DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 8, 2025

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

RE: CCN: 245368
Cycle Start Date: May 21, 2025

Dear Administrator:

On June 30, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 8, 2025

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

Re: Reinspection Results
Event ID: W0SP12

Dear Administrator:

On June 30, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 21, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 4, 2025

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

RE: CCN: 245368
Cycle Start Date: May 21, 2025

Dear Administrator:

On May 21, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 21, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 21, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 5/19/25 through 5/21/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/19/25 through 5/21/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed with NO deficiencies cited. : H53684729C (MN00107006). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/14/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		6/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the physician when a weight gain of greater than 3 pounds (lbs) in 48 hours or a weight gain of greater than 5 lbs in a week was identified for 1 of 1 (R124) residents reviewed for edema. Findings include: R124's undated Admission Record identified R124 was 65 years old and was admitted on 5/15/25. R124 had diagnoses that included acute respiratory failure with hypoxia (low oxygen levels), hypertensive heart disease, and congestive heart failure (CHF). R124's care plan dated 5/15/25, identified R124 had an altered respiratory status and staff were directed to observe for signs of increased edema (swelling) /increased weight related to fluid retention. Document and report to medical provider as necessary R124's physician orders dated 5/15/25, directed staff to obtain daily weights: Update nurse practitioner (NP) for weight gain of 3 pounds (lbs) or greater in 48 hours or 5 lbs in a week.	F 580	R 124s physician was notified of residents weight gain. Corrective action as it applies to other residents: All residents with orders for provider notification for changes in weight have the potential to be affected by this deficient practice. A house wide audit was completed on those with orders to update provider with weight changes, all were in compliance. LPNs, RNs, TMAs will be educated on the expectation of following orders and updating the provider when orders indicate to update the provider when there is a weight change. Recurrence will be prevented by: LPN, RN, TMA education as stated above at an all-staff education on 6/17/25. Team members who do not attend the education will receive the education prior to the start of their next shift. Daily order audits for residents with orders to update provider of weight changes starting 6/18/25 will be completed for two weeks, then once a week for two weeks, then once a month. The QAPI committee will determine when the audits may be discontinued. The correction will be monitored by DON or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3 R124's Weights and Vitals Summary dated 5/21/25, identified the following: - On 5/17/25 at 7:51 a.m., R124 weighed 318.8 lbs. - On 5/18/25 at 11:01 a.m., R124 weighed 325.2 lbs. However, the summary failed to identify a weight increase of increase 6.7 lbs. - On 5/19/25 at 9:03 a.m., R124 weighed 326.0 lbs. However, the summary failed to identify a weight increase of 0.8 lbs in 24 hours or increase of 7.2 lbs in 48 hours. - On 5/20/25 at 3:40 p.m., R124 weighed 331.4 lbs. However, the summary failed to identify a weight increase of 5.4 lbs in 24 hours or but total increase 12.6 lbs in 72 hours. R124's nursing progress note dated 5/20/25 at 4:56 p.m., identified staff spoke with R124 regarding his pain. R124 had a hospital follow up in house with the nurse practitioner (NP) that morning. R124 had no pain then and did not need any pain medication so R124 did not ask for it from the NP when the NP was here. Now R124 was asking for morphine or codeine for leg pain from "leg swelling from his water weight." R124 had 2+ edema (2+ edema is a moderate pitting edema. It is characterized by indentation that subsides rapidly. Edema is graded on a scale of 1 to 4, with 2+ being a moderate level of edema and is characterized by 3-4 millimeter (mm) of depression, rebounding in 15 seconds or less.) to his lower legs. R124 had his legs slightly elevated in bed and was refusing to move to have his legs elevated my more. R124 would not allow lower part the bed elevated either. No new orders have been received from the NP at this time from hospital follow up visit. Due to R124 having new onset of new pain, R124 would need to be	F 580	designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4 evaluated in the emergency room (ER); however, R124 refused to go into the ER. R124's medical lacked evidence the provider was contacted prior to 5/20/25. During an observation on 5/20/25 at 8:29 a.m., R124 was up and dressed for the day. R124 sat in his wheelchair at the dining room table eating breakfast. R124 was wearing oxygen via a nasal cannula. R124's face, hands and legs were swollen. During an interview on 5/20/25 at 3:47 p.m., registered nurse (RN)-D reviewed R124's weights and stated R124 did have a significant weight gain because R124 had gained greater than 3 lbs in 48 hours. RN-D reviewed R124's medical record and stated she did not see where staff notified R124's NP of R124's weight gain. During an interview on 5/20/25 at 4:17 p.m., RN-B stated R124's NP had been notified of R124 earlier in the day, but RN-B hadn't had time to document it yet. However, staff should have notified the provider on 5/18/25 of R124's weight gain or the staff may have waited until 5/19/25 due to the weekend but RN-B wasn't notified until 5/20/25. During interview on 5/20/25 at 4:27 p.m., the director of nursing (DON) stated staff were expected to follow the physician orders and should have notified R124's provider on 5/18/25 when R124's weight increase was identified. During an interview on 5/21/25 at 2:00 p.m., the administrator stated staff were expected to follow physician orders to ensure residents received the	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5 care they deserved. During a phone interview on 5/22/25 at 12:35 p.m., NP-A stated she evaluated R124 on 5/20/25 and was told R124 gained 5.2 lbs over the course of 5 days. NP-A contacted R124's cardiologist for guidance and R124 was evaluated by cardiology. NP-A was unaware of R124's physician order to contact the provider if a weight gain of 3 lbs in 48 hours and would have expected nursing to contact a provider on 5/18/25 to obtain care sooner. The facility policy Edema Scale and Assessment dated 5/2013, identified It is the policy of this facility to provide standardized assessment of lower leg edema and associated issues. Document any untoward results and as necessary by degree of problem, notify the Health Care Provider. The facility policy Change of Condition/Notification revised 3/25, identified Attending physician/NP, or physician on-call, is to be immediately contacted (not by voicemail) of residents change in condition/health status based on a comprehensive assessment. I. Facility must immediately inform the resident, consult with the physician, and notify representative when there is: A. An accident involving the resident which results in injury and has the potential for requiring physician intervention. B. A significant change in the resident's physical, mental, or psychosocial status. C. A need to alter treatment significantly - due to adverse consequences or new form of treatment. D. A decision to transfer or discharge the resident from the facility.	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a gradual dose reduction (GDR) or a clinical justification of a psychotropic medications was documented for 1 of 5 residents (R42) reviewed for unnecessary medication and	F 605	R42s haloperidol order was reviewed for GDR by her psych provider who rejected the GDR. Corrective action as it applies to other residents: All residents receiving psychotropic medications have the	6/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 605	Continued From page 7 were taking psychotropic medications. Findings include: R42's quarterly Minimum Data Set (MDS) dated 5/8/25, identified R42 had moderate cognitive impairment. R42 had verbal behaviors directed toward others and behaviors not direct toward others 1 to 3 days a week. R42's diagnoses included bipolar disorder (a mental health condition characterized by extreme mood swings, ranging from periods of intense highs to periods of deep lows) and anxiety. R42 received an antipsychotic medication and an antidepressant medication. The MDS identified the last gradual dose reduction (GDR) of medications was done 2/23/21, and a GDR was not documented as clinically contraindicated. R42's most recent Physician Order Report dated 5/21/25, identified haloperidol (typical antipsychotic medication) to be given twice a day related to bipolar disorder and was dated 11/22/23. R42 also received Zoloft (an antidepressant medication) given one time a day for depression related to bipolar disorder and was dated 11/29/22. R42's monthly pharmacy reviews were reviewed from 6/2024 to 5/2025, with no irregularities identified with antipsychotic medications or antidepressant medications. R42's medical record was reviewed and lacked evidence a GDR had been attempted or identified a medical justification for continued use and R42 was on the lowest effective dose, within the past calendar year for the haloperidol.	F 605	potential to be affected by this deficient practice. All LPNs and RNs will receive education on GDR expectations. A house wide audit was completed for all residents receiving psychotropic medications, any out of compliance with GDR expectations were addressed by their providers. Recurrence will be prevented by: LPNs and RNs will be educated on GDR expectations at an all-staff education on 6/17/25. Team members who do not attend the education will receive the education prior to the start of their next shift. A spreadsheet indicating last GDR for all psychotropic medications was created for tracking to be completed by RN managers; weekly audits for GDR compliance for psychotropic medications starting 6/18/25 will be completed once a week for four weeks, then once a month. The QAPI committee will determine when the audits may be discontinued. The correction will be monitored by DON or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 605	Continued From page 8 During an interview on 5/21/25 at 1:13 p.m., registered nurse (RN)-H, nurse manager, stated the resident's medications were reviewed on a regular basis and discussed with nursing and pharmacy consultant (CP). RN-H stated they did not look for when a GDR was due but waited for the CP to make a recommendation for a GDR. During a telephone interview on 5/21/25 at 2:00 p.m., the CP stated GDRs on psychotropic medications were done twice a year for new medications and yearly for established medications. The CP identified the last GDR attempt was done 2/2024. During an interview on 5/21/25 at 2:37 p.m., the director of nursing (DON) stated it was the expectation nursing staff would work with pharmacy to ensure psychotropic medication GDRs were addressed for the health of the residents. The facility's Psychopharmacological Drug Use policy dated 5/2025, the resident drug regimen must be free of unnecessary drugs. An unnecessary drug is any drug when used in an excessive dose, for an excessive duration, or without adequate indications for use.	F 605		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications were coded	F 641	R24□s MDS was corrected at the time identified as inaccurate. Corrective action	6/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 9 correctly on the Minimum Data Set (MDS) for 1 of 3 residents (R24) reviewed for injectable diabetes medications. Findings include: R24's quarterly Minimum Data Set (MDS) dated 2/26/25, identified R24 had diabetes (a disorder characterized high blood sugar levels due to either insufficient insulin production or the body's inability to effectively use insulin). The MDS identified R24 received an insulin injection and was receiving hypoglycemic medication (used to lower blood sugar levels). R24's Medication Administration Record (MAR) for the month of February 2025, identified R24 received Trulicity (a medication which increased insulin release, reduced glucagon secretion; however is not insulin) for diabetes. The February 2025, MAR did not identify R24 had received any insulin during the month. During an interview on 5/21/25 at 1:45 p.m., registered nurse (RN)-B stated the MDS was coded incorrectly and should not have identified R24 had received insulin. R24 had only received Trulicity during the assessment period and not insulin. During an interview on 5/21/25 at 2:47 p.m., the director of nursing (DON) would expect the MDS to be completed correctly and stated Trulicity was not insulin. The facility's Resident Assessment policy dated December 2013, identified staff needed to utilize information found in Point Click Care (an electronic health record) to complete sections	F 641	as it applies to other residents: An audit was completed for accuracy of coding of injections in section N. MDS nurses were educated on coding of section N on 6/9/25 and 6/10/25. An audit for accuracy of section N will be completed daily x 7 days starting 6/6/25, then once a week for four weeks, and then once a month. The QAPI committee will determine when the audits may be discontinued. The correction will be monitored by DON or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 10 required on the MDS.	F 641		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions for edema for 1 of 1 resident (R124) reviewed for edema. Findings include: R124's undated Admission Record identified R124 was 65 years old and was admitted on 5/15/25. R124 had diagnoses that included acute respiratory failure with hypoxia (low oxygen levels), hypertensive heart disease, and congestive heart failure (CHF). R124's care plan dated 5/15/25, identified R124 had an altered respiratory status and staff were directed to observe for signs of increased edema (swelling) /increased weight related to fluid retention. Document and report to medical provider as necessary R124's physician orders dated 5/15/25, directed to obtain daily weights: Update nurse practitioner	F 684	R 124s plan of care was updated to monitor edema along with intervention implemented. Corrective action as it applies to other residents: All residents have the potential to be affected by this deficient practice. A house wide audit for residents with edema was completed to ensure monitoring and interventions are in place. LPNs and RNs will be educated on edema, monitoring of edema and initiating interventions for edema. Recurrence will be prevented by: Nursing team members will be educated on residents with new onset edema, monitoring of edema and initiating interventions for edema at an all-staff education on 6/17/25. Team members who do not attend the education will receive the education prior to the start of their next shift. Audits for residents with new onset of edema, monitoring and interventions will be completed daily x 7 days starting 6/18/25, then once a week for 4 weeks, then once a month. The	6/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 11 (NP) for weight gain of 3 pounds (lbs) or greater in 48 hours or 5 lbs in a week. R124's Weights and Vitals Summary dated 5/21/25, identified the following: - On 5/17/25 at 7:51 a.m., R124 weighed 318.8 lbs. - On 5/18/25 at 11:01 a.m., R124 weighed 325.2 lbs. However, the summary failed to identify a weight increase of increase 6.7 lbs. - On 5/19/25 at 9:03 a.m., R124 weighed 326.0 lbs. However, the summary failed to identify a weight increase of 0.8 lbs in 24 hours or increase of 7.2 lbs in 48 hours. - On 5/20/25 at 3:40 p.m., R124 weighed 331.4 lbs. However, the summary failed to identify a weight increase of 5.4 lbs in 24 hours or but total increase 12.6 lbs in 72 hours. R124's nursing progress note dated 5/20/25 at 4:56 p.m., identified staff spoke with resident regarding his pain. R124 had a hospital follow up in house with the nurse practitioner (NP) that morning. R124 had no pain then and did not need any pain medication so R124 did not ask for it from the NP when the NP was here. Now R124 was asking for morphine or codeine for leg pain from "leg swelling from his water weight". R124 had 2+ edema (2+ edema is a moderate pitting edema. It is characterized by indentation that subsides rapidly. Edema is graded on a scale of 1 to 4, with 2+ being a moderate level of edema and is characterized by 3-4 millimeter (mm) of depression, rebounding in 15 seconds or less.) to his lower legs. R124 had his legs slightly elevated in bed and was refusing to move to have his legs elevated my more. R124 would not allow lower part the bed elevated either. No new orders have been received from the NP at this time from	F 684	QAPI committee will determine when the audits may be discontinued. The correction will be monitored by DON or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12 Hospital follow up visit. Due to R124 having new onset of new pain, R124 would need to be evaluated in the emergency room (ER). R124 refused to go into the ER. R124's medical lacked evidence if a nursing assessment was conducted and new interventions implemented. Further there was no evidence the provider was contacted prior to 5/20/25 During an observation on 5/20/25 at 8:29 a.m., R124 was up and dressed for the day. R124 sat in his wheelchair at the dining room table eating breakfast. R124 was wearing oxygen via a nasal cannula. R124's face, hands and legs were swollen. During an interview on 5/20/25 at 3:47 p.m., registered nurse (RN)-D reviewed R124's weights and stated R124 did have a significant weight gain because R124 had gained greater than 3 lbs in 48 hours. RN-D reviewed R124's medical record and stated she did not see where R124's weight gain or edema had been addressed. During an interview on 5/20/25 at 4:17 p.m., RN-B stated R124's NP had been notified of R124 earlier in the day but RN-B hadn't had time to document it yet. However, RN-B was not notified of R124's weight gain until 5/20/25. During interview on 5/20/25 at 4:27 p.m., the director of nursing (DON) stated staff were expected to monitor daily weights and ensure the appropriate actions were taken when a significant weight increase was identified. During an interview on 5/21/25 at 2:00 p.m., the	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 13 administrator stated staff were expected to monitor daily weights and take appropriate action when a significant weight gain was identified. During a phone interview on 5/22/25 at 12:35 p.m., NP-A stated she evaluated R124 on 5/20/25 and was told R124 gained 5.2 lbs over the course of 5 days. NP-A contacted R124's cardiologist for guidance and R124 was evaluated by cardiology. NP-A was unaware of R124's physician order to contact the provider if a weight gain of 3 lbs in 48 hours and would have expected nursing to contact a provider on 5/18/25 to obtain care sooner. The facility policy Edema Scale and Assessment dated 5/2013, identified It is the policy of this facility to provide standardized assessment of lower leg edema and associated issues. Document any untoward results and as necessary by degree of problem, notify the Health Care Provider.	F 684		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any	F 756		6/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 14 drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist (CP) identified the need for a gradual dose reduction (GDR) or medical justification of use for 1 of 5 residents (R42) reviewed for unnecessary medication and were taking psychotropic medications. Findings include: R42's quarterly Minimum Data Set (MDS) dated 5/8/25, identified moderate cognitive impairment with verbal behaviors directed toward others and	F 756	Consulting Pharmacist was educated on facilities policy and the F756 regulatory guidance for expectation of identifying the need of a GDR or medical justification of use for psychotropic medications. R42s haloperidol's order was reviewed for GDR by her psych provider. Corrective action as it applies to other residents: All residents receiving psychotropic medication are at risk of this deficient practice. A house wide audit was completed for all residents receiving psychotropic medications, any out of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 15 behaviors not direct toward others 1 to 3 days a week. R42's diagnoses included bipolar disorder (a mental health condition characterized by extreme mood swings, ranging from periods of intense highs to periods of deep lows) and anxiety. R42 received an antipsychotic medication and an antidepressant medication. The MDS identified the last gradual dose reduction (GDR) of medications was done 2/23/21, and a GDR was not documented as clinically contraindicated. R42's most recent Physician Order Report dated undated, identified haloperidol (typical antipsychotic medication) to be given twice a day related to bipolar disorder and was dated 11/22/23. R42 also received Zoloft (an antidepressant medication) given one time a day for depression related to bipolar disorder and was dated 11/29/22. R42's monthly pharmacy reviews were reviewed from 6/2024 to 5/2025, with no irregularities identified with antipsychotic medications or antidepressant medications. R42's medical record was reviewed and lacked evidence a GDR had been attempted or identified a medical justification for continued use within the past calendar year for antipsychotic or antidepressant medications. During an interview on 5/21/25 at 1:13 p.m., registered nurse (RN)-H stated the consulting pharmacist (CP) reviewed the residents' medication lists and identified if any residents were due to a GDR, and that is how she was flagged if a resident was due for one. RN-H stated R42's medical record lacked any evidence	F 756	compliance with GDR expectations were addressed by their providers. Nursing team members will be educated on psychotropic policy including GRD expectations. Recurrence will be prevented by: all nursing team members will be educated on psychotropic medication policy including GDRs at an all-staff education on 6/17/25. Team members who do not attend the education will receive the education prior to the start of their next shift. An audit on the pharmacy consultant reviews for residents with psychotropic medication orders will be conducted monthly. The QAPI committee will determine when the audits may be discontinued. The correction will be monitored by DON or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 16 a GDR had be attempted or a clinical justification for continued use. During a telephone interview on 5/21/25 at 2:00 p.m., the CP stated a resident's medication lists were reviewed monthly and medications were monitored, this included reviewing psychotropic medications (drugs that affect mental processes and behavior, often used to treat mental health conditions like anxiety, depression, and psychosis) for adverse reactions, monitor GDR or clinical contraindication for medication reduction. GDR's are to be attempted yearly. The CP stated the last documented GDR was from 2/2024, and a GDR or clinical contraindication should of be documented and was not. During an interview on 5/21/25 at 2:37 p.m., the director of nursing (DON) she would expect GDR's to be attempted or documented contraindication to be done yearly. The facility's Psychopharmacological Drug Use policy dated 5/2025, identified the CP would review resident medication records on a monthly basis for documentation/justification for the drug use and will recommend dosage reductions or modifications as appropriate.	F 756		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		6/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 17 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed ensure beard coverings were worn when preparing resident meals, to prevent the spread of food born illness. This had the potential to affect 68 out of 68 residents that received food out of the kitchen or kitchenette. Findings included: During initial kitchen tour on 5/19/25 at 11:19 a.m., cook-A was observed in the kitchen not wearing a beard covering. Cook-A stated he had just finished making lunch. On 5/20/25 at 8:27 a.m., cook-B was observed in a unit kitchenette serving food to residents without a beard net. Cook-B's facial hair went from below the ears to the top of the neck and under the chin, and was approximately 1.5 inches long and shaggy in areas. Cook-B stood over an open loaf of bread with one slice of bread on the countertop and putting a plate of food into the microwave. After several seconds cook-B removed the plate of food from the microwave, walked to the counter and handed the plate to	F 812	Cook-A and Cook-B applied beard net over facial hair. Corrective action as it applies to other residents: All residents have the potential to be affected by this deficient practice. Education was provided to the dietary team about expectations of hair coverings. Recurrence will be prevented by: All team members will receive education on hair covering policy at an all-staff education on 6/17/25. Team members who do not attend the education will receive the education prior to the start of their next shift. Audits for hair nets when preparing resident meals will be completed daily x 7 days starting on 6/18/25, then once a week x 4 weeks, then once a month. The QAPI committee will determine when the audits may be discontinued. The correction will be monitored by DON or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 18 another staff member who brought the plate to a resident. Cook-B stated his facial hair was long and needed to be trimmed. Cook-B stated beard coverings should be worn prior to the start of work although had not put on a beard covering because he was uncertain where to locate them. Cook-B stated the potential risks of not covering facial hair was that hair could fall into the food. On 5/20/25 09:02 a.m., dietary manager (DM) stated staff were instructed to always wear hair/beard coverings, including when prepping, cooking, serving foods, and anytime they are working with food. DM stated she was aware cook-B was not wearing a beard covering and stated she just hadn't had time to tell him to put one on. DM stated the potential risks of staff not wearing a hair/beard covering was hair could fall into the residents food and cause bacteria to grow. The Employee Sanitary Practices policy revised 7/19, identified staff were to wear hair restraints to prevent hair from contacting exposed food, including a beard net, when an employee had a beard. According to section 2-402.11 of the FDA Food code: "A hair restraint keeps dislodged hair from ending up in the food and may deter employees from touching their hair." This is crucial to prevent cross-contamination. Staphylococcus aureus is an example of a common pathogen that is found on skin and hair. If enough of the bacteria is ingested, it could cause illness. Common symptoms of this illness include vomiting, nausea, and stomach cramps.	F 812		
F 842 SS=D	Resident Records - Identifiable Information	F 842		6/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 19 CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 20 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure conflicting notes and orders transmission based precautions were clarified to ensure an accurate medical record was maintained for 1 of 1 resident (R127) whose medical record was found to lack admission notes. Findings include:	F 842	R127s medical record was updated for C-diff being resolved. Corrective action as it applies to other residents: All admitting residents have the potential to be affected by this deficient practice. An audit was completed for admissions to ensure there is an admission note and pertinent information is noted in the medical record. All licensed nursing team members were educated on pertinent information	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 21 R127's entry Minimum Data Set (MDS) dated 5/9/25, identified R127 was 86 years old and was admitted to the facility on 5/9/25. R127's Diagnosis Report dated 5/21/25, identified R127 had diagnoses that included enterocolitis due to Clostridium difficile (C. diff, or costridioides difficile, is a bacterium that can cause severe diarrhea and colitis (inflammation of the colon). It is often associated with antibiotic use, which can disrupt the normal gut flora, allowing C. diff to proliferate. Symptoms of a C. diff infection can range from mild diarrhea to severe, life-threatening conditions. Treatment typically involves specific antibiotics to target the infection.) R127's History and Physical dated 5/7/25, identified R127 had been diagnosed with C. diff, completed a 10-day course of oral vancomycin (an antibiotic used to treat C. diff) and R127's diarrhea had resolved. R127's Admission Screening dated 5/9/25, was a handwritten paper form that identified R127 had "C. diff 4/22". R127's Nursing Home Visit progress note dated 5/12/25, identified R127's C. diff was resolved. R127's nursing progress notes dated 5/9/25 through 5/21/25, failed to identify an admission note or a nurse-to-nurse communication (nurse-to-nurse communication refers to the exchange of information, opinions, and ideas between nurses, either face-to-face, through written reports, or electronically) regarding R127's hospital discharging condition. During an interview on 5/20/25 10:33 a.m., RN-B	F 842	documentation being added to the medical record, including any nurse-to-nurse and expectation of an admission note. Recurrence will be prevented by: All team members will receive education on entering an admission note and all pertinent information being documented in the medical record for any nurse-to-nurse report from discharging facilities at an all-staff education on 6/17/25. Team members who do not attend the education will receive the education prior to the start of their next shift. Audits on pertinent documentation being added to the medical record for admissions, and admission notes will be completed daily x 7 days starting 6/18/25, then once a week x 4 weeks, and then once a month. The QAPI committee will determine when the audits may be discontinued. The correction will be monitored by DON or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 22 stated the admission nurse completed R127's admission screening. The admission nurse completed the nurse-to-nurse communication and entered an admission note. During an interview on 5/20/25 at 10:40 a.m., RN-F stated the hospital usually sent a referral packet for any potential resident: history and physical, notes, etc. RN-F reviewed everything from medications to therapy notes to ensure the facility could meet the resident's needs. If the resident was accepted, that information was loaded into the electronic medical record. R127's C. diff diagnoses was on 4/22/25 and RN-F entered that on R127's screening form. R127's C. diff may have been resolved but that was the cue for the admission nurse to talk to the hospital nurse regarding R127's stool. That information should be entered into an admission note, however, RN-F was unable to find an admission note in R127's medical record. During an interview on 5/20/25 at 11:13 a.m., RN-C stated he did R127's admission, however, could not recall a nurse-to-nurse communication about R127 because he completed 3 admissions that day. RN-E did not enter an admission note because all that information was on the admission nurse's screening form. RN-C may have hand written notes of the conversation on that paper form, however, that form was sent to the shred box for destruction. "Yea, I guess if I don't enter a note and don't scan that form, it's not documented." RN-C stated days were "rapid fire" and staff got through what we needed to get done to get people settled. It was staff's responsibility to be aware of what residents needed. The IP nurse did send out a list every morning in an email and RN-C "thought" the cart	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 23 nurses did get that email but who had time to read their emails. Really, staff just did what they had to do to get through it. During an interview on 5/20/25 at 4:27 p.m., the director of nursing (DON) stated staff were expected to either enter an admission note or scan handwritten notes in the medical record to ensure the resident's medical record was complete and to document what condition the resident was in on admission. During an interview on 5/21/25 at 2:04 p.m., the administrator stated staff were expected to ensure a resident has a complete medical record to ensure the resident receives the quality of care they deserve. The facility policy Documentation Standards Policy dated 10/24, identified the following: a. All documentation must reflect the resident's condition, care provided, and any status changes. b. Documentation must be completed at the time of care or as soon as possible after care is provided.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		6/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 24 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 25 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was completed during personal cares for 1 of 3 residents (R121) whose cares were observed. Findings include: R121's 5-day Minimum Data Set (MDS) dated 5/14/25, identified R121 required set up to touching assistance for most care areas including toileting. R121's care plan revised 5/19/25, identified R121 required assist of one staff for toileting, dressing and grooming. During an observation on 5/20/25 at 3:02 p.m., nursing assistant (NA)-A assisted R121 to the bathroom for toileting. NA-A failed to use hand sanitizer and put on a pair of gloves R121 stood up from the toilet and NA-A stated R121 had a	F 880	NA-A was educated on appropriate hand hygiene during personal cares. Corrective action as it applies to other residents: All nursing team members will be educated on appropriate hand hygiene during personal cares at an all-staff education on 6/17/25. Team members who do not attend the education will receive the education prior to the start of their next shift. Recurrence will be prevented by: Daily audits of personal cares x 7 days starting on 6/18/25, then once a week, and then once a month. The QAPI committee will determine when the audits may be discontinued. The correction will be monitored by DON or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 26 medium bowel movement (BM) and used a disposable wipe to clean feces from R121's buttocks. NA-A with the contaminated gloves assisted R121 to sit down on the toilet. NA-A then assisted R121 to put on a clean pull-up brief and pajama pants without completing hand hygiene or changing gloves.NA-A flushed the toilet, continued to wear the same soiled gloves and assisted R121 back to his bed. NA-A hung R121's gait belt on R121's door and picked up R121's urinal off his overbed table and dumped it in the toilet. NA-A gave R121 the call light and removed her soiled gloves. During an interview on 5/20/25 at 3:19 p.m., NA-A stated she was always told you wear the same gloves from the start of a care until the care was finished. During an interview on 5/20/25 at 3:22 p.m., licensed practical nurse (LPN)-A stated staff were expected to change gloves after wiping BM because you don't want to cross contaminate anything with feces. During an interview on 5/20/25 at 3:27 p.m., registered nurse (RN)-A stated staff were expected to remove their soiled gloves after doing BM cares, before touching clean items to prevent cross contamination of clean items. During an interview on 5/20/25 at 4:27 p.m., the director of nursing (DON) stated staff were expected to immediately removed gloves soiled with feces and to put on clean gloves before completing cares to prevent cross contamination of clean items. During an interview on 5/21/25 at 2:00 p.m., the	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 27 administrator stated staff were expected to change gloves whenever going from dirty to clean to prevent transferring feces or bacteria on the resident's clothing. The facility policy Hand Hygiene revised 4/24, identified staff were expected to change gloves during patient care if the hand would move from a contaminated body site (e.g., perineal area) to a clean body site. Staff were directed to perform hand hygiene when removing gloves and before putting on a new pair of gloves.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 4, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: W0SP11

Dear Administrator:

The above facility was surveyed on May 19, 2025 through May 21, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/19/25-5/21/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed: H53684729C (MN00107006). NO citations were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265		6/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 3 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to notify the physician when a weight gain of greater than 3 pounds (lbs) in 48 hours or a weight gain of greater than 5 lbs in a week was identified for 1 of 1 (R124) residents reviewed for edema. Findings include: R124's undated Admission Record identified R124 was 65 years old and was admitted on 5/15/25. R124 had diagnoses that included acute respiratory failure with hypoxia (low oxygen levels), hypertensive heart disease, and congestive heart failure (CHF). R124's care plan dated 5/15/25, identified R124 had an altered respiratory status and staff were directed to observe for signs of increased edema (swelling) /increased weight related to fluid retention. Document and report to medical provider as necessary R124's physician orders dated 5/15/25, directed staff to obtain daily weights: Update nurse practitioner (NP) for weight gain of 3 pounds (lbs) or greater in 48 hours or 5 lbs in a week. R124's Weights and Vitals Summary dated 5/21/25, identified the following: - On 5/17/25 at 7:51 a.m., R124 weighed 318.8 lbs.	2 265	CORRECTED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 4 - On 5/18/25 at 11:01 a.m., R124 weighed 325.2 lbs. However, the summary failed to identify a weight increase of increase 6.7 lbs. - On 5/19/25 at 9:03 a.m., R124 weighed 326.0 lbs. However, the summary failed to identify a weight increase of 0.8 lbs in 24 hours or increase of 7.2 lbs in 48 hours. - On 5/20/25 at 3:40 p.m., R124 weighed 331.4 lbs. However, the summary failed to identify a weight increase of 5.4 lbs in 24 hours or but total increase 12.6 lbs in 72 hours. R124's nursing progress note dated 5/20/25 at 4:56 p.m., identified staff spoke with R124 regarding his pain. R124 had a hospital follow up in house with the nurse practitioner (NP) that morning. R124 had no pain then and did not need any pain medication so R124 did not ask for it from the NP when the NP was here. Now R124 was asking for morphine or codeine for leg pain from "leg swelling from his water weight." R124 had 2+ edema (2+ edema is a moderate pitting edema. It is characterized by indentation that subsides rapidly. Edema is graded on a scale of 1 to 4, with 2+ being a moderate level of edema and is characterized by 3-4 millimeter (mm) of depression, rebounding in 15 seconds or less.) to his lower legs. R124 had his legs slightly elevated in bed and was refusing to move to have his legs elevated my more. R124 would not allow lower part the bed elevated either. No new orders have been received from the NP at this time from hospital follow up visit. Due to R124 having new onset of new pain, R124 would need to be evaluated in the emergency room (ER); however, R124 refused to go into the ER. R124's medical lacked evidence the provider was contacted prior to 5/20/25.	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 5 During an observation on 5/20/25 at 8:29 a.m., R124 was up and dressed for the day. R124 sat in his wheelchair at the dining room table eating breakfast. R124 was wearing oxygen via a nasal cannula. R124's face, hands and legs were swollen. During an interview on 5/20/25 at 3:47 p.m., registered nurse (RN)-D reviewed R124's weights and stated R124 did have a significant weight gain because R124 had gained greater than 3 lbs in 48 hours. RN-D reviewed R124's medical record and stated she did not see where staff notified R124's NP of R124's weight gain. During an interview on 5/20/25 at 4:17 p.m., RN-B stated R124's NP had been notified of R124 earlier in the day, but RN-B hadn't had time to document it yet. However, staff should have notified the provider on 5/18/25 of R124's weight gain or the staff may have waited until 5/19/25 due to the weekend but RN-B wasn't notified until 5/20/25. During interview on 5/20/25 at 4:27 p.m., the director of nursing (DON) stated staff were expected to follow the physician orders and should have notified R124's provider on 5/18/25 when R124's weight increase was identified. During an interview on 5/21/25 at 2:00 p.m., the administrator stated staff were expected to follow physician orders to ensure residents received the care they deserved. During a phone interview on 5/22/25 at 12:35 p.m., NP-A stated she evaluated R124 on 5/20/25 and was told R124 gained 5.2 lbs over the course of 5 days. NP-A contacted R124's cardiologist for guidance and R124 was evaluated by cardiology.	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 6 NP-A was unaware of R124's physician order to contact the provider if a weight gain of 3 lbs in 48 hours and would have expected nursing to contact a provider on 5/18/25 to obtain care sooner. The facility policy Edema Scale and Assessment dated 5/2013, identified It is the policy of this facility to provide standardized assessment of lower leg edema and associated issues. Document any untoward results and as necessary by degree of problem, notify the Health Care Provider. The facility policy Change of Condition/Notification revised 3/25, identified Attending physician/NP, or physician on-call, is to be immediately contacted (not by voicemail) of residents change in condition/health status based on a comprehensive assessment. I. Facility must immediately inform the resident, consult with the physician, and notify representative when there is: A. An accident involving the resident which results in injury and has the potential for requiring physician intervention. B. A significant change in the resident's physical, mental, or psychosocial status. C. A need to alter treatment significantly - due to adverse consequences or new form of treatment. D. A decision to transfer or discharge the resident from the facility. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop and implement measure to ensure timely notification to the physician. The DON or designee could review and update as needed policies and procedures, educate staff on the expectations.The DON or designee could perform	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 7 measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications were coded correctly on the Minimum Data Set (MDS) for 1 of 3 residents (R24) reviewed for injectable diabetes medications. Findings include: R24's quarterly Minimum Data Set (MDS) dated 2/26/25, identified R24 had diabetes (a disorder characterized high blood sugar levels due to either insufficient insulin production or the body's inability to effectively use insulin). The MDS identified R24 received an insulin injection and was receiving hypoglycemic medication (used to lower blood sugar levels). R24's Medication Administration Record (MAR)	2 550	CORRECTED	6/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 550	Continued From page 8 for the month of February 2025, identified R24 received Trulicity (a medication which increased insulin release, reduced glucagon secretion; however is not insulin) for diabetes. The February 2025, MAR did not identify R24 had received any insulin during the month. During an interview on 5/21/25 at 1:45 p.m., registered nurse (RN)-B stated the MDS was coded incorrectly and should not have identified R24 had received insulin. R24 had only received Trulicity during the assessment period and not insulin. During an interview on 5/21/25 at 2:47 p.m., the director of nursing (DON) would expect the MDS to be completed correctly and stated Trulicity was not insulin. The facility's Resident Assessment policy dated December 2013, identified staff needed to utilize information found in Point Click Care (an electronic health record) to complete sections required on the MDS. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures related to ensuring that each individual resident's comprehensive assessment is accurately completed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff accurately complete assessments. The DON or designee could perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement.	2 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 550	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 625	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners;	2 625		6/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 625	Continued From page 10 L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure conflicting notes and orders transmission based precautions were clarified to ensure an accurate medical record was maintained for 1 of 1 resident (R127) whose medical record was found to lack admission notes. Findings include: R127's entry Minimum Data Set (MDS) dated 5/9/25, identified R127 was 86 years old and was admitted to the facility on 5/9/25. R127's Diagnosis Report dated 5/21/25, identified R127 had diagnoses that included enterocolitis due to Clostridium difficile (C. diff, or costridioides difficile, is a bacterium that can cause severe diarrhea and colitis (inflammation of the colon). It is often associated with antibiotic use, which can disrupt the normal gut flora, allowing C. diff to proliferate. Symptoms of a C. diff infection can range from mild diarrhea to severe, life-threatening conditions. Treatment typically involves specific antibiotics to target the	2 625	CORRECTED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 625	Continued From page 11 infection.) R127's History and Physical dated 5/7/25, identified R127 had been diagnosed with C. diff, completed a 10-day course of oral vancomycin (an antibiotic used to treat C. diff) and R127's diarrhea had resolved. R127's Admission Screening dated 5/9/25, was a handwritten paper form that identified R127 had "C. diff 4/22". R127's Nursing Home Visit progress note dated 5/12/25, identified R127's C. diff was resolved. R127's nursing progress notes dated 5/9/25 through 5/21/25, failed to identify an admission note or a nurse-to-nurse communication (nurse-to-nurse communication refers to the exchange of information, opinions, and ideas between nurses, either face-to-face, through written reports, or electronically) regarding R127's hospital discharging condition. During an interview on 5/20/25 10:33 a.m., RN-B stated the admission nurse completed R127's admission screening. The admission nurse completed the nurse-to-nurse communication and entered an admission note. During an interview on 5/20/25 at 10:40 a.m., RN-F stated the hospital usually sent a referral packet for any potential resident: history and physical, notes, etc. RN-F reviewed everything from medications to therapy notes to ensure the facility could meet the resident's needs. If the resident was accepted, that information was loaded into the electronic medical record. R127's C. diff diagnoses was on 4/22/25 and RN-F entered that on R127's screening form. R127's C.	2 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 625	Continued From page 12 diff may have been resolved but that was the cue for the admission nurse to talk to the hospital nurse regarding R127's stool. That information should be entered into an admission note, however, RN-F was unable to find an admission note in R127's medical record. During an interview on 5/20/25 at 11:13 a.m., RN-C stated he did R127's admission, however, could not recall a nurse-to-nurse communication about R127 because he completed 3 admissions that day. RN-E did not enter an admission note because all that information was on the admission nurse's screening form. RN-C may have hand written notes of the conversation on that paper form, however, that form was sent to the shred box for destruction. "Yea, I guess if I don't enter a note and don't scan that form, it's not documented." RN-C stated days were "rapid fire" and staff got through what we needed to get done to get people settled. It was staff's responsibility to be aware of what residents needed. The IP nurse did send out a list every morning in an email and RN-C "thought" the cart nurses did get that email but who had time to read their emails. Really, staff just did what they had to do to get through it. During an interview on 5/20/25 at 4:27 p.m., the director of nursing (DON) stated staff were expected to either enter an admission note or scan handwritten notes in the medical record to ensure the resident's medical record was complete and to document what condition the resident was in on admission. During an interview on 5/21/25 at 2:04 p.m., the administrator stated staff were expected to ensure a resident has a complete medical record to ensure the resident receives the quality of care	2 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 625	Continued From page 13 they deserve. The facility policy Documentation Standards Policy dated 10/24, identified the following: a. All documentation must reflect the resident's condition, care provided, and any status changes. b. Documentation must be completed at the time of care or as soon as possible after care is provided. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could review/revise policies and procedures for maintaining complete and accurate medical records. The administrator, DON, or designee could educate all staff on these policies and procedures. The administrator, DON, or designee could audit to ensure resident medical records are complete and accurate. The administrator, DON, or designee could then take that information to their quality assessment and performance improvement (QAPI) committee to assess the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 625		
2 875	MN Rule 4658.0520 Subp. 2 I Adequate and Proper Nursing Care; Monitor TPR Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly.	2 875		6/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 875	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions for edema for 1 of 1 resident (R124) reviewed for edema. Findings include: R124's undated Admission Record identified R124 was 65 years old and was admitted on 5/15/25. R124 had diagnoses that included acute respiratory failure with hypoxia (low oxygen levels), hypertensive heart disease, and congestive heart failure (CHF). R124's care plan dated 5/15/25, identified R124 had an altered respiratory status and staff were directed to observe for signs of increased edema (swelling) /increased weight related to fluid retention. Document and report to medical provider as necessary R124's physician orders dated 5/15/25, directed to obtain daily weights: Update nurse practitioner (NP) for weight gain of 3 pounds (lbs) or greater in 48 hours or 5 lbs in a week. R124's Weights and Vitals Summary dated 5/21/25, identified the following: - On 5/17/25 at 7:51 a.m., R124 weighed 318.8 lbs. - On 5/18/25 at 11:01 a.m., R124 weighed 325.2 lbs. However, the summary failed to identify a weight increase of increase 6.7 lbs. - On 5/19/25 at 9:03 a.m., R124 weighed 326.0 lbs. However, the summary failed to identify a weight increase of 0.8 lbs in 24 hours or increase of 7.2 lbs in 48 hours.	2 875	CORRECTED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 875	Continued From page 15 - On 5/20/25 at 3:40 p.m., R124 weighed 331.4 lbs. However, the summary failed to identify a weight increase of 5.4 lbs in 24 hours or but total increase 12.6 lbs in 72 hours. R124's nursing progress note dated 5/20/25 at 4:56 p.m., identified staff spoke with resident regarding his pain. R124 had a hospital follow up in house with the nurse practitioner (NP) that morning. R124 had no pain then and did not need any pain medication so R124 did not ask for it from the NP when the NP was here. Now R124 was asking for morphine or codeine for leg pain from "leg swelling from his water weight". R124 had 2+ edema (2+ edema is a moderate pitting edema. It is characterized by indentation that subsides rapidly. Edema is graded on a scale of 1 to 4, with 2+ being a moderate level of edema and is characterized by 3-4 millimeter (mm) of depression, rebounding in 15 seconds or less.) to his lower legs. R124 had his legs slightly elevated in bed and was refusing to move to have his legs elevated my more. R124 would not allow lower part the bed elevated either. No new orders have been received from the NP at this time from Hospital follow up visit. Due to R124 having new onset of new pain, R124 would need to be evaluated in the emergency room (ER). R124 refused to go into the ER. R124's medical lacked evidence if a nursing assessment was conducted and new interventions implemented. Further there was no evidence the provider was contacted prior to 5/20/25 During an observation on 5/20/25 at 8:29 a.m., R124 was up and dressed for the day. R124 sat in his wheelchair at the dining room table eating breakfast. R124 was wearing oxygen via a nasal	2 875		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 875	Continued From page 16 cannula. R124's face, hands and legs were swollen. During an interview on 5/20/25 at 3:47 p.m., registered nurse (RN)-D reviewed R124's weights and stated R124 did have a significant weight gain because R124 had gained greater than 3 lbs in 48 hours. RN-D reviewed R124's medical record and stated she did not see where R124's weight gain or edema had been addressed. During an interview on 5/20/25 at 4:17 p.m., RN-B stated R124's NP had been notified of R124 earlier in the day but RN-B hadn't had time to document it yet. However, RN-B was not notified of R124's weight gain until 5/20/25. During interview on 5/20/25 at 4:27 p.m., the director of nursing (DON) stated staff were expected to monitor daily weights and ensure the appropriate actions were taken when a significant weight increase was identified. During an interview on 5/21/25 at 2:00 p.m., the administrator stated staff were expected to monitor daily weights and take appropriate action when a significant weight gain was identified. During a phone interview on 5/22/25 at 12:35 p.m., NP-A stated she evaluated R124 on 5/20/25 and was told R124 gained 5.2 lbs over the course of 5 days. NP-A contacted R124's cardiologist for guidance and R124 was evaluated by cardiology. NP-A was unaware of R124's physician order to contact the provider if a weight gain of 3 lbs in 48 hours and would have expected nursing to contact a provider on 5/18/25 to obtain care sooner. The facility policy Edema Scale and Assessment	2 875		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 875	Continued From page 17 dated 5/2013, identified It is the policy of this facility to provide standardized assessment of lower leg edema and associated issues. Document any untoward results and as necessary by degree of problem, notify the Health Care Provider. SUGGESTED METHOD OF CORRECTION: The DON or designee could review facility policy and procedures on follow up of change in condition, dialiy wieghts and edema. The DON or designee could provide education on these policies and procedures to all nursing staff. The DON or designee could conduct audits of resident discharge orders and records, and report the results of these audits to the Quality Assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 875		
2 995	MN Rule 4658.0610 Subp. 3 Dietary Staff Requirements -Grooming. Subp. 3. Grooming. Dietary staff must wear clean outer garments. Hairnets or other hair restraints must be worn to prevent the contamination of food, utensils, and equipment. Hair spray is not an acceptable hair restraint. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed ensure beard coverings were worn when preparing resident meals, to prevent the spread of food born illness. This had the potential to affect 68 out of 68 residents that	2 995	CORRECTED	6/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 995	Continued From page 18 received food out of the kitchen or kitchenette. Findings included: During initial kitchen tour on 5/19/25 at 11:19 a.m., cook-A was observed in the kitchen not wearing a beard covering. Cook-A stated he had just finished making lunch. On 5/20/25 at 8:27 a.m., cook-B was observed in a unit kitchenette serving food to residents without a beard net. Cook-B's facial hair went from below the ears to the top of the neck and under the chin, and was approximately 1.5 inches long and shaggy in areas. Cook-B stood over an open loaf of bread with one slice of bread on the countertop and putting a plate of food into the microwave. After several seconds cook-B removed the plate of food from the microwave, walked to the counter and handed the plate to another staff member who brought the plate to a resident. Cook-B stated his facial hair was long and needed to be trimmed. Cook-B stated beard coverings should be worn prior to the start of work although had not put on a beard covering because he was uncertain where to locate them. Cook-B stated the potential risks of not covering facial hair was that hair could fall into the food. On 5/20/25 09:02 a.m., dietary manager (DM) stated staff were instructed to always wear hair/beard coverings, including when prepping, cooking, serving foods, and anytime they are working with food. DM stated she was aware cook-B was not wearing a beard covering and stated she just hadn't had time to tell him to put one on. DM stated the potential risks of staff not wearing a hair/beard covering was hair could fall into the residents food and cause bacteria to grow.	2 995		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 995	Continued From page 19 The Employee Sanitary Practices policy revised 7/19, identified staff were to wear hair restraints to prevent hair from contacting exposed food, including a beard net, when an employee had a beard. According to section 2-402.11 of the FDA Food code: "A hair restraint keeps dislodged hair from ending up in the food and may deter employees from touching their hair." This is crucial to prevent cross-contamination. Staphylococcus aureus is an example of a common pathogen that is found on skin and hair. If enough of the bacteria is ingested, it could cause illness. Common symptoms of this illness include vomiting, nausea, and stomach cramps. SUGGESTED METHOD OF CORRECTION: The dietary manager or designee could ensure hair restraints are available for use , educate staff on the hair retraint requirement and conduct random audits. The result of the audits could be reported to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one Days (21) Days	2 995		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by:	21375		6/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 20 Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was completed during personal cares for 1 of 3 residents (R121) whose cares were observed. Findings include: R121's 5-day Minimum Data Set (MDS) dated 5/14/25, identified R121 required set up to touching assistance for most care areas including toileting. R121's care plan revised 5/19/25, identified R121 required assist of one staff for toileting, dressing and grooming. During an observation on 5/20/25 at 3:02 p.m., nursing assistant (NA)-A assisted R121 to the bathroom for toileting. NA-A failed to use hand sanitizer and put on a pair of gloves R121 stood up from the toilet and NA-A stated R121 had a medium bowel movement (BM) and used a disposable wipe to clean feces from R121's buttocks. NA-A with the contaminated gloves assisted R121 to sit down on the toilet. NA-A then assisted R121 to put on a clean pull-up brief and pajama pants without completing hand hygiene or changing gloves.NA-A flushed the toilet, continued to wear the same soiled gloves and assisted R121 back to his bed. NA-A hung R121's gait belt on R121's door and picked up R121's urinal off his overbed table and dumped it in the toilet. NA-A gave R121 the call light and removed her soiled gloves. During an interview on 5/20/25 at 3:19 p.m., NA-A stated she was always told you wear the same gloves from the start of a care until the care was finished.	21375	CORRECTED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 21 During an interview on 5/20/25 at 3:22 p.m., licensed practical nurse (LPN)-A stated staff were expected to change gloves after wiping BM because you don't want to cross contaminate anything with feces. During an interview on 5/20/25 at 3:27 p.m., registered nurse (RN)-A stated staff were expected to remove their soiled gloves after doing BM cares, before touching clean items to prevent cross contamination of clean items. During an interview on 5/20/25 at 4:27 p.m., the director of nursing (DON) stated staff were expected to immediately removed gloves soiled with feces and to put on clean gloves before completing cares to prevent cross contamination of clean items. During an interview on 5/21/25 at 2:00 p.m., the administrator stated staff were expected to change gloves whenever going from dirty to clean to prevent transferring feces or bacteria on the resident's clothing. The facility policy Hand Hygiene revised 4/24, identified staff were expected to change gloves during patient care if the hand would move from a contaminated body site (e.g., perineal area) to a clean body site. Staff were directed to perform hand hygiene when removing gloves and before putting on a new pair of gloves. SUGGESTED METHOD OF CORRECTION:The DON or designeed could review/revise facility policies on hand hygeine, including glove use, then educate the staff responsible with competency testing. The DON or designee could perform audits to ensure the policies are being	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 22 followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure either a tuberculin skin	21426	RN-G and UA-A's second step were completed. Corrective action as it applies	6/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 23 testing (TST) and/or an IGRA (test to determine presence of tuberculosis) was completed prior to working with residents for 2 of 5 employees (registered nurse (RN)-G, unit assistant (UA)-A) reviewed for tuberculosis. Findings include: The following employee files identified the following: - RN-G's step-1 baseline TB skin test was completed on 4/28/25. The employee file lacked documentation of step-2 baseline TB skin test and/or an IGRA. - UA-A step-1 baseline TB skin test was completed on 3/31/25. The employee file lacked documentation of step-2 baseline TB skin test and/or an IGRA. On 5/20/25, RN-E stated employee TB screening and step-1 skin tests were required to be completed prior to staff working with residents and step-2 should be completed within approximately 2 weeks of step-1. RN-E stated RN-G's 2nd step should have been completed 1 week ago. UA-A's 2nd step should have been completed mid-April. RN-E stated she was responsible for ensuring the TB skin tests were completed and didn't know why RN-G and UA-A's were not up to date. The facilirty Tuberculosis (TB) Prevention and Control Policy revised 11/23, identified prior to or upon hire, all employees will be screened for TB and will receive a baseline TST (including step-1 and step-2) and or TB blood test. SUGGESTED METHOD OF CORRECTION: The	21426	to other residents and team members: Team members who do not complete their second step when due, will be removed from the schedule until the second step is completed. All team members will be educated on this expectation. Recurrence will be prevented by: All team members will receive education on mantoux policy and expectations at an all-staff education on 6/17/25. Team members who do not attend the education will receive the education prior to the start of their next shift. An audit on mantoux□s will be conducted once a day for one week starting on 6/18/25, then once a week for four weeks, then once a month. The QAPI committee will determine when the audits may be discontinued. The correction will be monitored by DON or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 24 director of nursing (DON) and/or designee could review current CDC guidelines for tuberculosis control within health care facilities, audit resident and staff for requirements, update/complete any steps missing and complete ongoing monitoring of new admissions and new hires to ensure compliance. The facility should report audit findings to Quality Assurance Performance Improvement (QAPI) for further recommendations and to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does	21530		6/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 25 not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist (CP) identified the need for a gradual dose reduction (GDR) or medical justification of use for 1 of 5 residents (R42) reviewed for unnecessary medication and were taking psychotropic medications. Findings include: R42's quarterly Minimum Data Set (MDS) dated 5/8/25, identified moderate cognitive impairment with verbal behaviors directed toward others and behaviors not direct toward others 1 to 3 days a week. R42's diagnoses included bipolar disorder (a mental health condition characterized by extreme mood swings, ranging from periods of intense highs to periods of deep lows) and anxiety. R42 received an antipsychotic medication and an antidepressant medication. The MDS identified the last gradual dose	21530	CORRECTED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 26 reduction (GDR) of medications was done 2/23/21, and a GDR was not documented as clinically contraindicated. R42's most recent Physician Order Report dated undated, identified haloperidol (typical antipsychotic medication) to be given twice a day related to bipolar disorder and was dated 11/22/23. R42 also received Zoloft (an antidepressant medication) given one time a day for depression related to bipolar disorder and was dated 11/29/22. R42's monthly pharmacy reviews were reviewed from 6/2024 to 5/2025, with no irregularities identified with antipsychotic medications or antidepressant medications. R42's medical record was reviewed and lacked evidence a GDR had been attempted or identified a medical justification for continued use within the past calendar year for antipsychotic or antidepressant medications. During an interview on 5/21/25 at 1:13 p.m., registered nurse (RN)-H stated the consulting pharmacist (CP) reviewed the residents' medication lists and identified if any residents were due to a GDR, and that is how she was flagged if a resident was due for one. RN-H stated R42's medical record lacked any evidence a GDR had be attempted or a clinical justification for continued use. During a telephone interview on 5/21/25 at 2:00 p.m., the CP stated a resident's medication lists were reviewed monthly and medications were monitored, this included reviewing psychotropic medications (drugs that affect mental processes and behavior, often used to treat mental health	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 27 conditions like anxiety, depression, and psychosis) for adverse reactions, monitor GDR or clinical contraindication for medication reduction. GDR's are to be attempted yearly. The CP stated the last documented GDR was from 2/2024, and a GDR or clinical contraindication should of be documented and was not. During an interview on 5/21/25 at 2:37 p.m., the director of nursing (DON) she would expect GDR's to be attempted or documented contraindication to be done yearly. The facility's Psychopharmacological Drug Use policy dated 5/2025, identified the CP would review resident medication records on a monthly basis for documentation/justification for the drug use and will recommend dosage reductions or modifications as appropriate. SUGGESTED METHOD OF CORRECTION: The DON or designee and the consulting pharmacist could develop and/or revise policies to monitor for GDR or justifcation of continued use of psychotropic medications. Audits could be developed to monitor medications for adequate monitoring. The DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further education. TIME PERIOD FOR CORRECTION: 21 DAYS	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen	21535		6/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 28 must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a gradual dose reduction (GDR) or a clinical justification for a psychotropic medications was documented for 1 of 5 residents (R42) reviewed for unnecessary medication and were taking psychotropic medications. Findings include: R42's quarterly Minimum Data Set (MDS) dated 5/8/25, identified R42 had moderate cognitive impairment. R42 had verbal behaviors directed toward others and behaviors not direct toward others 1 to 3 days a week. R42's diagnoses	21535	CORRECTED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 29 included bipolar disorder (a mental health condition characterized by extreme mood swings, ranging from periods of intense highs to periods of deep lows) and anxiety. R42 received an antipsychotic medication and an antidepressant medication. The MDS identified the last gradual dose reduction (GDR) of medications was done 2/23/21, and a GDR was not documented as clinically contraindicated. R42's most recent Physician Order Report dated 5/21/25, identified haloperidol (typical antipsychotic medication) to be given twice a day related to bipolar disorder and was dated 11/22/23. R42 also received Zoloft (an antidepressant medication) given one time a day for depression related to bipolar disorder and was dated 11/29/22. R42's monthly pharmacy reviews were reviewed from 6/2024 to 5/2025, with no irregularities identified with antipsychotic medications or antidepressant medications. R42's medical record was reviewed and lacked evidence a GDR had been attempted or identified a medical justification for continued use and R42 was on the lowest effective dose, within the past calendar year for the haloperidol. During an interview on 5/21/25 at 1:13 p.m., registered nurse (RN)-H, nurse manager, stated the resident's medications were reviewed on a regular basis and discussed with nursing and pharmacy consultant (CP). RN-H stated they did not look for when a GDR was due but waited for the CP to make a recommendation for a GDR. During a telephone interview on 5/21/25 at 2:00 p.m., the CP stated GDRs on psychotropic	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 30 medications were done twice a year for new medications and yearly for established medications. The CP identified the last GDR attempt was done 2/2024. During an interview on 5/21/25 at 2:37 p.m., the director of nursing (DON) stated it was the expectation nursing staff would work with pharmacy to ensure psychotropic medication GDRs were addressed for the health of the residents. The facility's Psychopharmacological Drug Use policy dated 5/2025, the resident drug regimen must be free of unnecessary drugs. An unnecessary drug is any drug when used in an excessive dose, for an excessive duration, or without adequate indications for use. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist could develop and/or revise policies to monitor medications for to ensure GDR's and or justification of use is obtained as directed from the provider. Audits could be developed to monitor residents to ensure GDR's and or justifiation of use was obtained. The DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further education. TIME PERIOD FOR CORRECTION: 21 DAYS	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **02 - SUB ACUTE** B. WING _____	**05/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE GRAND RAPIDS, MN 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/20/2025. At the time of this survey, Grand Village was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 06/13/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **02 - SUB ACUTE** B. WING _____	**05/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE GRAND RAPIDS, MN 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Grand Village was built in 5 different stages. The original building was built in the early 1900's of which only a small 1-story portion remains. It is Type II (222) construction and is separated from all other additions by at least 2-hour fire rated barriers. In 1972 a 1-story addition, without a basement, was constructed to the south of the existing building and was determined to be Type II (000) construction. In 1992, two 1-story additions, without basements, were constructed. One to the south of the 1972 building's west wing	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **02 - SUB ACUTE** B. WING _____	**05/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE GRAND RAPIDS, MN 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 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. The facility has a capacity of 114 beds and had a census of 69 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.	K 353		6/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **02 - SUB ACUTE** B. WING _____	**05/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE GRAND RAPIDS, MN 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 3 a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a patterned impact on the residents within the facility. Findings include: On 05/20/2025, at 11:48am, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in the following locations: 1) Kitchen storage 2) Theater viewing room An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 353	The kitchen storage and theater viewing room were 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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **02 - SUB ACUTE** B. WING _____	**05/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE GRAND RAPIDS, MN 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/20/2025 between 9:00am and 1:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors in the following areas; 1) Lodge entrance by theatre room 2) By gift shop 119A 3) At entrance to Waters Wing double doors 4) At entrance to Spruce Wing double doors 5) by Room 229 6) At entrance to Cedar Wing	K 372	The identified areas will be corrected by 6/25/2025 by filling the identified penetrations above the fire doors. All smoke barriers will be audited and corrected if applicable. The policies regarding fire safety were reviewed and are current. Maintenance staff will be educated on smoke departments and checking fire doors and areas around them. Weekly audits will be completed for the first 30 days and then audits will be done monthly and after outside contractors' complete work near fire doors. 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. The QAPI committee will review the results of the audits to determine whether	6/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **02 - SUB ACUTE** B. WING _____	**05/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE GRAND RAPIDS, MN 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 5 7) At entrance to Burch Wing 8) At entrance to Woods Wing An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 372	the plan of corrections was effective or if continuous monitoring and system changes need to be implemented.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/20/2025, at 09:05am, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: first shift 01/17/25 @ 1120am, 04/18/25 @ 1000am, and 07/22/24 @ 1015am. These drills do not	K 712	All residents have potential to be affected by deficient practice. Facility will correct deficient practice by continuing to holding fire drills as varying times and under varying conditions at expected and unexpected times at least quarterly on each shift. Education will be completed with the maintenance team and safety committee on requirements for fire drills. The Facility will ensure that the drills held per schedule are documented by completing monthly audits. They will review 1 year of drills prior to scheduling the months drill.	6/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **02 - SUB ACUTE** B. WING _____	**05/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE GRAND RAPIDS, MN 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 6 reflect vering times. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 712	How we will monitor future performance to ensure solutions are sustained: Audits will be reviewed at the monthly Safety committee meetings for direction or change as well as timeline for completion based on compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and	K 918		6/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **02 - SUB ACUTE** B. WING _____	**05/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE GRAND RAPIDS, MN 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 7 separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 and 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/20/2025, at 09:18am, it was revealed by a review of available documentation of the emergency generator maintenance and testing annual generator inspections were not performed from 05/20/2024 to 05/20/2025. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 918	Annual generator testing will be scheduled and completed before 6/25/2025. The preventative maintenance tracking system was updated to ensure annual testing is scheduled by regulation moving forward and will be monitored by the Quality Assurance Performance Improvement Committee. The measures that will be taken to ensure deficiency does not reoccur is a facility review of the emergency generator policy. The person responsible for compliance is the director of environmental services.	