



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
December 6, 2023

Administrator  
Grand Village  
923 Hale Lake Pointe  
Grand Rapids, MN 55744

RE: CCN: 245368  
Cycle Start Date: September 12, 2023

Dear Administrator:

On October 11, 2023, we notified you a remedy was imposed. On November 7, 2023 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 November 2, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 12, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 11, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 12, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 2, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

Kamala Fiske-Downing  
Minnesota Department of Health  
Health Regulation Division  
Telephone: (651) 201-4112  
Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)





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December 6, 2023

Administrator  
Grand Village  
923 Hale Lake Pointe  
Grand Rapids, MN 55744

Re: Reinspection Results  
Event ID: PEQ512

Dear Administrator:

On November 7, 2023 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 September 27, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Kamala Fiske-Downing  
Minnesota Department of Health  
Health Regulation Division  
Telephone: (651) 201-4112  
Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)





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October 11, 2023

Administrator  
Grand Village  
923 Hale Lake Pointe  
Grand Rapids, MN 55744

RE: CCN: 245368  
Cycle Start Date: September 12, 2023

Dear Administrator:

On September 22, 2023, we informed you that we may impose enforcement remedies.

On September 27, 2023, the Minnesota Department(s) of Health and Public Safety completed a revisit/survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

## **REMEDIES**

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 12, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 12, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 12, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.



This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

## **NURSE AIDE TRAINING PROHIBITION**

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 12, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Grand Village will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 12, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

## **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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

#### **DEPARTMENT CONTACT**

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

Jen Bahr, RN, Unit Supervisor  
Bemidji District Office  
Licensing and Certification Program  
Health Regulation Division  
Minnesota Department of Health  
705 5th Street NW, Suite A  
Bemidji, Minnesota 56601-2933  
Email: Jennifer.bahr@state.mn.us  
Office: (218) 308-2104 Mobile: (218) 368-3683

#### **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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY**

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 12, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

## **APPEAL RIGHTS**

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

[Steven.Delich@cms.hhs.gov](mailto:Steven.Delich@cms.hhs.gov)

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services  
Departmental Appeals Board, MS 6132  
Director, Civil Remedies Division  
330 Independence Avenue, S.W.  
Cohen Building – Room G-644  
Washington, D.C. 20201  
202-795-7490**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to [Steven.Delich@cms.hhs.gov](mailto:Steven.Delich@cms.hhs.gov).

## **INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)**

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process



Minnesota Department of Health  
Health Regulation Division  
P.O. Box 64900  
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing  
Minnesota Department of Health  
Health Regulation Division  
Telephone: (651) 201-4112  
Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)



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

PRINTED: 11/06/2023  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245368</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>09/27/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GRAND VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>923 HALE LAKE POINTE</b><br><b>GRAND RAPIDS, MN 55744</b>                    |  |                                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                             |
| E 000                                                    | Initial Comments<br><br>On 9/25/23 - 9/27/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance.<br><br>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<br><br>On 9/25/23 - 9/27/23, 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.<br><br>The following complaints were reviewed with no deficiencies cited: H536858060 (MN90961). 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.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. | F 000                                                                      |                                                                                                                          |  |                                                                        |
| F 583<br>SS=D                                            | Personal Privacy/Confidentiality of Records<br>CFR(s): 483.10(h)(1)-(3)(i)(ii)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | F 583                                                                      |                                                                                                                          |  | 10/20/23                                                               |

|                                                                       |       |            |
|-----------------------------------------------------------------------|-------|------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE  |
| Electronically Signed                                                 |       | 10/18/2023 |

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.



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

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GRAND VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>923 HALE LAKE POINTE</b><br><b>GRAND RAPIDS, MN 55744</b>                                                                  |  |                                                                        |
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| F 583                                                    | <p>Continued From page 1</p> <p>§483.10(h) Privacy and Confidentiality.<br/>The resident has a right to personal privacy and confidentiality of his or her personal and medical records.</p> <p>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.<br/>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.<br/>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.<br/>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview and document review, the facility failed to honor resident's right for privacy for 1 of 1 resident (R10) reviewed for resident privacy.</p> | F 583                                                                      |                                                                                                                                                                        |  |                                                                        |
|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | Corrective action: NA-E was re-educated on Privacy and Confidentiality rights of residents. Corrective action as it applies to other residents: All residents have the |  |                                                                        |



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| F 583                                                    | <p>Continued From page 2</p> <p>Findings included:</p> <p>R10's annual Minimum Data Set (MDS) dated 8/1/23, identified no cognitive impairment and a diagnosis of COVID-19.</p> <p>R10's progress note dated 9/25/23 at 4:42 p.m., identified R10 returned following a hospitalization for acute respiratory failure due to COVID-19 and was to remain in isolation until 9/28/23, at 11:59 p.m.</p> <p>During an observation on 9/25/23 at 5:17 p.m., a visitor and seven other residents were in the dining room. The visitor asked if R10 would be coming to the dining room to join for the meal. Nursing assistant (NA)-E stated residents had to maintain a 6 foot distance between each other because R10 was positive for COVID-19. Other residents began asking NA-E questions about how long they had to do that, etc. NA-E wasn't up-to-date with COVID requirements, but NA-E thought it was 10 days. NA-E told the residents they needed to stay 6 feet apart at least for a few more days.</p> <p>During an interview on 9/25/23 at 5:34 p.m., NA-E stated the residents already knew R10 had COVID-19 because R10 told them, but, no, we're not supposed to tell people that.</p> <p>During an interview on 9/25/23 at 6:67 p.m., R10 stated he valued his privacy and did not want the other residents in the facility to know he was hospitalized with COVID-19; and didn't want the other resident spreading rumors around about him.</p> | F 583                                                                      | <p>potential to be affected by this deficient practice. All staff education on privacy and confidentiality will be provided on 10/18 and 10/19. Recurrence will be prevented by: All staff education on privacy and confidentiality. Audits will be completed once daily for one week then three times a week for two weeks, then weekly for two weeks then once a month. The QAPI committee will determine when the audits may be discontinued. Corrective action will be monitored by DON or designee.</p> |  |                                                                        |



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| F 583                                                    | Continued From page 3<br><br>During an interview on 9/27/23 at 9:19 a.m., NA-A<br>stated you never discuss a resident's health<br>status or illnesses with other residents.<br><br>During an interview on 9/27/23 at 1:25 p.m., the<br>director of nursing (DON) stated staff should not<br>talk with residents about the health status or<br>illness of another resident. It was an expected<br>right for R10 to have privacy.<br><br>The facility's Health Insurance Portability and<br>Accountability Act (HIPAA) Privacy Policy and<br>Procedure dated 9/2016, identified the facility was<br>responsible for ensuring the employees were<br>trained to adhere to HIPAA privacy policy and<br>procedures.                                                                                                                                                | F 583                                                                      |                                                                                                                          |  |                                                                        |
| F 880<br>SS=F                                            | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an<br>infection prevention and control program<br>designed to provide a safe, sanitary and<br>comfortable environment and to help prevent the<br>development and transmission of communicable<br>diseases and infections.<br><br>§483.80(a) Infection prevention and control<br>program.<br>The facility must establish an infection prevention<br>and control program (IPCP) that must include, at<br>a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying,<br>reporting, investigating, and controlling infections<br>and communicable diseases for all residents,<br>staff, volunteers, visitors, and other individuals<br>providing services under a contractual | F 880                                                                      |                                                                                                                          |  | 11/2/23                                                                |



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| F 880                                                    | <p>Continued From page 4</p> <p>arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens.<br/>Personnel must handle, store, process, and</p> | F 880                                                                      |                                                                                                                          |  |                                                                        |



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| F 880                                                    | <p>Continued From page 5</p> <p>transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.<br/>The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and document review, failed to implement timely transmission-based precautions (TBP) and testing according to the Centers for Disease Control (CDC) for 1 of 1 residents (R10) who were displaying COVID-19 symptoms; and the facility failed to conduct COVID-19 outbreak testing was conducted according to CDC guidance for 4 of 4 residents (R21, R26, R21, R41) who were exposed to COVID-19 and 1 of 1 staff (NA-D) who worked without participating in outbreak testing; and failed to ensure surveillance tracking of infections was completed for 6 of 6 residents (R118, R1, R14, R49, R15, R45) who displayed signs and symptoms of potential infection. This had the potential to affect all residents and staff. In addition, the facility failed to ensure catheter care was done to prevent transmission of organisms for 1 of 1 residents (R121).</p> <p>Findings include:</p> <p>COVID:</p> <p>The Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the Coronavirus Disease 2019 (COVID-19) Pandemic updated 5/8/23, identified when performing an outbreak response to a</p> | F 880                                                                      | <p>F880 Corrective Action: All staff and residents were tested. Nurse managers were immediately educated on CDC COVID-19 Infection Prevention and Control. All team members were educated immediately on testing and mask wearing protocols. Team members were educated on COVID symptoms, team members with any COVID symptoms were cue tested. An audit was conducted on all residents and residents with any COVID symptoms were immediately placed in TBP and Cue Tested. An audit was conducted for residents who had high risk exposure. An audit was completed on those who had high risk exposure for wearing masks, individuals were re-educated on mask wearing expectations. LPN-C was educated on barrier placement for catheter care. Catheter care policy was reviewed and updated to include placing a barrier. An audit was done on all residents with catheters. Corrective action as it applies to other residents-All residents have the potential to be affected by this deficient practice. All staff education was done on 10/18/23 and 10/19/23 on CDC guidance, COVID-19 symptoms, source control (masking), PPE, testing, contact tracing, catheter care, TBP, and infection control logs. Any team members who did</p> |  |                                                                        |



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| F 880                                                    | <p>Continued From page 6</p> <p>known case, facilities should always defer to the recommendations of the jurisdiction's public health authority.</p> <ul style="list-style-type: none"><li>- A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed.</li><li>- The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.</li><li>- Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.</li><li>- In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of Empiric use of</li></ul> | F 880                                                                      | <p>not attend the mandatory meeting are being met with by the charge nurse prior to their next shift for the education. Infection Preventionist will check CDC and MDH guidance for updates at least weekly, provide education to the nurse leadership team when changes are noted, and will start attending APIC meetings. Any resident or staff with symptoms are to be reported to the nurse manager or charge nurse to ensure proper procedure is being done including testing, TBP, isolation, and masking and ensure IP is updated for tracking. Nurse managers will review nursing notes and compare to infection control log to ensure potential and actual infection compliance. Testing will be done for staff and residents every 3-5 days for 14 days when facility is in outbreak. Staff and residents will mask when in outbreak. Audits on catheter care, resident symptoms, testing, masking, TBP, and infection control logs will be completed three times a week for one week, then once a week for four weeks, and then once a month. The QAPI committee will determine when the audits may be discontinued. Corrective action will be monitored by DON or designee.</p> |  |                                                                        |



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| F 880                                                    | <p>Continued From page 7</p> <p>Transmission-Based Precautions for residents and work restriction of HCP with higher-risk exposures. In addition, there might be other circumstances for which the jurisdiction 's public authority recommends these and additional precautions.</p> <ul style="list-style-type: none"><li>- If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated. Empiric use of Transmission-Based Precautions for residents and work restriction for HCP who met criteria can be discontinued as described in Section 2 and the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, respectively.</li><li>- If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every 3 days), should be considered.</li></ul> <p>The CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 updated 9/23/22, identified HCP with even mild symptoms of COVID-19 should be prioritized for viral testing with nucleic acid or antigen detection assays. When testing a person with symptoms of COVID-19, negative results from at least one viral test indicate that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected. If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical</p> | F 880                                                                      |                                                                                                                          |  |                                                                        |



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| F 880                                                    | <p>Continued From page 8</p> <p>suspicion for SARS-CoV-2 infection exists, consider maintaining work restrictions and confirming with a second negative NAAT. If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test. For HCP who were initially suspected of having COVID-19 but, following evaluation, another diagnosis is suspected or confirmed, return-to-work decisions should be based on their other suspected or confirmed diagnoses.</p> <p>R10's annual Minimum Data Set dated 8/1/23, identified no cognitive impairment and diagnoses included atrial fibrillation, hypertension, renal insufficiency, and diabetes.</p> <p>The Easy Reporting testing log dated 9/26/23, identified R10 tested positive for COVID-19 on 9/20/23, and 9/21/23.</p> <p>R10's nursing progress notes identified the following:</p> <ul style="list-style-type: none"><li>- 9/21/23 at 3:12 a.m., R10 put on his call light and complained of not feeling well. R10 sounded congested/nasal congestion. R10's temperature was 97.5 degrees Fahrenheit (F). No coughing noted. R10 stated he felt achy all over and requested to be COVID tested which was negative. The note lacked to identify if R10 was placed in transmission-based precautions.</li><li>- 9/21/23 at 5:16 p.m., staff approached R10 at approximately 4:00 p.m. in the commons area to complete an informed consent for use of escitalopram. R10 had a congested cough, moderate amounts of bright green mucous at the edge of his nose, and face was flush. R10 stated he was feeling under the weather and that it was</li></ul> | F 880                                                                      |                                                                                                                          |  |                                                                        |



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| F 880                                                    | <p>Continued From page 9</p> <p>worsening throughout the day. R10 was chilled. R10's skin was warm and clammy to touch. R10 was rapid tested earlier and was negative. R10 was retested which was positive. R10 was assisted to his room, updated on status, and R10 would like to take an antiviral if he was eligible. Director of nursing (DON), medical director, administrator, and infection control nurse were updated. An isolation cart was placed outside R10's room and immediate contract tracing was completed with shift staff on at that time and residents who R10 had contact with greater than 15 minutes of high-risk exposure. These residents were scheduled for Covid testing on days 1, 3, and 5.</p> <p>- 9/22/23 at 1:33 a.m., R10 was admitted to the hospital due to COVID-19.</p> <p>- 9/22/23 at 1:47 a.m., late entry for 9/21/23: unidentified trained medication assistant (TMA) reported to writer R10 was not doing well and wanted to go to the ER. The TMA stated R10's oxygen saturations were 77% on 2 liters per minute (lpm) per nasal cannula (nc). R10 had yellow mucus from his nose, lung sounds were adventitious (abnormal lung sounds heard over the lungs and airways) bilaterally. Called the provider on call and received order to send R10 to ER for evaluation and treatment. R10's blood pressure was 139/29, pulse 99, temperature 103.2 degrees F, and oxygen saturations were 77% on 2 lpm via nc. R10 was transported to the hospital via ambulance at 6:55 p.m.</p> <p>R21's significant change MDS dated 6/26/23, identified R21 had no cognitive impairment and diagnoses included atrial fibrillation, heart failure, hypertension, renal insufficiency, and diabetes.</p> <p>The Easy Reporting testing log dated 9/26/23,</p> | F 880                                                                      |                                                                                                                          |  |                                                                        |



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| F 880                                                    | <p>Continued From page 10</p> <p>identified R21 tested negative for COVID-19 on 9/21/23, 9/22/23 and 9/23/23.</p> <p>During an interview on 9/27/23 at 9:06 a.m., RN-B stated R21's COVID-19 testing was initiated by RN-C during contact tracing from R10's positive COVID-19 test. R21 should have been tested on day 1, day 3 and day 5. R21 tested on day 0, day 1 and day 3. This did not meet the facility's testing plan.</p> <p>R26's significant change MDS dated 6/29/23, identified R26 had a severe cognitive impairment and diagnoses included Alzheimer's disease, renal insufficiency, and hypertension.</p> <p>The Easy Reporting testing log dated 9/26/23, identified R26 tested negative for COVID-19 on 9/22/23 and 9/24/23.</p> <p>During an interview on 9/27/23 at 9:06 a.m., RN-B stated R26's COVID-19 testing was initiated by RN-C during contact tracing from R10's positive COVID-19 test. R26 should have been tested on day 1, day 3 and day 5. R21 tested on day 1 and day 3, but the log did not identify R26 was tested on day 5. This did not meet the facility's testing plan.</p> <p>R27's quarterly MDS dated 9/6/23, identified R27 had severe cognitive impairment and diagnoses included Alzheimer's disease, hypertension, renal insufficiency, and diabetes.</p> <p>The Easy Reporting testing log dated 9/26/23, identified R27 tested negative for COVID-19 on 9/22/23 and 9/24/23.</p> <p>During an interview on 9/27/23 at 9:20 a.m.,</p> | F 880                                                                      |                                                                                                                          |  |                                                                        |



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| F 880                                                    | <p>Continued From page 11</p> <p>RN-B stated R27's COVID-19 testing was also initiated because of her exposure to R10. R10 should have completed testing according to the facility's testing plan.</p> <p>R41's quarterly MDS dated 6/13/23, identified R41 had a severe cognitive impairment and diagnoses included Alzheimer's disease.</p> <p>The Easy Reporting testing log dated 9/26/23, identified R41 tested negative for COVID-19 on 9/22/23 and 9/24/23.</p> <p>During an interview on 9/27/23 at 9:25 a.m., RN-B stated R41 was also exposed to R10. R10 should have completed testing according to the facility's testing plan. R41 tested the morning of 9/27/23, due to exhibiting possible symptoms of COVID-19.</p> <p>NA-D's Sample Risk Assessment for Healthcare Workers Potentially Exposed to COVID-19 in Minnesota dated 9/21/23, identified NA-D was within 6 ft of a person with confirmed COVID-19 for greater than 15 minutes without personal protective equipment (PPE). NA-D was determined to be high-risk due to NA-D had prolonged close contact with R10 and was not wearing a surgical mask or respirator.</p> <p>The Easy Reporting testing log dated 9/26/23, identified NA-D tested negative on 9/22/23 and 9/24/23. The log did not identify if NA-D tested for COVID-19 on 9/26/23.</p> <p>During an interview on 9/27/23 at 7:16 a.m., NA-B stated staff really didn't have to do anything with R10. R10 did his own cares, staff picked up his trash and his dirty clothes. That was about it. The</p> |                                                                            |  | F 880                                                                                                 |                                                                                                                          |                                                                        |                            |



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| F 880                                                    | <p>Continued From page 12</p> <p>day R10 became ill, R10 was in the dining room, the common area, he was "all over". No one was wearing PPE. The next day, NA-B tested and threw the test away. It was negative. NA-B did not know if the facility had to track any testing results. NA-B did not write it down anywhere.</p> <p>During an interview on 9/27/23 at 7:48 a.m., LPN-B was observed unmasked and stated she worked the day R10 became sick. R10 was saying he had a "little tickle" but did not have a fever. Later that day, he became sick. LPN-B didn't think anything of it. R10 was independent with supervision to make sure he's clean and his bathroom was clean. R10 was about and about. He ate at the corner table in the common area. His tablemate, most of the time, ate his meals in his room. LPN-B could not say if R10 ate alone that day. All staff tested for COVID-19, the results were written down on the sign in sheet and staff with close contact masked for 10 days. Staff would know if they had close contact because you knew what you've done with the resident every day. For LPN-B, close contact meant if you had to assist the resident to eat or if you had to help with daily cares. LPN-B passed medications to R10 but R10 thought he was the boss, so you don't like to hang around. It really depended on how much care a resident required. Staff tested that day, you can't lie, staff reported to the nurse manager and RN-B. RN-B took care of all that for staff.</p> <p>During an interview on 9/27/23 at 8:00 a.m., NA-F was observed unmasked and stated she worked until 5:00 p.m. the day R10 became ill. R10 was sitting in his recliner in the common area like he always did, and he sounded horrible. Coughing, congested. NA-F told the nurse but could not</p> | F 880                                                                      |                                                                                                                          |  |                                                                        |



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| F 880                                                    | <p>Continued From page 13</p> <p>remember who the nurse was. R10 was tested after NA-F left for the day and was sent to the hospital. The next day, NA-F had to test. Staff collected their own swab in the nurses' station and the nurse put the swab in the card. The nurse took care of it after that. Afterwards, NA-F was instructed to wear a mask for 10 days. NA-F stated 9/27/23, was day 6. NA-F was off and when she came to the facility that morning the sign in sheet did not say she needed to mask or not. So, NA-F did not need to.</p> <p>During an interview on 9/27/23 at 9:06 a.m., RN-B stated she was responsible for the facility's infection control program for a little less than three months. If a resident was feeling ill, the cart nurse should update the nurse manager and, if there were any concerns, the nurse manager would let RN-B know. RN-B was also available during off hours by phone and email. There was always a RN on-call, and they should call her for guidance as well. RN-B was informed of R10's positive COVID-19 test on Monday, 9/25/23, because she was on vacation. R10 wasn't feeling good, the nurse manager tested him that morning and R10 was negative. Then, the nurse went to get a consent form that afternoon, R10 was clammy and didn't feel good. R10 was tested again, and it was positive. Test results are entered in the assessment tab in R10's electronic health record (EHR) and the result automatically populated on the Easy Reporting testing log. In R10's progress notes, it showed R10 was tested at 3:12 a.m. on 9/21/23, but nursing did not enter the test in the assessment. R10 complained of nasal congestion and achy all over. On rounding notes, it just said R10 wasn't feeling well, and no monitoring was initiated. Ideally, monitoring should have been implemented in R10's EHR.</p> | F 880                                                                      |                                                                                                                          |  |                                                                        |



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| F 880                                                    | <p>Continued From page 14</p> <p>Because R10's COVID-19 antigen test was negative and there was no known exposure, R10 was not placed in transmission-based precautions prior to his COVID-19 antigen test was positive. RN-B did not know the CDC guidance regarding using antigen tests for residents or staff that were symptomatic for COVID-19. The facility policy one test confirmed a resident was negative. RN- B stated it would make sense to place R10 in transmission-based precautions because he was symptomatic. Symptoms could mean he was contagious to other staff and residents. RN-C and the director of nursing (DON) did contact tracing the day R10 tested positive. For residents, they determine who was exposed for greater than 15 minutes in 24 hours. Staff did not observe every resident at all times because it just was not possible. RN-C and the DON filled out the contract tracing sheets and found only two staff that needed to test: NA-D and NA-E. RN-B was unaware of any other staff that needed testing. Staff were to notify RN-B when a test was completed for tracking of the information. When RN-B was in the facility and was notified of a staff's exposure, RN-B would put in a note prior to the shift to make sure the staff tested. The result was entered into Easy Reporting. RN-B stated there are antigen tests on the units, so the nurses have them for residents. Staff used them though and didn't communicate that. If RN-B did not know of a test, she was unable to document it and track it properly. RN-B has spoken to the DON about that because, according to the contact tracing forms, only NA-D was supposed to test for COVID-19.</p> <p>During an interivew on 9/27/23 at 10:25 a.m., RN-C stated when a resident exhibited signs or symptoms of COVID-19, nursing assessed them</p> | F 880                                                                      |                                                                                                                          |  |                                                                        |



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| F 880                                                    | <p>Continued From page 15</p> <p>depending on the symptoms and the resident's medical history. It really didn't matter what symptoms, a COVID-19 antigen test was done because it either rule it out or clarified the problem. R10 was tested at approximately 3:00 a.m. on 9/21/23, with an antigen test with a negative result. That's what was reported off to day shift. R10 was not placed into transmission-based precautions but was greater than 6 feet away from residents and staff. Contact tracing was done. There were four residents and two staff that needed to be tested. Initially two staff tested right away because they had direct contact, but with further evaluation no one had more than 15 minutes with R10. R10 usually sat by himself and talks to others but sits so most are more than 6 feet away from him. Basically, we're told if a resident is acting "abnormal" to test. The nurse practitioner always asked if we tested a resident when we call her. RN-C was unaware of CDC guidance for use of antigen tests with symptomatic residents and stated, in her experience, one COVID-19 antigen test with a negative result ruled out COVID-19. Typically, nursing looked for a persistent cough, fever, burning in the chest, loss of taste or smell.</p> <p>During an interview on 9/27/23 at 10:45 a.m., the DON stated the unit nurse managers were responsible for infection control on their unit, implementing transmission-based precautions and tracking/trending of infections during the month. Staff should update the nurse manager or charge nurse with symptoms so they can be assessed and tested. All testing should be documented. I know we were doing it wrong.</p> <p>During an interview on 9/27/23 at 12:53 p.m., the DON stated the staff figured out where problems</p> | F 880                                                                      |                                                                                                                          |  |                                                                        |



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| F 880                                                    | <p>Continued From page 16</p> <p>began. Prior to June, the facility was using a quantative real-time PCR or "q test" which only required one test. After June, the staff began using the antigen tests and did not realize they needed to change the testing process.</p> <p>The facility policy COVID-19 Community Testing Plan dated 8/6/21, identified the purpose of the policy was to identify COVID-19 positive residents and staff through viral testing; testing was a priority to help inform clinical care and infection prevention and control practices in the facility's setting. A negative RT-PCR test only indicated that an individual did not have detectable virus material present at the time of testing, and repeat testing might be needed. Widespread community transmission as well as movement of staff and residents in and out of a facility result in continuous introduction. Testing complimented existing infection control interventions but did not replace good infection control. However, the policy did not address the use of antigen tests.</p> <p>The facility policy COVID-19 policy undated, identified residents and team members with suspected/confirmed COVID-19 or exposures would be quarantined/isolated based on the most up-to-date CDC guidance. Residents and team members with symptoms of COVID-19 would be tested unless an alternate diagnosis was provided by a healthcare provider with the appropriate scope of practice. Admission testing, outbreak testing, and exposure-related testing of residents and team members would be based on the most up-to-date CDC guidelines. Residents would be placed under enhanced respiratory precautions until symptoms could be ruled-out as COVID (via testing or alternate diagnosis). However, the policy did not address the use of</p> | F 880                                                                      |                                                                                                                          |  |                                                                        |



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| F 880                                                    | <p>Continued From page 17<br/>antigen tests.</p> <p>Surveillance</p> <p>R118's Admission Record dated 9/27/23,<br/>identified R118 was admitted to the facility on<br/>9/8/23. R118 had diagnoses that included chronic<br/>obstructive pulmonary disease (COPD) and<br/>diabetes.</p> <p>R118's progress notes identified the following:<br/>- 9/8/23 at 4:35 p.m., R118 admitted to the facility<br/>with a primary diagnosis of left femur fracture and<br/>UTI. Resident is alert and oriented to person,<br/>place, and time, pleasant and cooperative upon<br/>assessment. Faint crackles in lower lobes.<br/>Resident reports a dry cough. COVID test was<br/>negative. Does report having issues with<br/>dizziness and vertigo. Educated R118 to change<br/>positions slowly and not to get up without staff<br/>present until cleared by therapy to do so.<br/>Educated on the use of the call light and was able<br/>to verbalize understanding of its use. No further<br/>questions or concerns at this time.</p> <p>- 9/10/23 at 3:32 p.m., identified R118 complained<br/>of nausea and general gastrointestinal distress.<br/>R118 had her morning medication sitting on<br/>bedside table and stated, "I'm just not going to<br/>take them with me being nauseated, I was going<br/>to earlier but decided not to as won't keep them<br/>down". Resident sat at bedside, alert and<br/>orientated, complained of nausea, pneumand<br/>was given Maalox. R118's COVID test negative.<br/>R118 just could not give specific symptoms of not<br/>feeling right; just nauseated. R118 had large<br/>normal bowel movement, denied shortness of<br/>breath or respiratory distress, chest pain or<br/>discomfort. Vital signs were within normal range</p> |                                                                            |  | F 880                                                                                                 |                                                                                                                          |                                                                        |                            |



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| F 880                                                    | <p>Continued From page 18</p> <p>for R118's baseline. Staff encouraged resident to be up and see if that helped.</p> <p>During an interview on 9/27/23 at 9:06 a.m., RN-B stated she was unaware of R118's cough or symptoms.</p> <p>R1's significant change MDS dated 8/16/23, identified R1 had a moderate cognitive impairment and diagnoses that included dementia, pneumonia, and respiratory failure.</p> <p>R1's progress note dated 9/10/23 at 5:53 a.m., identified R1 was awake this shift since 01 :30 and was irritable. R1 had a non-productive cough since 1 :30 a.m. which was unaided by an Albuterol nebulizer but responded somewhat to Tussin cough syrup. COVID swab administered at 3:30 a.m. and was negative.</p> <p>R1's progress note dated 9/10/23 at 5:44 a.m., identified at 1:00 R1 started having an infrequent nonproductive cough. At 3:00 a.m., R1's cough had increased in frequency but remained non-productive. Vitals were within normal limits. R1's lung sounds were wheezy on left and mildly congested on right in all lobes. R1 was given an Albuterol nebulizer treatment and was somewhat effective. Cough decreased in frequency and respirations came down to 20. At 3:28 a.m., Tussin cough syrup was offered and accepted for cough (medication was effective). At 3:30 a.m., COVID swab administered with negative results.</p> <p>During an interview on 9/27/23 at 9:06 a.m., RN-B stated R1 had repetitive aspiration pneumonia. R1 was not added to the Monthly Infection log.</p> | F 880                                                                      |                                                                                                                          |  |                                                                        |



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| F 880                                                    | <p>Continued From page 19</p> <p>R14 annual MDS dated 9/7/23, identified R14 had a severe cognitive impairment and had diagnoses that included Alzheimer's disease.</p> <p>R14's progress note dated 9/10/23 at 5:52 a.m., identified at 3 :30 a.m. a COVID swab was administered to R14 with negative results. R14 had a frequent, non-productive cough from 03:30 - 05:00 with a temperature of 97.5 degrees F. R14's EHR failed to identify further documentation related to R14's cough.</p> <p>During an interview on 9/27/23 at 9:06 a.m., RN-B stated R14 did not have a repeat test. RN-B read the progress note and was aware of R14's symptoms but did not add R14 to the Monthly Infection log.</p> <p>R49's admission MDS dated 8/19/23, identified R49 had no cognitive impairment and had diagnoses that included atrial fibrillation, hypertension, and diabetes.</p> <p>R49's progress notes identified the following:<br/>- 9/17/23 at 8:19 p.m., R49 was out of the facility, returned with upper wheeze vocal sounds with breathing. Only happened when breathing through his nose. Denied any allergies. COVID test was done, lungs assessed, clear throughout. Denied shortness of breath. Denied wanting to go to ER. Fell asleep during the assessment. Noted short periods of apnea, and then R49 coughed and took a deep breath.</p> <p>-9/17/23 at 11:09 p.m., identified R49 was of the facility for a birthday party. R49 came back very fatigued and went straight to bed. He did not get up for supper so R10's insulin was held and continued to monitor his blood sugar. Later, R49</p> | F 880                                                                      |                                                                                                                          |  |                                                                        |



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| F 880                                                    | <p>Continued From page 20</p> <p>was complaining of a cough and phlegm in his throat. His lungs were clear. Blood pressure was 111/73, oxygen saturations were 93%, pulse was 77, temperature 98 degrees F and respirations 14. R49 continued to state that he was not feeling well, he thought this may be because of taking the suboxone. This was his third dose, but R49 stated his symptoms started shortly after. Nursing continued to check in on the R49 multiple times throughout the remainder of the shift. R49 was having longer periods of apnea and staff reminded him to breathe. R49 was still refusing to go into the ER.</p> <p>During an interview on 9/27/23 at 9:06 a.m., RN-B stated the charge nurse stated in her note R49 said it was a side effect of his meds, but R49 had signs of COVID-19. RN-B was unaware of R49's symptoms.</p> <p>R15's significant change MDS dated 8/19/23, identified R15 had no cognitive impairment and had diagnoses that included atrial fibrillation, renal insufficiency, and cancer.</p> <p>R15's progress notes identified the following:</p> <ul style="list-style-type: none"><li>- 9/17/23 at 8:27 a.m., identified the nursing assistant summoned nursing to R15's room and stated she thought R15 was "sick". R15 was lying in bed with blankets and all clothes stripped away, a flushed complexion, and covered in yellow vomit. R15 stated "I feel like horseshit". R15's rapid COVID test was negative. R15 was taking chemotherapy. Charge nurse was updated.</li><li>- 9/17/23 at 11:00 a.m., identified staff stopped and spoke with R15. R15 reported he was not feeling well "all over". Rapid COVID test was</li></ul> | F 880                                                                      |                                                                                                                          |  |                                                                        |



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| F 880                                                    | <p>Continued From page 21</p> <p>negative. R15 was in bed resting.</p> <p>- 9/17/23 at 1:27 p.m., identified R15 was in bed since 9:30 a.m., stating "I feel sick". Supervisor updated.</p> <p>During an interview on 9/27/23 at 9:06 a.m., RN-B stated, yes, R15 was showing signs and symptoms of COVID-19. RN-B was unaware of his symptoms.</p> <p>R45's significant change MDS dated 9/14/23, identified R45 had a mild cognitive impairment and had diagnoses that included hypertension, pneumonia, and diabetes.</p> <p>R45's progress note dated 9/23/23 at 4:25 p.m., identified R45 told staff she had been sneezing and coughing and had a burning throat. A COVID-19 test was administered and was negative.</p> <p>R45's EHR lacked to identify further information regarding R45's symptoms.</p> <p>During an interview on 9/27/23 at 9:06 a.m., RN-B stated she was unaware of R45's symptoms but R45 had previously been positive for COVID-19 less than 30 days prior.</p> <p>The facility Monthly Infection log dated September 2023, identified room number, resident name, site, criteria met, date of admit, date of symptoms, signs/symptoms, antibiotic treatment, antibiotics entered in antibiotic tracker, 72-hour hold completed in antibiotic tracker and resolved date. The log identified five UTI, one sepsis, one right ankle repair and one cellulitis. The log lacked to identify any infection not</p> |                                                                            |  | F 880                                                                                                 |                                                                                                                          |                                                                        |                            |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GRAND VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>923 HALE LAKE POINTE</b><br><b>GRAND RAPIDS, MN 55744</b> |                                                                                                                          |                                                                        |                            |
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| F 880                                                    | <p>Continued From page 22</p> <p>requiring antibiotic treatment, including R10's COVID-19 infection; and R118, R1, R14, R49 or R15 potential infection symptoms.</p> <p>During an interview on 9/27/23 at 9:06 a.m., RN-B stated she would need to speak with the DON because she was unsure what was requested when asked for the surveillance logs. RN-B provided a large green binder and stated the facility conducted infection prevention rounds weekly. A map of the facility was color coded by infection type to determine if there were any common factors such as room location. The log identified any resident who required antibiotic treatment for an infection. RN-B reviewed nursing progress notes daily and ensured "monitoring" was entered into the resident's EHR. On the units, nursing also had a log where they entered information, but this was also for residents treated with an antibiotic. RN-B reviewed the unit logs at the end of the month and entered them onto the log in the binder. Because R118, R1, R14, R49 or R15 were not prescribed an antibiotic, they would not be entered into the log for trending and/or tracking.</p> <p>During an interview on 9/27/23 at 10:45 a.m., the DON stated RN-B was in the infection prevention role for approximately three months. In the beginning, the DON was pretty involved, but RN-B seemed to catch on quickly. General surveillance logs should be reviewed by the nurse managers consistently and then given to RN-B at the end of the month to review them. The nurse managers were responsible for infection prevention on their units, were responsible to implement transmission-based precautions, and tracking and/or trending of infections during the month. The nursing staff should update the nurse</p> |                                                                            |  | F 880                                                                                                 |                                                                                                                          |                                                                        |                            |



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| F 880                                                    | <p>Continued From page 23</p> <p>managers with any signs/symptoms of infection and enter the information on the log.</p> <p>During an interview on 9/27/23 at 12:54 p.m., RN-B stated she was aware of the missing months of Monthly Infection Control Reporting Logs from the units and the Lodge unit never completed them. Raquel verified there are months missing from the Monthly Infection Control Reporting Log and The Lodge unit never completed them. They should have and the unit managers were educated about that.</p> <p>The facility policy Surveillance for Infections revised September 2017, identified the Infection Preventionist would conduct ongoing surveillance for healthcare acquired infections and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. Infections that will be included in routine surveillance include those with:</p> <ul style="list-style-type: none"><li>a. Evidence of transmissibility in a healthcare environment;</li><li>b. Available processes and procedures that prevent or reduce the spread of infection;</li><li>c. Clinically significant morbidity or mortality associated with infection (e.g., pneumonia, UTIs, C. diff); and</li><li>d. Pathogens associated with serious outbreaks. (e.g., invasive Streptococcus Group A, acute viral hepatitis, norovirus, scabies, influenza).</li></ul> <p>In addition to collecting data on the incidence of infections, the surveillance system is designed to capture certain epidemiologically important data that may influence how the overall surveillance data is interpreted; for example, focused surveillance data may be gathered for residents</p> | F 880                                                                      |                                                                                                                          |  |                                                                        |



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| F 880                                                    | <p>Continued From page 24</p> <p>with a high-risk for infection or those with a recent hospital stay.</p> <p>Catheter Care:</p> <p>R121's admission MDS dated 9/19/23, identified R121 had no cognitive impairment and R121 used an indwelling urinary catheter.</p> <p>R121's Order Summary Report dated 9/26/23, identified the following:</p> <ol style="list-style-type: none"><li>1. Staff were to provide education regarding catheter care every shift.</li><li>2. Change foley catheter as needed based on clinical indications such as infection, obstruction or when the system is compromised.</li></ol> <p>During an observation on 9/26/23 at 10:23 a.m., LPN-C emptied R121's catheter leg bag. LPN-C applied gloves and obtained R121's graduate from his bathroom. LPN-C placed the graduate on the floor under the R121's catheter leg bag port, opened the port and drained the bag. LPN-C cleaned the catheter bag port with an alcohol swab and closed the port. LPN-C then poured the urine into the toilet and rinsed the graduate with water.</p> <p>During an interview on 9/26/23 at 10:32 a.m., LPN-C stated you needed to make sure to wipe the port with alcohol before opening the catheter bag port. Normally, she would have placed a barrier between the graduate and the floor. She just didn't today. LPN-C believed she cleaned the port before opening.</p> <p>During an interview on 9/27/23 at 1:05 p.m., RN-D stated she expected staff to follow the facility's procedure for catheter care by placing a</p> | F 880                                                                      |                                                                                                                          |  |                                                                        |



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| F 880                                                    | Continued From page 25<br><br>barrier between the graduate and the floor and<br>cleaning the port before and after opening.<br><br>During an interview on 9/27/23 at 1:14 p.m., the<br>DON stated she expected staff to perform<br>catheter care per procedure by placing a barrier<br>between the floor and the graduate as well as<br>cleaning the port prior to opening to prevent the<br>spread of possible bacteria.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | F 880                                                                      |                                                                                                                          |  |                                                                        |
| F 883<br>SS=E                                            | The facility's catheter care policy was requested<br>but not received.<br><br>Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal<br>immunizations<br>§483.80(d)(1) Influenza. The facility must develop<br>policies and procedures to ensure that-<br>(i) Before offering the influenza immunization,<br>each resident or the resident's representative<br>receives education regarding the benefits and<br>potential side effects of the immunization;<br>(ii) Each resident is offered an influenza<br>immunization October 1 through March 31<br>annually, unless the immunization is medically<br>contraindicated or the resident has already been<br>immunized during this time period;<br>(iii) The resident or the resident's representative<br>has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes<br>documentation that indicates, at a minimum, the<br>following:<br>(A) That the resident or resident's representative<br>was provided education regarding the benefits<br>and potential side effects of influenza<br>immunization; and<br>(B) That the resident either received the influenza | F 883                                                                      |                                                                                                                          |  | 10/20/23                                                               |



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| F 883                                                    | <p>Continued From page 26</p> <p>immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to provide the most recent Centers for Disease Control (CDC) education regarding the potential risks and benefits of the pneumococcal vaccine for 5 of 5 residents (R5, R26, R19, R58, R61) reviewed for immunizations.</p> <p>Findings include:</p> | F 883                                                                      | <p>Corrective Action: R26, R 19, R 5, R 58, R 61 were offered pneumococcal 20. House wide audit was performed on all residents to identify those out of compliance with pneumococcal immunization update that went into effect in March 2023. Corrective Action as it applies to other residents: All residents</p> |  |                                                                    |



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| F 883                                                    | <p>Continued From page 27</p> <p>R5's quarterly Minimum Data Set (MDS) dated 6/15/23, identified R2 admitted to the facility on 4/8/17, was 95 years old, at had diagnoses including hypertension, atrial fibrillation, and history of pancreatic cancer.</p> <p>The facility Immunization Report dated 9/27/23, identified R5 received the pneumococcal polysaccharide vaccine (PPSV23) on 12/2/08 and the pneumococcal conjugate vaccine (PCV13) on 10/30/15. R5's electronic health record did not include evidence R5 or R5's representative received education regarding pneumococcal vaccine booster and there was no indication R5 was offered the pneumococcal vaccine per CDC guidance.</p> <p>R26's quarterly MDS dated 6/1/23, identified R26 was admitted to the facility on 11/6/16, was 88 years old and had diagnoses including hypertension and stage 3 chronic kidney disease.</p> <p>The facility Immunization Report dated 9/27/23, identified R5 received the PPSV23 on 11/3/05, and the PCV13 on 6/9/16. R26's electronic health record did not include evidence R26 or R26's representative received education regarding pneumococcal vaccine booster and there was no indication R26 was offered the pneumococcal vaccine per CDC guidance.</p> <p>R19's quarterly MDS dated 6/27/23, identified R19 was admitted to the facility on 1/10/20, was 53 years old and had diagnoses including diabetes mellitus type 2 and hypertension.</p> <p>The facility Immunization Report dated 9/27/23, identified R19 received the PPSV23 on 9/22/10.</p> | F 883                                                                      | <p>have the potential to be affected by this deficient practice. All residents found to be out of compliance with the offering of pneumococcal were offered vaccination. Recurrence will be prevented by: Policy was updated to include new guidance. Nursing staff responsible for vaccination review were educated on the policy update. Audits will be conducted once a week for four weeks and then once a month. The QAPI committee will determine when the audits may be discontinued. Corrective action will be monitored by DON or designee.</p> |  |                                                                        |



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| F 883                                                    | <p>Continued From page 28</p> <p>R19's electronic health record did not include evidence R19 or R19's representative received education regarding pneumococcal vaccine booster and there was no indication R19 was offered the pneumococcal vaccine per CDC guidance.</p> <p>R58's significant change MDS dated 8/2/23, identified R58 was re-admitted to the facility on 3/3/23, was 79 years old and had diagnoses including coronary artery disease, hypertension, and ischemic cardiomyopathy.</p> <p>The facility Immunization Report dated 9/27/23, identified R58 received the PPSV23 on 10/2/09, and the PCV13 on 2/1/16. R58's electronic health record did not include evidence R58 or R58's representative received education regarding pneumococcal vaccine booster and there was no indication R58 was offered the pneumococcal vaccine per CDC guidance.</p> <p>R61's admission MDS dated 8/1/23, identified R61 was admitted to the facility on 7/26/23, was 77 years old and had diagnoses including coronary artery disease, hypertension, and rheumatoid arthritis.</p> <p>The facility Immunization Report dated 9/27/23, identified R61 received the PPSV23 on 1/4/12, and the PCV13 on 5/2/17. R61's electronic health record did not include evidence R61 or R61's representative received education regarding pneumococcal vaccine booster and there was no indication R61 was offered the pneumococcal vaccine per CDC guidance.</p> <p>During interview on 9/27/23 at 2:30 p.m., the director of nursing (DON) stated upon admission</p> | F 883                                                                      |                                                                                                                          |  |                                                                        |



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

PRINTED: 11/06/2023  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245368</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                  |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>09/27/2023</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GRAND VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>923 HALE LAKE POINTE</b><br><b>GRAND RAPIDS, MN 55744</b> |                                                                                                                          |                                                                        |                            |
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| F 883                                                    | <p>Continued From page 29</p> <p>the nursing staff review the residents medical record as well as the Minnesota Immunization Information Connection (MIIC) database for immunizations and enter the data into the facility immunization assessment. The assessment would identify what immunizations the resident was due for, then staff would offer the immunizations to the resident and/or family representative. The DON was aware the guidance for pneumococcal vaccines had recently changed, and their assessment was updated accordingly.</p> <p>During interview on 9/27/23 at 2:47 p.m., registered nurse (RN)-A, stated they were looking at pneumococcal vaccines with new admission, quarterly, and significant change assessments. The electronic assessment was recently updated but was not updated according to the newest CDC guidance. When there was a new admission, the staff would assess the residents needs and then offer the pneumococcal vaccine, if indicated. They did not have a plan in place to offer or administer pneumococcal vaccinations for current residents.</p> <p>The facility Pneumococcal Vaccine policy version 2.2 (H5MAPL0650), identified upon admission, residents would be assessed for eligibility to receive pneumococcal vaccines and when indicated, would be offered on of the pneumococcal vaccines within thirty days of admission unless medically contraindicated. Before receiving a pneumococcal vaccine, the resident or legal representative would receive education regarding the benefits and potential side effects of the pneumococcal vaccine according to the current vaccine information statements. Provisions of such education would</p> |                                                                            |  | F 883                                                                                                 |                                                                                                                          |                                                                        |                            |



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

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GRAND VILLAGE</b> |                                                                                                                                                                                                                                                                  |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>923 HALE LAKE POINTE</b><br><b>GRAND RAPIDS, MN 55744</b>                    |  |                                                                        |
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| F 883                                                    | Continued From page 30<br>be documented in the resident's medical record.<br>The policy did not address the updated CDC<br>guidance.<br><br>The facility copy of the currently used<br>Pneumococcal Vaccine Information Sheet was<br>requested but not received. | F 883                                                                      |                                                                                                                          |  |                                                                        |





*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
October 11, 2023

Administrator  
Grand Village  
923 Hale Lake Pointe  
Grand Rapids, MN 55744

Re: State Nursing Home Licensing Orders  
Event ID: PEQ511

Dear Administrator:

The above facility was surveyed on September 25, 2023 through September 27, 2023 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](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:

Jen Bahr, RN, Unit Supervisor  
Bemidji District Office  
Licensing and Certification Program  
Health Regulation Division  
Minnesota Department of Health  
705 5th Street NW, Suite A  
Bemidji, Minnesota 56601-2933  
Email: [Jennifer.bahr@state.mn.us](mailto:Jennifer.bahr@state.mn.us)  
Office: (218) 308-2104 Mobile: (218) 368-3683

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,



Kamala Fiske-Downing  
Minnesota Department of Health  
Health Regulation Division  
Telephone: (651) 201-4112  
Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)



Minnesota Department of Health

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| 2 000                                                    | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS:<br/>On 9/25/23 - 9/27/23, 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</p> | 2 000                                                                  |                                                                                                                          |  |                                                                 |

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

10/18/23



Minnesota Department of Health

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                 |                                                                                                                          |  |                                                                 |
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| 2 000                                                    | <p>Continued From page 1</p> <p>identify the date when they will be completed.</p> <p>The following complaints were reviewed during the survey: H536858060 (MN90961) and no licensing orders were issued.</p> <p>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.</p> <p>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin<br/>&lt;<a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html</a>&gt; 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.</p> <p>PLEASE DISREGARD THE HEADING OF THE</p> | 2 000                                                                                           |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

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| 2 000                                                    | Continued From page 2<br><br>FOURTH COLUMN WHICH STATES,<br>"PROVIDER'S PLAN OF CORRECTION." THIS<br>APPLIES TO FEDERAL DEFICIENCIES ONLY.<br>THIS WILL APPEAR ON EACH PAGE. THERE<br>IS NO REQUIREMENT TO SUBMIT A PLAN OF<br>CORRECTION FOR VIOLATIONS OF<br>MINNESOTA STATE STATUTES/RULES.<br><a href="http://www.health.state.mn.us/divs/fpc/oproinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/oproinfo/infobul.htm</a> . The State licensing orders are<br>delineated on the attached Minnesota<br>Department of Health orders being submitted to<br>you electronically. Although no plan of correction<br>is necessary for State Statutes/Rules, please<br>enter the word "CORRECTED" in the box<br>available for text. You must then indicate in the<br>electronic State licensure process, under the<br>heading completion date, the date your orders will<br>be corrected prior to electronically submitting to<br>the Minnesota Department of Health. The facility<br>is enrolled in ePOC and therefore a signature is<br>not required at the bottom of the first page of<br>state form.<br><br>PLEASE DISREGARD THE HEADING OF THE<br>FOURTH COLUMN WHICH STATES,<br>"PROVIDER'S PLAN OF CORRECTION." THIS<br>APPLIES TO FEDERAL DEFICIENCIES ONLY.<br>THIS WILL APPEAR ON EACH PAGE. | 2 000                                                                                           |                                                                                                                          |  |                                                                    |
| 21375                                                    | MN Rule 4658.0800 Subp. 1 Infection Control;<br>Program<br><br>Subpart 1. Infection control program. A nursing<br>home must establish and maintain an infection<br>control program designed to provide a safe and<br>sanitary environment.<br><br>This MN Requirement is not met as evidenced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 21375                                                                                           |                                                                                                                          |  | 10/20/23                                                           |



Minnesota Department of Health

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| 21375                                                    | <p>Continued From page 3</p> <p>by:<br/>Based on observation, interview and document review, failed to implement timely transmission-based precautions (TBP) and testing according to the Centers for Disease Control (CDC) for 1 of 1 residents (R10) who were displaying COVID-19 symptoms; and the facility failed to conduct COVID-19 outbreak testing was conducted according to CDC guidance for 4 of 4 residents (R21, R26, R21, R41) who were exposed to COVID-19 and 1 of 1 staff ( NA-D) who worked without participating in outbreak testing; and failed to ensure surveillance tracking of infections was completed for 6 of 6 residents (R118, R1, R14, R49, R15, R45) who displayed signs and symptoms of potential infection. This had the potential to affect all residents and staff. In addition, the facility failed to ensure catheter care was done to prevent transmission of organisms for 1 of 1 residents (R121).</p> <p>Findings include:</p> <p>COVID:</p> <p>The Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the Coronavirus Disease 2019 (COVID-19) Pandemic updated 5/8/23, identified when performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction's public health authority.</p> <ul style="list-style-type: none"> <li>- A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed.</li> <li>- The approach to an outbreak investigation could</li> </ul> | 21375                                                                                           | CORRECTED                                                                                                                |                                                                 |



Minnesota Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GRAND VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>923 HALE LAKE POINTE<br/>GRAND RAPIDS, MN 55744</b> |                                                                                                                          |  |                                                                    |
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| 21375                                                    | <p>Continued From page 4</p> <p>involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.</p> <ul style="list-style-type: none"> <li>- Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.</li> <li>- In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of Empiric use of Transmission-Based Precautions for residents and work restriction of HCP with higher-risk exposures. In addition, there might be other circumstances for which the jurisdiction 's public authority recommends these and additional precautions.</li> <li>- If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated. Empiric use of</li> </ul> | 21375                                                                                           |                                                                                                                          |  |                                                                    |



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| 21375                                                    | <p>Continued From page 5</p> <p>Transmission-Based Precautions for residents and work restriction for HCP who met criteria can be discontinued as described in Section 2 and the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, respectively.</p> <p>- If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every 3 days), should be considered.</p> <p>The CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 updated 9/23/22, identified HCP with even mild symptoms of COVID-19 should be prioritized for viral testing with nucleic acid or antigen detection assays. When testing a person with symptoms of COVID-19, negative results from at least one viral test indicate that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected. If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining work restrictions and confirming with a second negative NAAT. If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test. For HCP who were initially suspected of having COVID-19 but, following evaluation, another diagnosis is suspected or confirmed, return-to-work decisions</p> | 21375                                                                                           |                                                                                                                          |  |                                                                 |



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| 21375                                                    | <p>Continued From page 6</p> <p>should be based on their other suspected or confirmed diagnoses.</p> <p>R10's annual Minimum Data Set dated 8/1/23, identified no cognitive impairment and diagnoses included atrial fibrillation, hypertension, renal insufficiency, and diabetes.</p> <p>The Easy Reporting testing log dated 9/26/23, identified R10 tested positive for COVID-19 on 9/20/23, and 9/21/23.</p> <p>R10's nursing progress notes identified the following:</p> <ul style="list-style-type: none"> <li>- 9/21/23 at 3:12 a.m., R10 put on his call light and complained of not feeling well. R10 sounded congested/nasal congestion. R10's temperature was 97.5 degrees Fahrenheit (F). No coughing noted. R10 stated he felt achy all over and requested to be COVID tested which was negative. The note lacked to identify if R10 was placed in transmission-based precautions.</li> <li>- 9/21/23 at 5:16 p.m., staff approached R10 at approximately 4:00 p.m. in the commons area to complete an informed consent for use of escitalopram. R10 had a congested cough, moderate amounts of bright green mucous at the edge of his nose, and face was flush. R10 stated he was feeling under the weather and that it was worsening throughout the day. R10 was chilled. R10's skin was warm and clammy to touch. R10 was rapid tested earlier and was negative. R10 was retested which was positive. R10 was assisted to his room, updated on status, and R10 would like to take an antiviral if he was eligible. Director of nursing (DON), medical director, administrator, and infection control nurse were updated. An isolation cart was placed outside R10's room and immediate contract tracing was completed with shift staff on at that time and</li> </ul> | 21375                                                                                           |                                                                                                                          |  |                                                                    |



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| 21375                                                    | <p>Continued From page 7</p> <p>residents who R10 had contact with greater than 15 minutes of high-risk exposure. These residents were scheduled for Covid testing on days 1, 3, and 5.</p> <p>- 9/22/23 at 1:33 a.m., R10 was admitted to the hospital due to COVID-19.</p> <p>- 9/22/23 at 1:47 a.m., late entry for 9/21/23: unidentified trained medication assistant (TMA) reported to writer R10 was not doing well and wanted to go to the ER. The TMA stated R10's oxygen saturations were 77% on 2 liters per minute (lpm) per nasal cannula (nc). R10 had yellow mucus from his nose, lung sounds were adventitious (abnormal lung sounds heard over the lungs and airways) bilaterally. Called the provider on call and received order to send R10 to ER for evaluation and treatment. R10's blood pressure was 139/29, pulse 99, temperature 103.2 degrees F, and oxygen saturations were 77% on 2 lpm via nc. R10 was transported to the hospital via ambulance at 6:55 p.m.</p> <p>R21's significant change MDS dated 6/26/23, identified R21 had no cognitive impairment and diagnoses included atrial fibrillation, heart failure, hypertension, renal insufficiency, and diabetes.</p> <p>The Easy Reporting testing log dated 9/26/23, identified R21 tested negative for COVID-19 on 9/21/23, 9/22/23 and 9/23/23.</p> <p>During an interview on 9/27/23 at 9:06 a.m., RN-B stated R21's COVID-19 testing was initiated by RN-C during contact tracing from R10's positive COVID-19 test. R21 should have been tested on day 1, day 3 and day 5. R21 tested on day 0, day 1 and day 3. This did not meet the facility's testing plan.</p> <p>R26's significant change MDS dated 6/29/23,</p> | 21375                                                                                           |                                                                                                                          |  |                                                                    |



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| 21375                                                    | <p>Continued From page 8</p> <p>identified R26 had a severe cognitive impairment and diagnoses included Alzheimer's disease, renal insufficiency, and hypertension.</p> <p>The Easy Reporting testing log dated 9/26/23, identified R26 tested negative for COVID-19 on 9/22/23 and 9/24/23.</p> <p>During an interview on 9/27/23 at 9:06 a.m., RN-B stated R26's COVID-19 testing was initiated by RN-C during contact tracing from R10's positive COVID-19 test. R26 should have been tested on day 1, day 3 and day 5. R21 tested on day 1 and day 3, but the log did not identify R26 was tested on day 5. This did not meet the facility's testing plan.</p> <p>R27's quarterly MDS dated 9/6/23, identified R27 had severe cognitive impairment and diagnoses included Alzheimer's disease, hypertension, renal insufficiency, and diabetes.</p> <p>The Easy Reporting testing log dated 9/26/23, identified R27 tested negative for COVID-19 on 9/22/23 and 9/24/23.</p> <p>During an interview on 9/27/23 at 9:20 a.m., RN-B stated R27's COVID-19 testing was also initiated because of her exposure to R10. R10 should have completed testing according to the facility's testing plan.</p> <p>R41's quarterly MDS dated 6/13/23, identified R41 had a severe cognitive impairment and diagnoses included Alzheimer's disease.</p> <p>The Easy Reporting testing log dated 9/26/23, identified R41 tested negative for COVID-19 on 9/22/23 and 9/24/23.</p> | 21375                                                                                           |                                                                                                                          |  |                                                                    |



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| 21375                                                    | <p>Continued From page 9</p> <p>During an interview on 9/27/23 at 9:25 a.m., RN-B stated R41 was also exposed to R10. R10 should have completed testing according to the facility's testing plan. R41 tested the morning of 9/27/23, due to exhibiting possible symptoms of COVID-19.</p> <p>NA-D's Sample Risk Assessment for Healthcare Workers Potentially Exposed to COVID-19 in Minnesota dated 9/21/23, identified NA-D was within 6 ft of a person with confirmed COVID-19 for greater than 15 minutes without personal protective equipment (PPE). NA-D was determined to be high-risk due to NA-D had prolonged close contact with R10 and was not wearing a surgical mask or respirator.</p> <p>The Easy Reporting testing log dated 9/26/23, identified NA-D tested negative on 9/22/23 and 9/24/23. The log did not identify if NA-D tested for COVID-19 on 9/26/23.</p> <p>During an interview on 9/27/23 at 7:16 a.m., NA-B stated staff really didn't have to do anything with R10. R10 did his own cares, staff picked up his trash and his dirty clothes. That was about it. The day R10 became ill, R10 was in the dining room, the common area, he was "all over". No one was wearing PPE. The next day, NA-B tested and threw the test away. It was negative. NA-B did not know if the facility had to track any testing results. NA-B did not write it down anywhere.</p> <p>During an interview on 9/27/23 at 7:48 a.m., LPN-B was observed unmasked and stated she worked the day R10 became sick. R10 was saying he had a "little tickle" but did not have a fever. Later that day, he became sick. LPN-B didn't think anything of it. R10 was independent with supervision to make sure he's clean and his</p> | 21375                                                                                                 |                                                                                                                          |  |                                                                    |



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| 21375                                                    | <p>Continued From page 10</p> <p>bathroom was clean. R10 was about and about. He ate at the corner table in the common area. His tablemate, most of the time, ate his meals in his room. LPN-B could not say if R10 ate alone that day. All staff tested for COVID-19, the results were written down on the sign in sheet and staff with close contact masked for 10 days. Staff would know if they had close contact because you knew what you've done with the resident every day. For LPN-B, close contact meant if you had to assist the resident to eat or if you had to help with daily cares. LPN-B passed medications to R10 but R10 thought he was the boss, so you don't like to hang around. It really depended on how much care a resident required. Staff tested that day, you can't lie, staff reported to the nurse manager and RN-B. RN-B took care of all that for staff.</p> <p>During an interview on 9/27/23 at 8:00 a.m., NA-F was observed unmasked and stated she worked until 5:00 p.m. the day R10 became ill. R10 was sitting in his recliner in the common area like he always did, and he sounded horrible. Coughing, congested. NA-F told the nurse but could not remember who the nurse was. R10 was tested after NA-F left for the day and was sent to the hospital. The next day, NA-F had to test. Staff collected their own swab in the nurses' station and the nurse put the swab in the card. The nurse took care of it after that. Afterwards, NA-F was instructed to wear a mask for 10 days. NA-F stated 9/27/23, was day 6. NA-F was off and when she came to the facility that morning the sign in sheet did not say she needed to mask or not. So, NA-F did not need to.</p> <p>During an interview on 9/27/23 at 9:06 a.m., RN-B stated she was responsible for the facility's infection control program for a little less than</p> | 21375                                                                                           |                                                                                                                          |  |                                                                    |



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| 21375                                                    | Continued From page 11<br><br>three months. If a resident was feeling ill, the cart nurse should update the nurse manager and, if there were any concerns, the nurse manager would let RN-B know. RN-B was also available during off hours by phone and email. There was always a RN on-call, and they should call her for guidance as well. RN-B was informed of R10's positive COVID-19 test on Monday, 9/25/23, because she was on vacation. R10 wasn't feeling good, the nurse manager tested him that morning and R10 was negative. Then, the nurse went to get a consent form that afternoon, R10 was clammy and didn't feel good. R10 was tested again, and it was positive. Test results are entered in the assessment tab in R10's electronic health record (EHR) and the result automatically populated on the Easy Reporting testing log. In R10's progress notes, it showed R10 was tested at 3:12 a.m. on 9/21/23, but nursing did not enter the test in the assessment. R10 complained of nasal congestion and achy all over. On rounding notes, it just said R10 wasn't feeling well, and no monitoring was initiated. Ideally, monitoring should have been implemented in R10's EHR. Because R10's COVID-19 antigen test was negative and there was no known exposure, R10 was not placed in transmission-based precautions prior to his COVID-19 antigen test was positive. RN-B did not know the CDC guidance regarding using antigen tests for residents or staff that were symptomatic for COVID-19. The facility policy one test confirmed a resident was negative. RN- B stated it would make sense to place R10 in transmission-based precautions because he was symptomatic. Symptoms could mean he was contagious to other staff and residents. RN-C and the director of nursing (DON) did contact tracing the day R10 tested positive. For residents, they determine who was exposed for greater than 15 minutes in 24 | 21375                                                                                                 |                                                                                                                          |  |                                                                    |



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| 21375                                                    | <p>Continued From page 12</p> <p>hours. Staff did not observe every resident at all times because it just was not possible. RN-C and the DON filled out the contract tracing sheets and found only two staff that needed to test: NA-D and NA-E. RN-B was unaware of any other staff that needed testing. Staff were to notify RN-B when a test was completed for tracking of the information. When RN-B was in the facility and was notified of a staff's exposure, RN-B would put in a note prior to the shift to make sure the staff tested. The result was entered into Easy Reporting. RN-B stated there are antigen tests on the units, so the nurses have them for residents. Staff used them though and didn't communicate that. If RN-B did not know of a test, she was unable to document it and track it properly. RN-B has spoken to the DON about that because, according to the contact tracing forms, only NA-D was supposed to test for COVID-19.</p> <p>During an interview on 9/27/23 at 10:25 a.m., RN-C stated when a resident exhibited signs or symptoms of COVID-19, nursing assessed them depending on the symptoms and the resident's medical history. It really didn't matter what symptoms, a COVID-19 antigen test was done because it either rule it out or clarified the problem. R10 was tested at approximately 3:00 a.m. on 9/21/23, with an antigen test with a negative result. That's what was reported off to day shift. R10 was not placed into transmission-based precautions but was greater than 6 feet away from residents and staff. Contact tracing was done. There were four residents and two staff that needed to be tested. Initially two staff tested right away because they had direct contact, but with further evaluation no one had more than 15 minutes with R10. R10 usually sat by himself and talks to others but sits so most are more than 6 feet away from him. Basically, we're</p> | 21375                                                                                           |                                                                                                                          |  |                                                                    |



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| 21375                                                    | <p>Continued From page 13</p> <p>told if a resident is acting "abnormal" to test. The nurse practitioner always asked if we tested a resident when we call her. RN-C was unaware of CDC guidance for use of antigen tests with symptomatic residents and stated, in her experience, one COVID-19 antigen test with a negative result ruled out COVID-19. Typically, nursing looked for a persistent cough, fever, burning in the chest, loss of taste or smell.</p> <p>During an interview on 9/27/23 at 10:45 a.m., the DON stated the unit nurse managers were responsible for infection control on their unit, implementing transmission-based precautions and tracking/trending of infections during the month. Staff should update the nurse manager or charge nurse with symptoms so they can be assessed and tested. All testing should be documented. I know we were doing it wrong.</p> <p>During an interview on 9/27/23 at 12:53 p.m., the DON stated the staff figured out where problems began. Prior to June, the facility was using a quantitative real-time PCR or "q test" which only required one test. After June, the staff began using the antigen tests and did not realize they needed to change the testing process.</p> <p>The facility policy COVID-19 Community Testing Plan dated 8/6/21, identified the purpose of the policy was to identify COVID-19 positive residents and staff through viral testing; testing was a priority to help inform clinical care and infection prevention and control practices in the facility's setting. A negative RT-PCR test only indicated that an individual did not have detectable virus material present at the time of testing, and repeat testing might be needed. Widespread community transmission as well as movement of staff and residents in and out of a facility result in</p> | 21375                                                                                           |                                                                                                                          |  |                                                                    |



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| 21375                                                    | <p>Continued From page 14</p> <p>continuous introduction. Testing complimented existing infection control interventions but did not replace good infection control. However, the policy did not address the use of antigen tests.</p> <p>The facility policy COVID-19 policy undated, identified residents and team members with suspected/confirmed COVID-19 or exposures would be quarantined/isolated based on the most up-to-date CDC guidance. Residents and team members with symptoms of COVID-19 would be tested unless an alternate diagnosis was provided by a healthcare provider with the appropriate scope of practice. Admission testing, outbreak testing, and exposure-related testing of residents and team members would be based on the most up-to-date CDC guidelines. Residents would be placed under enhanced respiratory precautions until symptoms could be ruled-out as COVID (via testing or alternate diagnosis). However, the policy did not address the use of antigen tests.</p> <p>Surveillance</p> <p>R118's Admission Record dated 9/27/23, identified R118 was admitted to the facility on 9/8/23. R118 had diagnoses that included chronic obstructive pulmonary disease (COPD) and diabetes.</p> <p>R118's progress notes identified the following:<br/>- 9/8/23 at 4:35 p.m., R118 admitted to the facility with a primary diagnosis of left femur fracture and UTI. Resident is alert and oriented to person, place, and time, pleasant and cooperative upon assessment. Faint crackles in lower lobes. Resident reports a dry cough. COVID test was negative. Does report having issues with dizziness and vertigo. Educated R118 to change</p> | 21375                                                                  |                                                                                                                          |  |                                                                 |



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| 21375                                                    | <p>Continued From page 15</p> <p>positions slowly and not to get up without staff present until cleared by therapy to do so. Educated on the use of the call light and was able to verbalize understanding of its use. No further questions or concerns at this time.</p> <p>- 9/10/23 at 3:32 p.m., identified R118 complained of nausea and general gastrointestinal distress. R118 had her morning medication sitting on bedside table and stated, "I'm just not going to take them with me being nauseated, I was going to earlier but decided not to as won't keep them down". Resident sat at bedside, alert and orientated, complained of nausea, pneumonia and was given Maalox. R118's COVID test negative. R118 just could not give specific symptoms of not feeling right; just nauseated. R118 had large normal bowel movement, denied shortness of breath or respiratory distress, chest pain or discomfort. Vital signs were within normal range for R118's baseline. Staff encouraged resident to be up and see if that helped.</p> <p>During an interview on 9/27/23 at 9:06 a.m., RN-B stated she was unaware of R118's cough or symptoms.</p> <p>R1's significant change MDS dated 8/16/23, identified R1 had a moderate cognitive impairment and diagnoses that included dementia, pneumonia, and respiratory failure.</p> <p>R1's progress note dated 9/10/23 at 5:53 a.m., identified R1 was awake this shift since 01 :30 and was irritable. R1 had a non-productive cough since 1 :30 a.m. which was unaided by an Albuterol nebulizer but responded somewhat to Tussin cough syrup. COVID swab administered at 3:30 a.m. and was negative.</p> | 21375                                                                                           |                                                                                                                          |  |                                                                    |



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| 21375                                                    | <p>Continued From page 16</p> <p>R1's progress note dated 9/10/23 at 5:44 a.m., identified at 1:00 R1 started having an infrequent nonproductive cough. At 3:00 a.m., R1's cough had increased in frequency but remained non-productive. Vitals were within normal limits. R1's lung sounds were wheezy on left and mildly congested on right in all lobes. R1 was given an Albuterol nebulizer treatment and was somewhat effective. Cough decreased in frequency and respirations came down to 20. At 3:28 a.m., Tussin cough syrup was offered and accepted for cough (medication was effective). At 3:30 a.m., COVID swab administered with negative results.</p> <p>During an interview on 9/27/23 at 9:06 a.m., RN-B stated R1 had repetitive aspiration pneumonia. R1 was not added to the Monthly Infection log.</p> <p>R14 annual MDS dated 9/7/23, identified R14 had a severe cognitive impairment and had diagnoses that included Alzheimer's disease.</p> <p>R14's progress note dated 9/10/23 at 5:52 a.m., identified at 3 :30 a.m. a COVID swab was administered to R14 with negative results. R14 had a frequent, non-productive cough from 03:30 - 05:00 with a temperature of 97.5 degrees F. R14's EHR failed to identify further documentation related to R14's cough.</p> <p>During an interview on 9/27/23 at 9:06 a.m., RN-B stated R14 did not have a repeat test. RN-B read the progress note and was aware of R14's symptoms but did not add R14 to the Monthly Infection log.</p> <p>R49's admission MDS dated 8/19/23, identified R49 had no cognitive impairment and had diagnoses that included atrial fibrillation,</p> | 21375                                                                                           |                                                                                                                          |  |                                                                 |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GRAND VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>923 HALE LAKE POINTE<br/>GRAND RAPIDS, MN 55744</b> |                                                                                                                          |  |                                                                    |
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| 21375                                                    | <p>Continued From page 17</p> <p>hypertension, and diabetes.</p> <p>R49's progress notes identified the following:</p> <ul style="list-style-type: none"> <li>- 9/17/23 at 8:19 p.m., R49 was out of the facility, returned with upper wheeze vocal sounds with breathing. Only happened when breathing through his nose. Denied any allergies. COVID test was done, lungs assessed, clear throughout. Denied shortness of breath. Denied wanting to go to ER. Fell asleep during the assessment. Noted short periods of apnea, and then R49 coughed and took a deep breath.</li> <li>-9/17/23 at 11:09 p.m., identified R49 was of the facility for a birthday party. R49 came back very fatigued and went straight to bed. He did not get up for supper so R10's insulin was held and continued to monitor his blood sugar. Later, R49 was complaining of a cough and phlegm in his throat. His lungs were clear. Blood pressure was 111/73, oxygen saturations were 93%, pulse was 77, temperature 98 degrees F and respirations 14. R49 continued to state that he was not feeling well, he thought this may be because of taking the suboxone. This was his third dose, but R49 stated his symptoms started shortly after. Nursing continued to check in on the R49 multiple times throughout the remainder of the shift. R49 was having longer periods of apnea and staff reminded him to breathe. R49 was still refusing to go into the ER.</li> <li>During an interview on 9/27/23 at 9:06 a.m., RN-B stated the charge nurse stated in her note R49 said it was a side effect of his meds, but R49 had signs of COVID-19. RN-B was unaware of R49's symptoms.</li> <li>R15's significant change MDS dated 8/19/23, identified R15 had no cognitive impairment and</li> </ul> | 21375                                                                                           |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

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| 21375                                                    | <p>Continued From page 18</p> <p>had diagnoses that included atrial fibrillation, renal insufficiency, and cancer.</p> <p>R15's progress notes identified the following:</p> <ul style="list-style-type: none"> <li>- 9/17/23 at 8:27 a.m., identified the nursing assistant summoned nursing to R15's room and stated she thought R15 was "sick". R15 was lying in bed with blankets and all clothes stripped away, a flushed complexion, and covered in yellow vomit. R15 stated "I feel like horseshit". R15's rapid COVID test was negative. R15 was taking chemotherapy. Charge nurse was updated.</li> <li>- 9/17/23 at 11:00 a.m., identified staff stopped and spoke with R15. R15 reported he was not feeling well "all over". Rapid COVID test was negative. R15 was in bed resting.</li> <li>- 9/17/23 at 1:27 p.m., identified R15 was in bed since 9:30 a.m., stating "I feel sick". Supervisor updated.</li> </ul> <p>During an interview on 9/27/23 at 9:06 a.m., RN-B stated, yes, R15 was showing signs and symptoms of COVID-19. RN-B was unaware of his symptoms.</p> <p>R45's significant change MDS dated 9/14/23, identified R45 had a mild cognitive impairment and had diagnoses that included hypertension, pneumonia, and diabetes.</p> <p>R45's progress note dated 9/23/23 at 4:25 p.m., identified R45 told staff she had been sneezing and coughing and had a burning throat. A COVID-19 test was administered and was negative.</p> <p>R45's EHR lacked to identify further information</p> | 21375                                                                                           |                                                                                                                          |  |                                                                    |



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| 21375                                                    | <p>Continued From page 19</p> <p>regarding R45's symptoms.</p> <p>During an interview on 9/27/23 at 9:06 a.m., RN-B stated she was unaware of R45's symptoms but R45 had previously been positive for COVID-19 less than 30 days prior.</p> <p>The facility Monthly Infection log dated September 2023, identified room number, resident name, site, criteria met, date of admit, date of symptoms, signs/symptoms, antibiotic treatment, antibiotics entered in antibiotic tracker, 72-hour hold completed in antibiotic tracker and resolved date. The log identified five UTI, one sepsis, one right ankle repair and one cellulitis. The log lacked to identify any infection not requiring antibiotic treatment, including R10's COVID-19 infection; and R118, R1, R14, R49 or R15 potential infection symptoms.</p> <p>During an interview on 9/27/23 at 9:06 a.m., RN-B stated she would need to speak with the DON because she was unsure what was requested when asked for the surveillance logs. RN-B provided a large green binder and stated the facility conducted infection prevention rounds weekly. A map of the facility was color coded by infection type to determine if there were any common factors such as room location. The log identified any resident who required antibiotic treatment for an infection. RN-B reviewed nursing progress notes daily and ensured "monitoring" was entered into the resident's EHR. On the units, nursing also had a log where they entered information, but this was also for residents treated with an antibiotic. RN-B reviewed the unit logs at the end of the month and entered them onto the log in the binder. Because R118, R1, R14, R49 or R15 were not prescribed an antibiotic, they would not be entered into the log</p> | 21375                                                                                           |                                                                                                                          |  |                                                                 |



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| 21375                                                    | <p>Continued From page 20</p> <p>for trending and/or tracking.</p> <p>During an interview on 9/27/23 at 10:45 a.m., the DON stated RN-B was in the infection prevention role for approximately three months. In the beginning, the DON was pretty involved, but RN-B seemed to catch on quickly. General surveillance logs should be reviewed by the nurse managers consistently and then given to RN-B at the end of the month to review them. The nurse managers were responsible for infection prevention on their units, were responsible to implement transmission-based precautions, and tracking and/or trending of infections during the month. The nursing staff should update the nurse managers with any signs/symptoms of infection and enter the information on the log.</p> <p>During an interview on 9/27/23 at 12:54 p.m., RN-B stated she was aware of the missing months of Monthly Infection Control Reporting Logs from the units and the Lodge unit never completed them. Raquel verified there are months missing from the Monthly Infection Control Reporting Log and The Lodge unit never completed them. They should have and the unit managers were educated about that.</p> <p>The facility policy Surveillance for Infections revised September 2017, identified the Infection Preventionist would conduct ongoing surveillance for healthcare acquired infections and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. Infections that will be included in routine surveillance include those with:</p> <p>a. Evidence of transmissibility in a healthcare environment;</p> | 21375                                                                  |                                                                                                                          |  |                                                                 |



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| 21375                                                    | <p>Continued From page 21</p> <p>b. Available processes and procedures that prevent or reduce the spread of infection;<br/>c. Clinically significant morbidity or mortality associated with infection (e.g., pneumonia, UTIs, C. diff); and<br/>d. Pathogens associated with serious outbreaks. (e.g., invasive Streptococcus Group A, acute viral hepatitis, norovirus, scabies, influenza).<br/>In addition to collecting data on the incidence of infections, the surveillance system is designed to capture certain epidemiologically important data that may influence how the overall surveillance data is interpreted; for example, focused surveillance data may be gathered for residents with a high-risk for infection or those with a recent hospital stay.</p> <p>Catheter Care:</p> <p>R121's admission MDS dated 9/19/23, identified R121 had no cognitive impairment and R121 used an indwelling urinary catheter.</p> <p>R121's Order Summary Report dated 9/26/23, identified the following:</p> <ol style="list-style-type: none"> <li>1. Staff were to provide education regarding catheter care every shift.</li> <li>2. Change foley catheter as needed based on clinical indications such as infection, obstruction or when the system is compromised.</li> </ol> <p>During an observation on 9/26/23 at 10:23 a.m., LPN-C emptied R121's catheter leg bag. LPN-C applied gloves and obtained R121's graduate from his bathroom. LPN-C placed the graduate on the floor under the R121's catheter leg bag port, opened the port and drained the bag. LPN-C cleaned the catheter bag port with an alcohol swab and closed the port. LPN-C then poured the urine into the toilet and rinsed the graduate with</p> | 21375                                                                                           |                                                                                                                          |                                                                    |



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| 21375                                                    | <p>Continued From page 22</p> <p>water.</p> <p>During an interview on 9/26/23 at 10:32 a.m., LPN-C stated you needed to make sure to wipe the port with alcohol before opening the catheter bag port. Normally, she would have placed a barrier between the graduate and the floor. She just didn't today. LPN-C believed she cleaned the port before opening.</p> <p>During an interview on 9/27/23 at 1:05 p.m., RN-D stated she expected staff to follow the facility's procedure for catheter care by placing a barrier between the graduate and the floor and cleaning the port before and after opening.</p> <p>During an interview on 9/27/23 at 1:14 p.m., the DON stated she expected staff to perform catheter care per procedure by placing a barrier between the floor and the graduate as well as cleaning the port prior to opening to prevent the spread of possible bacteria.</p> <p>The facility's catheter care policy was requested but not received.</p> <p><b>SUGGESTED METHOD OF CORRECTION:</b><br/>The DON or designee could review and revise, as necessary, policy and procedures related to transmission based precautions, testing, tracking and trending of communicable diseases and catheter care; then educate staff on the expectations; and could monitor and develop an audit system to ensure compliance.</p> <p><b>TIME PERIOD FOR CORRECTION:</b><br/>Twenty-One (21) days.</p> | 21375                                                                  |                                                                                                                          |  |                                                                 |



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| 21855                                                    | Continued From page 23                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 21855                                                                                           |                                                                                                                          |  | 10/20/23                                                           |
| 21855                                                    | <p>MN St. Statute 144.651 Subd. 15 Patients &amp; Residents of HC Fac.Bill of Rights</p> <p>Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and document review, the facility failed to honor resident's right for privacy for 1 of 1 resident (R10) reviewed for resident privacy.</p> <p>Findings included:</p> <p>R10's annual Minimum Data Set (MDS) dated 8/1/23, identified no cognitive impairment and a diagnosis of COVID-19.</p> <p>R10's progress note dated 9/25/23 at 4:42 p.m., identified R10 returned following a hospitalization for acute respiratory failure due to COVID-19 and was to remain in isolation until 9/28/23, at 11:59 p.m.</p> <p>During an observation on 9/25/23 at 5:17 p.m., a visitor and seven other residents were in the dining room. The visitor asked if R10 would be coming to the dining room to join for the meal. Nursing assistant (NA)-E stated residents had to maintain a 6 foot distance between each other</p> | 21855                                                                                           |                                                                                                                          |  |                                                                    |



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| 21855                                                    | <p>Continued From page 24</p> <p>because R10 was positive for COVID-19. Other residents began asking NA-E questions about how long they had to do that, etc. NA-E wasn't up-to-date with COVID requirements, but NA-E thought it was 10 days. NA-E told the residents they needed to stay 6 feet apart at least for a few more days.</p> <p>During an interview on 9/25/23 at 5:34 p.m., NA-E stated the residents already knew R10 had COVID-19 because R10 told them, but, no, we're not supposed to tell people that.</p> <p>During an interview on 9/25/23 at 6:67 p.m., R10 stated he valued his privacy and did not want the other residents in the facility to know he was hospitalized with COVID-19; and didn't want the other resident spreading rumors around about him.</p> <p>During an interview on 9/27/23 at 9:19 a.m., NA-A stated you never discuss a resident's health status or illnesses with other residents.</p> <p>During an interview on 9/27/23 at 1:25 p.m., the director of nursing (DON) stated staff should not talk with residents about the health status or illness of another resident. It was an expected right for R10 to have privacy.</p> <p>The facility's Health Insurance Portability and Accountability Act (HIPAA) Privacy Policy and Procedure dated 9/2016, identified the facility was responsible for ensuring the employees were trained to adhere to HIPAA privacy policy and procedures.</p> <p><b>SUGGESTED METHOD OF CORRECTION:</b><br/>The DON or designee could train staff to ensure the personal privacy of residents, and then</p> | 21855                                                                                           |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GRAND VILLAGE</b> |                                                                                                                                                                       |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>923 HALE LAKE POINTE<br/>GRAND RAPIDS, MN 55744</b>                          |  |                                                                    |
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| 21855                                                    | Continued From page 25<br><br>perform audits to ensure each resident's right to<br>privacy is maintained.<br><br>TIME PERIOD FOR CORRECTION: Twenty One<br>(21) days. | 21855                                                                     |                                                                                                                          |  |                                                                    |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GRAND VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>923 HALE LAKE POINTE<br/>GRAND RAPIDS, MN 55744</b> |                                                                                                                          |                                                        |                            |
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| K 000                                                    | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/26/2023. At the time of this survey, Grand Village - Grand 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.<br><br>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.<br><br>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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>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  
  
Electronically Signed

TITLE

(X6) DATE  
  
10/20/2023

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.



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

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GRAND VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>923 HALE LAKE POINTE<br/>GRAND RAPIDS, MN 55744</b>                          |  |                                                        |
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| K 000                                                    | <p>Continued From page 1</p> <p>Healthcare Fire Inspections<br/>State Fire Marshal Division<br/>445 Minnesota St., Suite 145<br/>St. Paul, MN 55101-5145, OR</p> <p>By email to:<br/>FM.HC.Inspections@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH<br/>DEFICIENCY MUST INCLUDE ALL OF THE<br/>FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"><li>1. A detailed description of the corrective action<br/>taken or planned to correct the deficiency.</li><li>2. Address the measures that will be put in<br/>place to ensure the deficiency does not reoccur.</li><li>3. Indicate how the facility plans to monitor<br/>future performance to ensure solutions are<br/>sustained.</li><li>4. Identify who is responsible for the corrective<br/>actions and monitoring of compliance.</li><li>5. The actual or proposed date for completion of<br/>the remedy.</li></ol> <p>Grand Village was built in 5 different stages. The<br/>original building was built in the early 1900's of<br/>which only a small 1-story portion remains. It is<br/>Type II (222) construction and is separated from<br/>all other additions by at least 2-hour fire rated<br/>barriers. In 1972 a 1-story addition, without a<br/>basement, was constructed to the south of the<br/>existing building and was determined to be Type<br/>II (000) construction. In 1992, two 1-story<br/>additions, without basements, were constructed.<br/>One to the south of the 1972 building's west wing</p> | K 000                                                                      |                                                                                                                          |  |                                                        |



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| K 000                                                    | Continued From page 2<br><br>and one to the west of the 1972 building. Both addition were determined to be Type II (000) construction. The upper levels of the 1900's building were no longer used for healthcare. The 1992 west addition is separated from the rest of the building with 2-hour fire barriers. In 2000 the laundry/kitchen addition was constructed in between the original building and the 1992 west addition. It is 1-story, without a basement and is Type II (111) construction. In 2004 the Sub-acute building was constructed to the north of the original building with the majority of the 1900's original building raised. It is 1-story, without a basement, was determined to be Type V (111) construction and is separated by 2-hour fire rated barriers. In 2011 a connecting link between the 1992 additions was created. The building is divided into 12 smoke zones with 1/2 hour and 1 hour fire rated barriers.<br><br>The facility has a capacity of 95 beds and had a census of 80 at the time of the survey. | K 000                                                                      |                                                                                                                          |  |                                                        |
| K 281<br>SS=D                                            | The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:<br>Illumination of Means of Egress<br>CFR(s): NFPA 101<br><br>Illumination of Means of Egress<br>Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention.<br>18.2.8, 19.2.8<br>This REQUIREMENT is not met as evidenced by:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | K 281                                                                      |                                                                                                                          |  | 11/22/23                                               |



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| K 281                                                    | Continued From page 3<br><br>Based on observation and staff interview the facility failed to provide the level of lighting as required by the Life Safety Code, (NFPA 101) 2012 edition section 7.8.1.4. This deficient finding could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 09/26/2023 at 10:32am, it was revealed by observation that the exterior lights for Burch Wing has an exit discharge that had only one bulb for illumination and was not back up with emergency generator power.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery.                                        | K 281                                                                      | The identified area will have lights added and will be backed up by the generator. The policies regarding emergency preparedness were reviewed and are current. All staff will be educated on policies related to emergency lighting. The QAPI committee will review emergency lighting annually to ensure it complies. Exterior light audits will be completed weekly for 30 days and then monthly after that. TELS, the preventative maintenance system, has been updated to include monthly audits. These audits will be printed, added to our file, and saved in TELS for secondary access. Audits will be reviewed by the QAPI committee to ensure compliance and make recommendations for improvement as necessary. The corrections will be monitored by The Director of Maintenance or Designee. |  |                                                        |
| K 321<br>SS=F                                            | Hazardous Areas - Enclosure<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>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.<br>Describe the floor and zone locations of | K 321                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 11/1/23                                                |



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| K 321                                                    | <p>Continued From page 4</p> <p>hazardous areas that are deficient in REMARKS.<br/>19.3.2.1, 19.3.5.9</p> <p>Area                                      Automatic Sprinkler<br/>Separation   N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms<br/>b. Laundries (larger than 100 square feet)<br/>c. Repair, Maintenance, and Paint Shops<br/>d. Soiled Linen Rooms (exceeding 64 gallons)<br/>e. Trash Collection Rooms<br/>(exceeding 64 gallons)<br/>f. Combustible Storage Rooms/Spaces<br/>(over 50 square feet)<br/>g. Laboratories (if classified as Severe<br/>Hazard - see K322)</p> <p>This REQUIREMENT is not met as evidenced<br/>by:<br/>Based on observation and staff interview, the<br/>facility failed to maintain hazardous storage<br/>rooms per NFPA 101 (2012 edition), Life Safety<br/>Code, sections 19.3.2.1.3 and 7.2.1.8.1. These<br/>deficient finding could have a patterned impact on<br/>the residents within the facility.</p> <p>Findings include:</p> <p>On 09/26/2023 at 11:50am, it was revealed by<br/>observation that unused patient rooms on the<br/>Moose Wing had been converted to storage<br/>rooms that did not have a self-closing devices.</p> <p>An interview with the Maintenance Director<br/>verified this deficient finding at the time of<br/>discovery.</p> | K 321                                                                      | <p>Self-closing door hinges will be installed<br/>on the storage rooms by 11/1/23. All<br/>other storage areas were identified and<br/>audited to ensure proper fire protection is<br/>in place. All staff educated on K321 and<br/>using converted rooms as storage.<br/>Weekly audits of empty resident rooms<br/>will be conducted for 30 days and then<br/>audits will be conducted monthly after<br/>that. TELS, the preventative maintenance<br/>system, has been updated to include<br/>monthly audits. These audits will be<br/>printed, added to our file, and saved in<br/>TELS for secondary access. Audits will<br/>be reviewed by The QAPI committee to<br/>ensure compliance and make<br/>recommendations for improvement as<br/>necessary. The correction will be<br/>monitored by The director of maintenance<br/>or designee.</p> |  |                                                        |
| K 353<br>SS=D                                            | Sprinkler System - Maintenance and Testing                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | K 353                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10/20/23                                               |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GRAND VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>923 HALE LAKE POINTE<br/>GRAND RAPIDS, MN 55744</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                        |                            |
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| K 353                                                    | <p>Continued From page 5<br/>CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing<br/>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked<br/>_____</p> <p>b) Who provided system test<br/>_____</p> <p>c) Water system supply source<br/>_____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br/>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br/>This REQUIREMENT is not met as evidenced by:<br/>Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could an isolated impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 09/26/2023 at 10:50am, it was revealed by observation that storage materials had been</p> |                                                                            |  | K 353                                                                                           | <p>The storage room was immediately rearranged so nothing was within 18 inches of sprinkler heads. The policies regarding fire safety were reviewed. All staff were educated on policies relating to the fire sprinkler system and storing items within 18 inches of sprinklers. The QAPI committee will review the fire sprinkler system annually to ensure compliance. Audits will be performed twice a week for 30 days, then weekly for the next 30 days, and then monthly to ensure the facility is compliant. TELS, the preventative maintenance system, has been updated to include monthly audits. These audits will be printed, added to our</p> |                                                        |                            |



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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245368</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>02 - SUB ACUTE</b><br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/26/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GRAND VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>923 HALE LAKE POINTE<br/>GRAND RAPIDS, MN 55744</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                        |
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| K 353                                                    | Continued From page 6<br>placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in the storage room on Spruce Wing.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | K 353                                                                      | file, and saved in TELS for secondary access. Audits will be reviewed by the QAPI committee to ensure compliance and make recommendations for improvement as necessary. The correction will be monitored by The Director of Maintenance or designee.                                                                                                                                                                                                                |  |                                                        |
| K 355<br>SS=D                                            | Portable Fire Extinguishers<br>CFR(s): NFPA 101<br><br>Portable Fire Extinguishers<br>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.<br>18.3.5.12, 19.3.5.12, NFPA 10<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 09/26/2023 at 10:04am, it was revealed by documentation review that the fire extinguishers annual inspection documentation could not be provided.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of | K 355                                                                      | Facility has now found documentation and has placed documentation in correct area. Audits will be completed quarterly to ensure that facility can provide documentation. Audits will be recorded in TELS. Policies regarding fire safety have been reviewed. Audits will be reviewed by the QAPI Committee to ensure compliance and make recommendations for improvement as necessary. The correction will be monitored by the Director of Maintenance or Designee. |  | 11/1/23                                                |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GRAND VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>923 HALE LAKE POINTE<br/>GRAND RAPIDS, MN 55744</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                        |                            |
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| K 355                                                    | Continued From page 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |  | K 355                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                        |                            |
| K 372<br>SS=F                                            | Subdivision of Building Spaces - Smoke Barrie<br>CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier<br>Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour<br>fire resistance rating per 8.5. Smoke barriers shall<br>be permitted to terminate at an atrium wall.<br>Smoke dampers are not required in duct<br>penetrations in fully ducted HVAC systems where<br>an approved sprinkler system is installed for<br>smoke compartments adjacent to the smoke<br>barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system<br>in REMARKS.<br>This REQUIREMENT is not met as evidenced<br>by:<br>Based on observation and staff interview, the<br>facility failed to maintain their smoke barrier per<br>NFPA 101 (2012 edition), Life Safety Code,<br>sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5.<br>These deficient findings could have a widespread<br>impact on the residents within the facility.<br><br>Findings include:<br><br>On 09/26/2023 between 9:00am and 12:30pm, it<br>was revealed by observation that there was a<br>penetration running from one smoke<br>compartment to another above the following fire<br>doors<br><br>1) Fire doors on Aspen Wing<br>2) Fire doors on Main corridor - Door #2<br>3) Fire doors near 119A-Gift Shop Storage |                                                                            |  | K 372                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                        | 10/20/23                   |
|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |  |                                                                                                 | The identified areas were corrected on<br>10/20/23 by filling the identified<br>penetrations above the fire doors. All<br>smoke barriers were audited and<br>corrected if applicable.<br>The policies regarding fire safety were<br>reviewed and are current. Maintenance<br>staff will be educated on smoke<br>departments and checking fire doors and<br>areas around them. Weekly audits will be<br>completed for the first 30 days and then<br>audits will be done monthly and after<br>outside contractors complete work near<br>fire doors. TELS, the preventative<br>maintenance system, has been updated<br>to include monthly audits. These audits<br>will be printed, added to our file, and<br>saved in TELS for secondary access. |                                                        |                            |



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| K 372                                                    | Continued From page 8<br>4) Fire doors near 1310 - Kitchen<br>5) Fire doors in Link<br>6) Fire doors on Spruce Wing<br><br>All fire doors should be checked for penetrations.<br>Even those that are not listed above.<br><br>An interview with the Maintenance Director<br>verified this deficient finding at the time of<br>discovery.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | K 372                                                                      | The QAPI committee will review the<br>results of the audits to determine whether<br>the plan of corrections was effective or if<br>continuous monitoring and system<br>changes need to be implemented. The<br>correction will be monitored by The<br>Director of Maintenance or Designee. |  |                                                        |
| K 914<br>SS=F                                            | Electrical Systems - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Electrical Systems - Maintenance and Testing<br>Hospital-grade receptacles at patient bed<br>locations and where deep sedation or general<br>anesthesia is administered, are tested after initial<br>installation, replacement or servicing. Additional<br>testing is performed at intervals defined by<br>documented performance data. Receptacles not<br>listed as hospital-grade at these locations are<br>tested at intervals not exceeding 12 months. Line<br>isolation monitors (LIM), if installed, are tested at<br>intervals of less than or equal to 1 month by<br>actuating the LIM test switch per 6.3.2.6.3.6,<br>which activates both visual and audible alarm. For<br>LIM circuits with automated self-testing, this<br>manual test is performed at intervals less than or<br>equal to 12 months. LIM circuits are tested per<br>6.3.3.3.2 after any repair or renovation to the<br>electric distribution system. Records are<br>maintained of required tests and associated<br>repairs or modifications, containing date, room or<br>area tested, and results.<br>6.3.4 (NFPA 99)<br>This REQUIREMENT is not met as evidenced<br>by:<br>Based on a review of available documentation | K 914                                                                      |                                                                                                                                                                                                                                                                                           |  | 11/1/23                                                |
|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            | The electrical receptacle systems will be                                                                                                                                                                                                                                                 |  |                                                        |



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| K 914                                                    | <p>Continued From page 9</p> <p>and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient findings could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 09/26/2023 at 9:47am, it was revealed by review of available documentation the required annual receptacle inspection documentation was not available at the time of the survey.</p> <p>An interview with the Maintenance Director verified this deficient finding at the time of discovery.</p> | K 914                                                                      | <p>inspected to ensure compliance. The policies regarding emergency preparedness were reviewed and are current. All maintenance staff were re-educated on policies related to the electrical system. The form used for documentation has been updated to include the date and name of person reviewing. Audits will be completed quarterly to ensure that documentation is complete and available. The QAPI committee will review the electrical system annually to ensure it is compliant. The correction will be monitored by The Director of Maintenance or Designee</p> |                            |                                                        |