p.m., again a nebulizer canister was observed full of liquid substance, not running, and no medical staff with him. At that time R29 turned on the nebulizer machine and started administering the liquid in the nebulizer canister. During an interview on 3/25/25 at 2:10 p.m. licensed practical nurse (LPN)-B stated prior to a medication left at bedside there must be a self-administration of medication (SAM) form completed, which showed resident was safe to leave medication at bedside and that resident wanted to have medication left at bedside. After that an order would be obtained from the provider to leave medication at bedside. LPN-B entered R13's room and confirmed a tube of Diclofenac cream had been left at R13's bedside shelf. LPN-B then reviewed R13's medical record and indicated there was no SAM or order to keep any medication at bedside. During a second interview on 3/26/25 at 12:56 p.m., LPN-B entered R29's room and confirmed R29 had a full canister of liquid in the canister he was administering medication with. LPN-B reviewed R29's medication administration record (MAR) and stated the last documented administration of inhaled nebulizer medication was done at 11:38 a.m., and not at the current time. LPN-B stated based on the amount of liquid in the canister R29 had just started the nebulizer at the current time and not at 11:38 a.m., as documented. R29 did not have a SAM or provider order to keep medication of any kind at bedside, so the staff member should have made sure the nebulizer had been utilized at 11:38 a.m., when documented as administered. During an interview on 3/27/25 at 1:54 p.m., the	21565		

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21565	Continued From page 41 director of nursing (DON) stated if the resident did not have a SAM assessment or provider order to leave medication at bedside. Staff should not leave at bedside and should stay with the resident while they took the medication. The facility Self-Administration of Medications policy last revised 2/24 indicated the facility would deem if a resident was safe to self administer medication through assessment forms and provider orders. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21565		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300.	21620		5/2/25

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21620	Continued From page 42 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure medications were properly labeled with direction for use for 1 of 1 resident (R13). Findings include: R13's quarterly Minimum Data Set (MDS) assessment dated 2/12/25, indicated R13 had intact cognition. Diagnoses included heart failure, hypertension, and renal insufficiency. R13's Order Summary Report dated 3/29/24, indicated R13 had ordered Diclofenac sodium topical gel, apply 2gms topically to shoulders, upper and mid back 4 times a day. During an observation of R13's room on 3/24/25 at 3:17 p.m., a box with a tube of diclofenac cream was noted on the shelf to the right of the bed. The box and the tube lacked any kind of label with resident name, medication dosage or times to administer. During an interview on 3/24/25 at 3:17 p.m., R13 stated the staff utilize the diclofenac cream on her back and just leave it on the shelf so it would be available when they needed it. During a second observation of R13's room on 3/25/25 at 2:06 p.m., a box with a tube of diclofenac cream was again noted on the shelf to the right of the bed. The box and the tube lacked any kind of label with resident name, medication dosage or times to administer. During an interview on 3/25/25 at 2:10 p.m.,	21620	Corrected.	

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21620	Continued From page 43 licensed practical nurse (LPN)-B stated any medication left at the resident's bedside needed to have a label with the resident's name, dosage of medication to administer, and frequency to administer so everybody was aware of the correct order. LPN-B entered R13's room and observed the box and tube of diclofenac cream in R13's room. She confirmed there was no label on the box or the tube. Since there was no label on the box or the tube, nobody would know the appropriate dosage or if the resident should have the medication. There was an increased risk of a resident getting a medication not ordered or the incorrect dosage. During an interview on 3/27/25 at 1:54 p.m., the director of nursing (DON) stated any medication left at a resident bedside should have at least the name of the resident, the dosage of medication to give and the frequency the medication should be administered. Facility policy Medication and Treatment Orders last revised 2/24, indicated all ordered medications and treatments would include: a. Name and strength of the drug b. Number of doses, start and stop date, and/or specific duration of therapy. c. Dosage and frequency of administration d. Route of administration e. Clinical condition or symptoms for which the medication is prescribed. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist should review, revise, or create policies and procedures for proper labeling and storage of medications and or/ storage of items in the medication room or refrigerators. Nursing and/or medication aide staff should be	21620		

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21620	Continued From page 44 educated to those changes. The DON or designee, and pharmacist, should routinely audit all medications and storage to ensure compliance. The results of those audits should be taken to QAPI ongoing to determine compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		

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	245495	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/24/2025**

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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 on 03/24/2025. At the time of this survey, The Emerals at Grnd Rapids 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 | 04/23/2025

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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	245495	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/24/2025**

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
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 49 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and	K 223		5/2/25

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K 223	Continued From page 3 * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 03/24/2025 between 1:00pm and 4:00pm, it was revealed by observation that smoke barrier door 102 did not completely close when tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 223	Immediate Corrective Action: Smoke barrier door 102, was adjusted to close completely. Corrective Action as it applies to others: All facility smoke barrier doors will audited to ensure they completely close per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. If they do not close correctly they will be fixed. Recurrence will be prevented by: Maintenance Director and Maintenance Assistant will be educated on smoke barrier doors, and the need for them to close completely per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. Smoke barrier doors will be audited weekly x3 weeks, and then monthly for 2 months. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Maintenance Director or Designee	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101	K 321		5/2/25

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K 321	Continued From page 4 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have a patterned impact on the residents within the facility.	K 321	Immediate Corrective Action: Self-closing device added to new employee office door. Corrective Action as it applies to others:	

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K 321	Continued From page 5 Findings include: On 03/24/2025 between 1:00pm and 4:00pm, it was revealed by observation that New Employee Office that is being used for storage did not have a self-closing device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 321	Facility will be audited to identify if any storage areas need a self-closing device added to door. Maintenance Director and Maintenance Assistant will be educated on NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. in regard to storage areas needing self-closing devices. Recurrence will be prevented by: Facility will be audited monthly x 3 months to identify if any storage areas need a self-closing device added to door. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Maintenance Director or Designee.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible	K 363		5/2/25

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K 363	Continued From page 6 materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/24/2025, between 1:00pm and 4:00pm, it was revealed by observation that clean laundry	K 363	Immediate Corrective Action: Clean Laundry Room on north wing, and F15 boiler room door were adjusted to latch. Corrective Action as it applies to others: All corridor doors will be audited to ensure corridor doors latch.	

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K 363	Continued From page 7 room on north wing and door F15 boiler room door on the lower level did not close and latch when tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 363	Maintenance Director and Maintenance Assistant will be educated on NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5 in regards to corridor doors latching. Recurrence will be prevented by: Corridor doors will be audited weekly x3 weeks, and then monthly for 2 months that doors latch. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Maintenance Director or Designee.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.	K 372		5/2/25

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K 372	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a pattered impact on the residents within the facility. Findings include: On 03/24/2025 between 1:00pm and 4:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors leading to wing 1 and in wall located in HVAC room in admin office. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372	Immediate Corrective Action: Penetrations above doors leading to wing 1, and HVAC room in admin office have been sealed. Corrective Action as it applies to others: Smoke compartments will be audited to identify if there are any penetrations. Maintenance Director, and Maintenance Assistant will be educated on NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. in regard to penetration for smoke compartments. Recurrence will be prevented by: Facility will be audited monthly x 3 months to identify penetrations in smoke compartments. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Maintenance Director or Designee.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and	K 712		5/2/25

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K 712	Continued From page 9 unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/24/2025, between 1:00pm and 4:00pm, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: 1) Fire drills conducted on first shift; during third quarter, fourth quarter of 2024 and first quarter of 2025 were conducted within 30 mins. of each other. 2) Fire drills conducted on second shift; during all four quarters fire drills were conducted within 1 hour of each other. 3) Fire drills conducted on third (NOC) shift; during third quarter, fourth quarter of 2024 and first quarter of 2025 were conducted within 30 mins. of each other.	K 712	Immediate Corrective Action: Fire drills are now on a schedule to ensure fire drills are more than 2 hours apart. Corrective Action as it applies to others: Maintenance Director and Maintenance Assistant will be educated on how to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code. sections 19.7.1.6, 4.7.4, and 4.6.1.1. Recurrence will be prevented by: Fire drills will be audited quarterly x 2 quarters. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Maintenance Director or Designee.	

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K 712	Continued From page 10 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/24/2025 between 1:00 pm and 4:00 pm, it was revealed by observation that the following fire doors and/or fire door frames were missing door rating tags.	K 761	Immediate Corrective Action: Fire Doors leading to Chapel, and F4 doors had tags added to door frame. Corrective Action as it applies to others: Facility fire doors will be audited to identify if they have a door tag and corrected as indicated on audit. Maintenance Director and Maintenance Assistant will be educated on NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition),	5/12/25

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K 761	Continued From page 11 1) Fire doors leading to Chapel - missing tags on door frame 2) Fire doors (F4) / doors leading to Admin - missing tags on door frame An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	Standard for Fire Doors and Other Opening Protectives, section 5.2.1. Recurrence will be prevented by: Audit frames monthly x3 months to ensure tags are on frames. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Maintenance Director or Designee.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.	K 920		5/2/25

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K 920	Continued From page 12 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/24/2025, between 1:00pm and 4:00pm, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following areas; 1) Multi-plug adapter in Nurse Managers office An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	Immediate Corrective Action: Power strip has been removed from W3 Nurse Manager office. Corrective Action as it applies to others: Facility offices will be audited to identify if there are any electronics plugged into power strips. Facility Management team will be educated on power strips and not plugging electronics into power strips per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. Recurrence will be prevented by: Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Maintenance Director or Designee	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 22, 2026

Administrator

The Emeralds at Grand Rapids LLC

2801 SOUTH HIGHWAY 169

GRAND RAPIDS, MN 55744

RE: CCN: 245495

Cycle Start Date: March 27, 2025

Dear Administrator:

On April 14, 2025, we notified you a remedy was imposed. On May 8, 2025, the Minnesota Departments 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 July 7, 2025

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 27, 2025 be discontinued as of July 7, 2025. (42 CFR 488.417 (b))

In our letter of April 14, 2025, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 27, 2025 This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 22, 2026

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

Re: Reinspection Results
Event ID: ERB312

Dear Administrator:

On May 8, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March27, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
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Saint Paul, MN 55164-0900
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