DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	CARE/MEDICAID CERTIFICA - TO BE COMPLETED BY TH		ID: ZR77 Facility ID: 00299
MEDICARE/MEDICAID PROVIDER NO. (L1) 245495 2.STATE VENDOR OR MEDICAID NO.	3. NAME AND ADDRESS OF FACIL (L3) THE EMERALDS AT GRAM (L4) 2801 SOUTH HIGHWAY 16	ITY ND RAPIDS LLC	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification
(L2) 606318700	(L5) GRAND RAPIDS, MN	(L6) 55744	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 02/01/2019	7. PROVIDER/SUPPLIER CATEGOI 01 Hospital 05 HHA	RY <u>02</u> (L7) 09 ESRD 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 10/08/2020 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited	03 SNF/NF/Distinct 07 X-Ray	10 NF 14 CORF 11 ICF/IID 15 ASC 12 RHC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 93 (L18) 93 (L17) 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 93		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director
(L37) (L38) (L39)	(L42) (L43)		
16. STATE SURVEY AGENCY REMARKS (IF APPLIC	ABLE SHOW LIC CANCELLATION DA	(IE):	
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY	APPROVAL Date:
Teresa Ament, Unit Supervisor	11/12/2020	(L19) Joanne Simon, Enforcement Spec	ialist 11/12/2020 (L20
PART II - TO BE	COMPLETED BY HCFA REG	SIONAL OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH C RIGHTS ACT:		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e:
22. ORIGINAL DATE 23. LTC AGRE	EMENT 24. LTC AGREEME	NT 26. TERMINATION ACTION	: (L30)
OF PARTICIPATION BEGINNIN 08/01/1987		VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburs	05-Fail to Meet Health/Safety
(L24) (L41)	(L25)	03-Risk of Involuntary Termination	on .
A. Suspens	TIVE SANCTIONS on of Admissions: (L44)	04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
(L27) B. Rescind	Suspension Date:		
	(L45)		
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS	
(L28)	06201	(L31)	

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

10/29/2020

(L32)

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 12, 2020 CMS Certification Number (CCN): 245495

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

Dear Administrator:

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

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

Effective October 30, 2020 the above facility is certified for:

93 Skilled Nursing Facility/Nursing Facility Beds

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

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 12, 2020

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

RE: CCN: 245495

Cycle Start Date: September 4, 2020

Dear Administrator:

On September 24, 2020, we notified you a remedy was imposed. On October 8, 2020 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 30, 2020.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective October 24, 2020 be discontinued as of October 30, 2020. (42 CFR 488.417 (b))

However, as we notified you in our letter of September 24, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 24, 2020. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		_	ARE/MEDICAII TO BE COMPL	_					ID: ZR77 Facility ID: 0	00299
1. MEDICARE/MEDICA (L1) 245495 2.STATE VENDOR OR M (L2) 606318700		Ю.	3. NAME AND AD (L3) THE EMER (L4) 2801 SOUTH (L5) GRAND RA	ALDS AT GR H HIGHWAY	AND RAPI		55744	4. TYPE OF A 1. Initial 3. Terminatio 5. Validation	2. Recer n 4. CHO 6. Comp	rtification W blaint
5. EFFECTIVE DATE C (L9) 02/01/2019 6. DATE OF SURVEY	HANGE OF OWN 09/04/20		7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual	PPLIER CATEC 05 HHA 06 PRTF	GORY 09 ESRD 10 NF	02 (L7) 13 PTIP 14 CORF	22 CLIA	7. On-Site Vis 8. Full Survey	sit 9. Other V After Complaint	•
8. ACCREDITATION ST 0 Unaccredited 2 AOA		(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC			FISCAL YEAR I		(L35)
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(L37) 16. STATE SURVEY AG	(L38) GENCY REMARK	(L39) SS (IF APPLICA	(L42) BLE SHOW LTC CA	(L43)	DATE):					
17. SURVEYOR SIGNA			Date :	0/10/2000		18. STATE SUF	RVEY AGENCY	APPROVAL	Date:	
Sativa Bush	ey, HFE - ſ	NE II		0/12/2020	(L19)	Joanne Simo	on, Enforceme	ent Specialist	10/2	26/2020 (L2
	PART	II - TO BE (COMPLETED E	BY HCFA RI	EGIONAL	OFFICE OF	R SINGLE S	TATE AGENC	Y	
DETERMINATION (1. Facility i 2. Facility		ipate (L21)		PLIANCE WITI ITS ACT:	H CIVIL	2. 0		cial Solvency (HCF. l Interest Disclosure :))
22. ORIGINAL DATE	23	3. LTC AGREEN	MENT 24	LTC AGREEN	MENT	26. TERMINA	TION ACTION:		(L30)	
OF PARTICIPATION 08/01/1987	N	BEGINNING	DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Clos	00		OLUNTARY ail to Meet Health/	Safety
(L24)		(L41)		(L25)			on W/ Reimburse		ail to Meet Agreem	nent
25. LTC EXTENSION I			VE SANCTIONS of Admissions:	(L44)		03-Risk of Involu	untary Termination for Withdrawal	07-P	I <u>ER</u> rovider Status Cha active	ange
	(L27)	D. Daggind Cr	gnangian Data:							

(L45)

30. REMARKS

DETERMINATION APPROVAL

(L31)

(L33)

29. INTERMEDIARY/CARRIER NO.

32. DETERMINATION OF APPROVAL DATE

06201

28. TERMINATION DATE:

31. RO RECEIPT OF CMS-1539

B. Rescind Suspension Date:

(L28)

(L32)



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 24, 2020

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

RE: CCN: 245495

Cycle Start Date: September 4, 2020

Dear Administrator:

On September 4, 2020, a survey was completed at your facility by the Minnesota Department(s) 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 24, 2020.
- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 24, 2020 They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 24, 2020.

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

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 24, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Emeralds At Grand Rapids Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 24, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us

Phone: (218) 302-6151

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 4, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

PRINTED: 10/13/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245495	B. WING		00	C / 04/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		704/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
F 000	Preparedness Requ 8/31/20, through 9/4 survey. The facility Appendix Z Emerge Requirements.	•	F 00	00		
	survey and a complyour facility. Comple conducted. Your fac compliance with the	h 9/4/20, a recertification laint survey was conducted at aint investigations were also cility was found not to be in e requirements of 42 CFR 483, ments for Long Term Care				
	The following compunsubstantiated: H5595078C H5595079C H5595080C H5595081C	laints were found				
	The following comp substantiated with r H5595082C	laint was found to be no deficiencies:				
	as your allegation on Department's accept enrolled in ePOC, year the bottom of the	f correction (POC) will serve f compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.				
	on-site revisit of you	acceptable electronic POC, an ur facility may be conducted to				
_aburator\	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURĒ	TITLE		(X6) DATE

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

Electronically Signed

09/25/2020

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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	E SURVEY IPLETED	
		245495	B. WING				C 04/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	IP CODE	1 03/	04/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 000	regulations has bee	ential compliance with the en attained in accordance with		000			
	CFR(s): 483.10(g)(19) (i) A facility must imconsult with the resconsistent with his representative(s) w (A) An accident invresults in injury and physician interventi (B) A significant chamental, or psychos deterioration in heastatus in either lifeclinical complication (C) A need to alter a need to discontinus treatment due to accommence a new f (D) A decision to traresident from the fa §483.15(c)(1)(ii). (ii) When making n (14)(i) of this sectionall pertinent informatics available and prophysician. (iii) The facility must resident and the rewhen there is-(A) A change in rocas specified in §483 (B) A change in resident resident resident in §483 (B) A change in resident in section in §483 (B) A change in resident in section in §483 (B) A change in resident in section in §483 (B) A change in resident in section in section in §483 (B) A change in resident in section in section in §483 (B) A change in resident in section in §483 (B) A change in resident in section in section in §483 (B) A change in resident in section in se	ification of Changes. Immediately inform the resident; Ident's physician; and notify, or her authority, the resident when there is- olving the resident which I has the potential for requiring on; ange in the resident's physical, ocial status (that is, a olth, mental, or psychosocial threatening conditions or ons); treatment significantly (that is, ue an existing form of diverse consequences, or to form of treatment); or ansfer or discharge the acility as specified in otification under paragraph (g) on, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the st also promptly notify the sident representative, if any, om or roommate assignment	F	580			10/7/20

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245495	B. WING		C 09/04/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	3373 112323
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F 580	(e)(10) of this sect (iv) The facility mu update the addres phone number of representative(s). §483.10(g)(15) Admission to a conthat is a composite §483.5) must discrite sphysical configurations that compart, and must speroom changes between the facility care provider was gained and edemar (R18) reviewed for R18's Admission FR18's Admission FR18's Minimum Deindicated R18 was limited assistance dressing, personal extensive assistant R18's medical recoverights: On 8/12/20, weigh On 8/17/20, weigh On 8/17/20, weigh	ion. Ist record and periodically is (mailing and email) and the resident Imposite distinct part. A facility is distinct part (as defined in lose in its admission agreement for a facility the policies that apply to ween its different locations in the policies that apply to ween its different locations in the policies that apply to ween its different locations in the primary and document failed to ensure the primary notified timely when weight a occurred for 1 of 3 residents in edema. Record printed 9/4/20, indicated included hypertension, and failure. In the policies that apply to ween its different locations in the primary in	F 580	F580: Notification of Change Immediate Corrective Action: R18 physician was notified of weigh and edema on 9/4/20. Action as it Applies to Others: Change in a Resident's Condition o Status policy was reviewed and remcurrent. All residents were reviewed for weig gain/edema to ensure that MD has notified. All nurses were re-educated on Resident's Condition or Status polic include timely MD notification of a rechange in weight of +/- 5 lbs or per order. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by: of 5 residents with a change in cond will be conducted weekly x 4 weeks monthly x2 months to assure physic notified of resident changes in cond	r nains ght been ey to esident MD Audit dition then cian is

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	СОМ	E SURVEY IPLETED
		245495	B. WING _			C 04/2020
	PROVIDER OR SUPPLIER ERALDS AT GRAND F	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 580	On 9/3/20, weight verification of the tigain. On 8/24/20, at the tigain. On 8/27/20, a progress of the tigain. On 8/29/20, two seindicated R18 had lower leg. On 8/30/20, a progress of the tigain of the left for the tigain. On 8/31/20, a progress of the tigain of the left for the tigain of the	rd lacked indication the practitioner (NP) was notified me of R18's 7.4 lbs weight ress note indicated R18 had parate progress notes edema to the left foot and ress note indicated R18 had not and lower leg. ress note indicated R18 had ess note indicated R18 had	F 58	The results of these audits with the facility QAPI common the need to increase, discontinue the audits. Corrections will be monito DON/Nurse Managers/De	mittee for input lecrease, or red by:	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	CON	TE SURVEY MPLETED C
		245495	B. WING_		1	/04/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 580	On 9/3/20, at 10:59 unaware R18 had week prior to that of medical record lac was notified of R18 edema prior to 9/2 should be notified greater in a week. On 9/3/20, at 11:39 reviewed resident she was aware of 8/24/20. LPN-C stoof R18's weight ga was already on the 8/24/20. LPN-C stoof R18's weight ga was already on the 8/24/20, because of stated she added for 9/2/20, because of stated the NP should be	5 a.m. LPN-F stated she was a weight gain of 7.4 lbs in a day. LPN-F verified R18's ked indication R18's physician 8's 7.4 lbs weight gain, and /20. LPN-F stated a physician of a weight gain of five lbs or 5 a.m. LPN-C stated she weights weekly. LPN-C stated R18's weight gain the week of ated she did not notify the NP in and edema because R18 e NP's schedule to bee seen on ated was unsure why R18 was 2 on 8/24/20, or 8/26/20. LPN-C R18 to the NP's schedule on the weight gain. LPN-C ald have been notified 8's weight gain and edema, and -C should have followed up	F 58			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	СОМ	E SURVEY IPLETED
		245495	B. WING _			C 04/2020
	PROVIDER OR SUPPLIER	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 584 SS=D	and weight gain wa NP did not see R18 On 9/4/20, at 3:51 (DON) stated she et to be notified of any either by fax or phowas discovered. The gain of 7.4 lbs wou underlying medical The facility policy Cor Status revised 5 the resident's phys resident's medical/Safe/Clean/Comfor CFR(s): 483.10(i) (1) §483.10(i) Safe En The resident has a comfortable and hobut not limited to resupports for daily limited to resupport	as also listed. LPN-I verified the 3 until 9/2/20. p.m. the director of nursing expected the physician or NP y weight gain over five lbs one the day the weight increase ne DON further stated a weight ld be a concern of changes in conditions. Change in Resident's Condition /17, directed to promptly notify ician of changes in the mental condition and/or status. rtable/Homelike Environment 1)-(7) vironment. right to a safe, clean, omelike environment, including eceiving treatment and ving safely.	F 58			10/7/20
	§483.10(i)(2) Hous	ekeeping and maintenance				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	` ´сом	E SURVEY IPLETED
		245495	B. WING _			C 04/2020
	PROVIDER OR SUPPLIER	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 584	and comfortable into §483.10(i)(3) Clear in good condition; §483.10(i)(4) Private resident room, as so §483.10(i)(5) Adeq levels in all areas; §483.10(i)(6) Comflevels. Facilities initi 1990 must maintain 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMED by: Based on observative review, the facility for was cleaned and in residents (R45) review, the facility for the sound levels. This REQUIREMED by: Based on observative review, the facility for the sound levels. This REQUIREMED by: Findings include: R45's Admission RR45's diagnoses in and muscle weakness. R45's annual Minin 7/30/20, indicated R45's MDS further	to maintain a sanitary, orderly, rerior; bed and bath linens that are the closet space in each recified in §483.90 (e)(2)(iv); that and comfortable lighting ortable and safe temperature rially certified after October 1, in a temperature range of 71 to the maintenance of comfortable NT is not met as evidenced tion, interview, and document ailed to ensure a wheelchair is sanitary condition for 1 of 8 riewed for environment.	F 58	F584: Safe/Clean/Comfor Environment Immediate Corrective Actin R45 s wheelchair was cleaded Action as it Applies to Othe All resident wheelchairs arwere cleaned. Nursing and maintenance on importance of cleaning monthly per schedule and Date of Compliance: 10/7/Reoccurrence will be prev of 5 resident wheelchairs/cleanliness will be conduct weeks then monthly x2	on: eaned on 9/4/20 ers: nd cushions staff educated wheelchairs when soiled. '2020 ented by: Audit cushions for ted weekly x 4	
	extensive assistance R45's care plan da	ted 7/29/20, directed staff to		resident wheelchairs/cush The results of these audits with the facility QAPI com	s will be shared	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		245495	B. WING _		09	C / 04/2020
	PROVIDER OR SUPPLIER	APIDS LLC		STREET ADDRESS, CITY, STATE, ZIP C 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 584	weekly. On 9/2/20, at 8:22 a was observed to ha crusted food debris approximately four assistant (NA)-G ar NA-G was observed wheelchair and look NA-G then walked a was observed to als NA-G and NA-F the wheelchair. R45 was oiled wheelchair color of 9/2/20, at 10:25 being transferred, but the bed. R45's was oiled. On 9/2/20, at 10:30 and confirmed R45 soiled. NA-H stated residue on R45's whot notice the residustated wheelchair color and when spills occord on 9/3/20, at 2:22 p (DON) stated she element of the stated wheelchair cushion. A wheelchair cleani but not provided by	a.m. R45's wheelchair cushion we dried, yellow, and white on it. The food debris was inches (in.) by two in. Nursing and NA-F were in R45's room. It to stand over R45's ked at the wheelchair cushion. It is a colock at R45's wheelchair. It is seated directly on top of the ushion. a.m., R45 was observed by NA-H, from his wheelchair cushion remained a.m., NA-H was interviewed by NA-H, from his wheelchair heelchair cushion was heelchair. NA-H stated he did use when he got R45 up. NA-H leaning was completed weekly sturred. b.m., the director of nursing a when it was dirty. In schedule was requested the facility heair cleaning was requested.	F 58	on the need to increase, de discontinue the audits. Corrections will be monitore Maintenance Supervisor/De	ed by:	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245495	B. WING		C 09/04/2020
	PROVIDER OR SUPPLIER	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	1 00.0 11.20.20
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION
F 609	CFR(s): 483.12(c)(§483.12(c) In response	d Violations	F 609		10/7/20
	involving abuse, ne mistreatment, inclusource and misapp are reported immer hours after the allest that cause the allest serious bodily injurithe events that cause and do not reported the administrator of officials (including the adult protective serior jurisdiction in lossing to a source and the administrator of the admin	are that all alleged violations eglect, exploitation or ding injuries of unknown propriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if use the allegation do not involve esult in serious bodily injury, to f the facility and to other to the State Survey Agency and evices where state law provides ing-term care facilities) in that the state is the state is a state in the state in the state is a state in the state is a state in the state in the state is a state in the state i			
	designated represe accordance with St Survey Agency, wit incident, and if the appropriate correct This REQUIREME by: Based on interview facility failed to imm	e administrator or his or her entative and to other officials in tate law, including to the State hin 5 working days of the alleged violation is verified tive action must be taken. NT is not met as evidenced and document review, the nediately report an allegation of I agency (SA) for 1 of 2		F609: Reporting of Alleged Violation Immediate Corrective Action: R7 discharged from facility on 9/19 Action as it Applies to Others: Abuse Prohibition/Vulnerable Adult policy was reviewed and remained	9/20 t Plan

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	COM	E SURVEY IPLETED
		245495	B. WING			C 04/2020
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIF 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		·v
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 609	R7's quarterly Mir 8/16/20, indicated impaired, and req bed mobility, and On 8/6/20, an unt around 6:40 p.m., to the unit, and as heard a nurse in facing R7's room bed, shut up and bed, just shut up.' indicated the NA rother nurses who and place it in the On 8/7/20, a facili nursing assistant toward the wing for nurse through the resident to, "Shut further indicated the but was not report (DON) and the adday. On 9/3/20, at 10:0 four staff member but it was not report day. The administreported to him in The facility policy Adult Plan dated residents in the fa abuse by anyone staff were responsi	nimum Data Set (MDS) dated I she was severely cognitively uired extensive assistance for total assistance for transfers. Itled facility document indicated a nursing assistant (NA) went is she approached the doors she front of the medication cart yelling, "[R7], shut up and go to go to bed, [R7], its time to go to "The document further reported the incident to two told her to write a statement DON's inbox. It is ported she was walking our hallway, and could hear a e doors loudly telling at a up and go to bed." The report he incident occurred on 8/6/20, ted to the director of nursing liministrator until the following trator stated it should have been	F 6	current. All staff educated on Abus Prohibition/Vulnerable Adu with regards to immediate suspected abuse to the D Administrator. Date of Compliance: 10/7 Reoccurrence will be prev of 5 staff members condu weeks then monthly x2 m staff know who to report a abuse to, how to report it, report it via verbal convers results of these audits will the facility QAPI committe the need to increase, decidiscontinue the audits. Corrections will be monito Services Director/Designer	ult Plan policy ely reporting any ON & /2020 /ented by: Audit cted weekly x 4 onths to assure my suspected and when to sation. The be shared with er for input on rease, or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245495	B. WING		1	C 09/04/2020	
	ROVIDER OR SUPPLIER	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORREX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 609	allegations of abuse policy directed susp	ator immediately of any e or suspected abuse. The pected abuse shall be reported nan two hours after forming a	F 6	509			
F 655 SS=D	Planning §483.21(a) Baselin §483.21(a)(1) The implement a baseli that includes the interfective and persor that meet profession. The baseline care profession of the baseline care profession. (ii) Be developed with admission. (ii) Include the mining necessary to proper including, but not ling (A) Initial goals base (B) Physician order (C) Dietary orders. (D) Therapy services (E) Social services. (F) PASARR recomform §483.21(a)(2) The comprehensive care care plan if the comform of th	ensive Person-Centered Care e Care Plans facility must develop and ne care plan for each resident structions needed to provide n-centered care of the resident anal standards of quality care. colan must- thin 48 hours of a resident's mum healthcare information arrly care for a resident mited to- ed on admission orders. s.	F6	555		10/7/20	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245495	B. WING			C 09/04/2020		
	PROVIDER OR SUPPLIER ERALDS AT GRAND F	RAPIDS LLC		2801	EET ADDRESS, CITY, STATE, ZIP CODE 1 SOUTH HIGHWAY 169 AND RAPIDS, MN 55744			
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 655	§483.21(a)(3) The resident and their rof the baseline care limited to: (i) The initial goals (ii) A summary of the dietary instructions (iii) Any services and administered by the on behalf of the factive) Any updated into the comprehens. This REQUIREMED by: Based on interview facility failed to enside veloped within 44 residents (R111) residen	facility must provide the epresentative with a summary e plan that includes but is not of the resident. The resident's medications and treatments to be a facility and personnel acting sility. Formation based on the details tive care plan, as necessary. The residence of the resid	F 6		F655: Baseline Care Plan Immediate Corrective Action: R111 Baseline Care Plan was compon 8/31/2020 Action as it Applies to Others: Care Planning policy was reviewed remained current. All current residents care plans were eviewed to ensure that their baselicare plans were completed and local management team members were ducated on the need to complete/the Baseline Care Plan within 48 hours of Compliance: 10/7/2020 Reoccurrence will be prevented by the facility and the second care plans are completed within 48 hours of admission. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by the facility of 5 resident admissions conducted weekly x 4 weeks then monthly x2 to assure Baseline Care Plans are completed within 48 hours of admission the results of these audits will be swith the facility QAPI committee for on the need to increase, decrease, discontinue the audits. Corrections will be monitored by:	and re ne ked. ere lock ours of : Audit d months ession. shared		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		245495	B. WING _			04/2020
	PROVIDER OR SUPPLIER	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 655	Continued From particle A facility policy on I requested but not particle.	paseline care plans was	F 65	5 Administrator/Designee		
	ADL Care Provided CFR(s): 483.24(a)(§483.24(a)(2) A resout activities of dai services to maintai personal and oral h	d for Dependent Residents (2) sident who is unable to carry ly living receives the necessary n good nutrition, grooming, and	F 67	7		10/7/20
	Based on observareview, the facility fremove facial hair R215, R45) review	tion, interview, and document failed to provide nail care and for 3 of 8 residents (R21, ed for activities of daily living ere dependent on staff for ADL		F677: ADL Care Provided for Dep Residents Immediate Corrective Action: Nail Care and Facial Hair Care wa completed for residents R21, R215 R45. Action as it Applies to Others: ADL Assistance per Care Plan poli	s 5, &	
	R21's diagnoses in fracture of the T11-lower part of the sp R21's admission M 6/24/20, indicated light	ecord dated 9/4/20, indicated acluded wedge compression et 12 vertebrae (fracture of the bine). Inimum Data Set (MDS) dated R21 was cognitively intact, and twith personal hygiene needs.		reviewed and remained current. All residents were offered/received assistance with nail care/facial hair removal. All nurses and NARs were educate providing nail care and removal of hair for residents based on resider preference. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by	r ed on facial nt	
	R21's weekly skin not been shaved o admission on 6/18/	ted 6/30/20, directed staff to of one for personal hygiene. inspections indicated R45 had r had his nails trimmed since /20. I a.m. R21 was interviewed		Observation audit of 5 residents conducted weekly x 4 weeks then x2 months to ensure facial hair is t and nail care is provided. The resuthese audits will be shared with the QAPI committee for input on the nincrease, decrease, or discontinue audits.	monthly trimmed ults of e facility eed to	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245495	B. WING			09/04/2020	
	PROVIDER OR SUPPLIER	RAPIDS LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	1 03/	04/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	and stated he did no staff to trim his fing observed to have lo hands, and long factors of the staff to trim his fing observed to have lo hands, and long factors of the staff to hands, and long factors of the staff to hands of the staff to hands of the staff to hands of the staff to hand get his shower. It and get his shower on 9/3/20, at 3:19 stated he still had respective to hand get his shower.	ernails and beard. R21 was ong, jagged fingernails on both cial hair. a.m. R21 was observed in bed, acial hair remained long and a.m. R21 put his call light on assistant (NA)-D if he could D stated R21's bath was evening. a.m. R21 was observed, and al hair remained long. R21 d stated he did not get his last evening. B. a.m. licensed practical nurse resident refused a bath, staff efusals on a weekly skin and report the refusal to the ed R21's weekly skin ated 9/2/20, and noted a zero grough, which indicated R21 wer. R21 further stated she have time last evening to give PN-F stated staff should try completed that day. D. m. R21 was interviewed and not been offered a shower, and him to get a shower, and have	F 6	577	Corrections will be monitored by: DON/Nurse Managers/Designee		
	verified R21 did no	p.m. nursing assistant (NA)-I t get a bath/shower last led. NA-I stated nail care and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED C	
		245495	B. WING		09	/ 04/2020
	PROVIDER OR SUPPLIER	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP C 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	•	77.2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 677	Continued From pa	age 14	F 6	77		
	as needed. NA-I's had not been shave weeks.	leted on bath/shower day and tated it looked like R21's had ed or nails trimmed in several p.m. the director of nursing				
	(DON) stated resid shaved and nails traction The DON further states, it was expect three times, have a reproach, and if course the refusal. The Doto get done, it was ask for assistance,	lents should be offered to be immed on bath/shower day. tated if a resident declined cted to reproach the resident a different staff member ntinued to decline, document ON stated if baths were unable expected to notify the nurse, offer at a later time, and reekly skin inspection sheet.				
	R21's diagnoses in	Record dated 9/4/20, indicated a wedge compression lumbar vertebral (fracture of				
	R21's cognition wa	MDS dated 9/1/20, indicated s moderately impaired, and assistance with personal				
		ated 8/28/20, indicated R21, groomed, and bathed.				
	indicated R21 rece	n inspection dated 8/28/20, ived assistance with a bed shaved, and fingernails and rimmed.				
	have dark facial ha jagged fingernails v	9 p.m. R215 was observed to hirs on the upper lip, and long with a brown debris underneath s of the nails on both hands.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245495	B. WING			C 09/04/2020	
	PROVIDER OR SUPPLIER	RAPIDS LLC		280	EET ADDRESS, CITY, STATE, ZIP CODE 1 SOUTH HIGHWAY 169 AND RAPIDS, MN 55744	1 00%	772020
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	/E ACTION SHOULD BE ID TO THE APPROPRIATE	
F 677	her room and had ji fingernails remaine underneath fingerna dark facial hairs about the properties of	p.m. R215 was observed in ust finished with lunch. R21's d long with a brown debris ails. R215 continued to have ove upper lip. a.m. R215's nails remained and facial hairs noted above was interviewed and stated ve her nails shorter, and facial o.m. licensed practical nurse at 15's facial hair to upper lip are long and dirty. LPN-F asked ike to have her fingernails d, and her hair removed from ated R215 stated "yes." b.m. the DON stated residents having and nail care each mented on the weekly skin	F6	77			
	R45's diagnoses in weakness. R45's annual MDS had intact cognition he had severely im	ecord dated 9/3/20, indicated cluded visual loss and muscle dated 7/30/20, indicated R45 . R45's MDS further indicated paired vision, and required se with personal hygiene.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245495	B. WING			C 09/04/2020	
	PROVIDER OR SUPPLIER			28	REET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744	1 03/	04/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	required extensive care plan directed Review of R45's w 8/26/20, and 8/31/assistance was last On 8/31/20, at 5:1 have long facial have lectric razor was window. NA-F and R45. On 9/2/20, at 2:25 he stated his preference was to preferred to be shave long facial two preferred to be shave long facial two." On 9/2/20, at 2:33 needed staff assis R45 did not have to NA-I stated he bel R45 was observed the presence of fabelieved the facial two." On 9/2/20, at 2:51 and stated R45 was himself. NA-H stated R45 was himself. NA-H stated R45 was nassistance, and stated R45 was himself. NA-H stated R45 was nassistance, and stated R45 was nassistance.	ated 7/29/20, indicated R45 assistance grooming. R45's staff to shave R45 as needed. Weekly skin inspections dated 20, indicated shaving st documented on 8/26/20. 3 p.m. R45 was observed to air. a.m. nursing assistant (NA)-Foserved to perform personal red R45 to his wheelchair. An noted on a table near R45's NA-G did not offer to shave p.m. R45 was interviewed and erence was to be clean shaven, smoothe skin." R45 stated his be shaven every few days, and	F	677			

245495 B. WING	C 09/04/2020
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NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT GRAND RAPIDS LLC STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677 Continued From page 17 was "a little longer" than a five o'clock shadow. NA-H stated he was unaware when R45 was last shaven, and further stated R45 was shaved on shower days. On 9/3/20, at 9:28 a.m. LPN-B stated R45 needed staff assistance with shaving. LPN-B confirmed staff shaved R45, and stated he was blind. On 9/3/20, at 2:20 p.m. the director of nursing (DON) stated R45 needed staff assisitance with shaving. The DON stated staff were expected to shave R45. The facility policy Monarch Healthcare ADL Assistance revised 5/18, directed based upon resident/resident representative desires, assessment and care plan, ADL assistance will be provided to any residents deemed necessary. Some examples would be shaving males and females as needed, and fingernails and toenails to be clean and trimmed. F 679 SS=E CFK(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced	10/7/20

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245495	B. WING			C 09/04/2020	
	PROVIDER OR SUPPLIER ERALDS AT GRAND I	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP CC 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 679	by: Based on observareview, the facility factivities were proven R16, R28, and R45 Findings include: R111's Admission Findicated diagnose failure, and chronic R111's care plan in was at risk for increrelated to decrease guidelines while mainterventions includes social isolation, and independent activit wishes. R111's care R111's specific action R111's Activity Part 8/31/20, indicated I staff and his own in and would participate choosing. R111's faccomplishments, watching TV, exercishort stories, trivia, roommate. R111's including needs, stidetermined to remaper R111's care pla Review did not add actually attended on The facility Activity	tion, interview, and document failed to ensure meaningful rided for 4 of 4 residents (R111, b) reviewed for activities. Record printed 9/4/20, s included chronic pain, heart c kidney disease. Itiated 8/31/20, indicated R111 eased depression and anxiety ed socialization due to federal anaging Coronavirus-19. Ided assessments for risk of diprovide appropriate ies per resident likes and re plan lacked identification of vity needs and preferences. Icipation Review dated R111 enjoyed one on ones with independent activity in his room, ate in hallway activities of his avorite activities, special and/or new interests included cises, the daily chronicles, and visiting with staff and his activity-related focuses rengths and preferences was ain appropriate and current as in. R111's Activity Participation liress activities R111 had	F 679	F679: Activities Meet Interest Each Resident Immediate Corrective Actions R111, R16, R28, & R45 were including family interviews to activities planned were sufficient meaningful, and additional added if indicated. Action as it Applies to Others Activity Programs policy was and remained current. All residents will be reassess activities planned are meaning sufficient. Activity Department staff will re-educated on the process of and planning for sufficient and activities for those residents activity set up. Date of Compliance: 10/7/20 Reoccurrence will be prevent of 5 residents requiring activities onducted weekly x 4 weeks x2 months to assure activities sufficient and meaningful via verbal response. The results audits will be shared with the committee for input on the neincrease, decrease, or disconducted. Corrections will be monitored Director/Designee	e reassessed assure all ient, ctivities reviewed ded to assure agful and be for assessing ad meaningful requiring 20 ted by: Audit ities set up then monthly s are verbal or non of these facility QAPI eed to attinue the		

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
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F 679	the Daily Chronicle any one to one vis activities, and prove materials, such as On 9/1/20, at 10:2 sitting in his room, on his door, and nin his room. R111's roommate. R111 going on, and he On 9/2/20, at 2:35 sitting in his room R111 had no activ on towards R111's On 9/2/20, at 2:45 room, and said he exercises. R111 sR111 pointed at the and asked, "Do you R111 stated it was R111 stated he like well. R111 had no On 9/3/20, at 10:2 talking on the phomaterials in sight. On 9/4/20, at 1:12 stated R111 had be not seen him doing was not sure what On 9/4/20, at 1:43 (LPN)-F stated R1 but had been in the	e, but lacked documentation of its, participation in any vision of independent activity books or magazines. 8 a.m. R111 was observed a quarantine sign was hanging o activity materials were visible s TV was turned toward his stated there were no activities got bored. p.m. R111 was observed to be with the door mostly closed. ity materials, and the TV was	F 67	9		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245495	B. WING _			/04/2020
	PROVIDER OR SUPPLIER	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP COD 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 679	activities with any roff a flier in their rooff activities, but was rooff the DON stated activities activities upport the part of the comprehens assessment and refincled facility-orgindependent individual activities programs were desinterests of the res	nat. LPN-F stated no staff do residents, other than dropping oms. p.m. the director of nursing rities should do one-to-one not sure what was happening. Etivity staff try to think of ways	F 67	79		
	indicated he was s and required exten of daily living (ADL	nange MDS dated 8/12/20, everely cognitively impaired, sive assistance for all activities s). The activity preference DS was not completed.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245495	B. WING			C 09/04/2020	
	PROVIDER OR SUPPLIER ERALDS AT GRAND I			STREET ADDRESS, CITY, STATE, ZIP 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		7.7.2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 679	R16's Care Area Adated 8/30/20, indicor pleasure in doin R16 was depender engaging him in acconfined to his roof further indicated st room visits, and ince television, listening the window open for R16's care plan dadependent on staff activities due to colimitations. The carconverse with R16 the window for fresindicated R16 liked with family on the I music. R16's care increased depress decreased socializ R16's Activity Particulated R16 enjostories, tons of pur On 9/1/20, at 9:07 on his back in bed his room. At 10:14 his eyes open and 10:16 a.m. activity resident room hand AA-A left the unit work on 9/2/20, at 8:33 on his back in bed	ssessment (CAA) for Activities cated R16 showed little interest g things. The CAA indicated nt on staff for setting up and ctivities, and indicated R16 was m related to infection. The CAA aff were to provide one to one dicated R16 liked watching to classical music, and liked or fresh air. Ited 8/30/20, indicated he was for setting up and engaging in gnitive deficits and physical re plan directed staff to while providing care, and open sh air. The care plan also I to watch television, converse Pad, and listen to classical plan further indicated a risk for ion and anxiety related to	F 67	79			

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		TE SURVEY MPLETED C
		245495	B. WING		09	/04/2020
	PROVIDER OR SUPPLIER	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP CO 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 679	and not engaged in On 9/3/20, at 8:28 lying in bed with no had awakened R16 shifting around in the Facility documents 9/2/20, included a identified the follow 7/17/20, R16 watch 7/21/20, activity log computer and indic watching television Chronicles, 10 min indication the activ 7/22/20 - 7/27/20, Ithe same as 7/21/2 7/28/20, activity log 7/30/20 and 7/31/2 again provided but completed. 8/1/20 - 8/19/20, no provided. 8/20/20, R16 had a the weather, and c 8/24/20, indicated R16. 8/27/20, staff sat w day. 9/1/20, R16 had a 9/2/20, indicated d. The activity logs la activity programmin On 9/3/20, at 11:28 stated R16 watched.	a.m. R16 was again observed of television or radio on. Staff 5 prior to 7:30 a.m. R16 was he bed and appeared restless. Ititled Wing 3 dated 7/17/20 - list of residents on the unit and ving: med television g was pre-filled out on a cated independent activity, a, visits with staff and Daily utes. The log lacked any ities were completed. Dre-filled activity log indicated 20. Ig was left blank. In the pre-filled activity log was no indication activities were activity attendance was a one to one visit talking about turrent events were read to with R16 and talked about the visit from family. Bally chronicles. Coked evidence of weekend	F 6	79		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245495	B. WING _		09	/04/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744			
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F 679	got up in his chair, R28's admission in he was severely or required assistant MDS indicated lococcurred during th MDS further indicated to do his favorite at fresh air, and lister R28's care plan dadisplayed little or rindicated he would activity with staff. inform R28 of scheefforts for attendard A facility documen 9/2/20, included a identified the follow 7/17/20, no activity 7/21/20, activity locomputer and indiwatching television Chronicles 10 min the activities were 7/22/20 - 7/24/20, attendance log productivities were con 7/28/20, copy of clinterested in librariand he accepted to 7/30/20, 7/31/20, provided with no incompleted.	MDS dated 6/30/20, indicated ognitively impaired, and he se from staff to transfer. The comotion off the unit had not be assessment period. R28's ated it was somewhat important activities, go outside and get in to music. Ated 7/17/20, indicated R28 in activity involvement, and diparticipate in one to one. The care plan directed staff to eduled activities, and praise ince of hallway activities. At titled Wing 3 dated 7/17/20 - list of residents on the unit and wing: Ay identified. By was pre-filled out on a cated independent activity, in and one to one, Daily utes. There was no indication completed. By and 7/27/20, Pre-filled ovided, but no indication the	F 67	79			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	IPLE CONSTRUCTION IG		C C		
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744			
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F 679	8/18/20, Daily Chro 8/21/20, Daily Chro 8/24/20, Daily Chro 8/27/20, Enjoying but R28 was tired 8/29/20, Daily Chro 9/2/20, Daily Chro 9/2/20, Daily Chro The activity logs la activity programmi On 9/1/20, at 9:01 wheelchair in his r 10:16 a.m. AA-A w Daily Chronicles. A stopping in R28's i On 9/2/20, at 7:45 laying in bed. At 9: bed, no staff had e any way. He rema On 9/3/20, at 11:20 and stated staff as chair, and stated h looked outside. NA of his room. NA-J did not provide any activities staff did a papers from activity participated. On 9/3/20, at 2:54 the activity director stated when she s facility developed to assessments (the that was pre-filled the direct care star	onicles. onicles. onicles. onicles. television, provided chronicles and declined further interaction. onicles. nicles. nicked evidence of weekend ng. a.m. R28 was sitting up in his oom with the television on. At vas on the unit handing out the AA-A left the unit without					

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744			
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F 679	started she did mo since COVID-19, report to one visits. The acceptance of the control of the administrator of the	age 25 ed when the activity director first ost of the activities, but stated most of the activities were one administrator stated the Daily hand out that described what curring each day, and her things like a word search. Stated the activity department or esidents, and went over it ministrator stated R16 had an sings, and had a bird feeder w. The administrator stated ld go in and chat with R16 in I it was difficult to have him lue to infection control ministrator stated he did not t said if something was written y, it was probably done.	F6	79			
		Record dated 9/3/20, indicated ncluded visual loss, muscle aring loss.					
	had intact cognitio and had highly imp self-assessment in around animals, till with the news. R48	6 dated 7/30/20, indicated R45 n, had severely impaired vision, paired hearing. R45's activity ndicated he enjoyed being me outdoors, and keeping up 5's activity self-assessment he enjoyed listening to music					

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NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT GRAND RAPIDS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744			
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F 679	and reading books, R45's care plan rev was dependent on stimulation, social i R45's care plan fur independently purs listen to a transistor refused to go outsid R45's Care Confere indicated R45 relied participated in one- The form further indinterest in activities R45's July 2020 activities were docu- Delivered mail and occurrence Watched television - Listened to transis occurrences No other activities R45's August activities Currence The Daily Chronic - Visited by staff "all occurrence Chatted about fall on one occurrence Verbal interactions - R45 refused to wa - No other activities	newspapers or magazines. riewed 7/29/20, indicated R45 staff for activities, cognitive interactions, and well-being. Ither indicated he ued activities, and he liked to r radio or the television. R45 de or attend group activities. ence form dated 8/3/20, d on staff for activities, and on-one activities with staff. dicated R45 did not have due vision and hearing loss. Itivity log indicated the following umented: d "talked a bit" on one on one occurrence. stor radio on eight were documented. Ity log indicated the following umented: and "current events" on one sles on five occurrences. bout his needs" on one and "reviewed today's events"	F 6	379		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245495	B. WING _			/04/2020
	PROVIDER OR SUPPLIER	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
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F 679	bedside table in frooff in the room. R4. wall. The television radio was observed used to enjoy fishir television. On 8/31/20, at 6:00 sitting in a wheelch eating dinner. R45 wall. The television On 9/2/20, at 8:22 assist R45 with mo a wheelchair, and pof him. The TV was activities assistant and placed a mug then exited the roo a.m., R45 was sea forward toward a woff. At 12:43 p.m. I wheelchair facing for television remained observed to walk proportunity to attendid not enter R45's p.m. R45 was obseappeared to be awand stated R45 he around." On 9/2/20, at 2:25 anything." R45 statkeep himself comformation was observed to walk proportunity to attendid not enter R45's p.m. R45 was obseappeared to be awand stated R45 he around."	air in his room. R45 had a ont of him, and the lights were 5 was facing forward toward a was noted to be off, and no d in R45's room. R45 stated he ig, reading, and watching D. p.m. R45 was observed air in his room. R45 was was facing forward toward a was noted to be off. a.m. NA-F was observed to rning cares, transferred him to blaced a bedside table in front is noted to be off. At 8:47 a.m. (AA)-B entered R45's room on his bedside table. AA-B im. From 9:29 a.m. to 10:17 ted in a wheelchair and facing rall. R45's television remained rall. R45's television remained rall. R45's room and entered ooms and offered them an of an exercise activity. AA-A room. At 1:42 p.m. At 2:14 erved lying in bed and ake. NA-I entered R45's room was "just kind of laying p.m. R45 stated, "I don't do ed he was "bored" and tried to ortable by lying in bed most of ision was noted to be off.	F 67	79		

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F 679	On 9/3/20, at 8:37 eating breakfast in was observed to be television was not observed in the roobserved in the roobserved in the roobserved in the roof observed in the radio, did not know if the right now. NA-D stattended activities assisted R45 to play provided "a daily set they read it to him his roommates teles "found peace" with stated R45 barely	a.m. R45 was observed to be his room. At 8:52 a.m. R45 e facing toward a wall. R45's ed to be off and no radio was om. a.m. NA-D stated R45 liked to but not often. NA-D stated he re was a radio in R45's room ated he did not know if R45. NA-F stated in the past, staff ay bingo. NA-D stated staff heet" and was "pretty sure". NA-D stated R45 listened to evision. NA-D stated R45 in "peace and quiet." NA-D talked. When asked what types provided to R45, NA-D stated	F 67	9			
		2 a.m. R45 was observed to be forward toward a wall. R45's ed to be off.					
	"have much going unable to see and stated there was need being blind and habelieved music was just "living day R45's activity parti	a.m. NA-E stated R45 didn't on." NA-E stated R45 was had hearing issues. NA-E not much for R45 to do due him and of hearing. NA-E stated he as provided in the past, and R45 y-to-day." When asked about cipation, NA-E stated ovided R45 with exercises.					
	On 9/3/20, at 9:41 and offered him th	a.m. AA-B entered R45's room e Daily Chronicle.					
		a.m. AA-B stated R45 was Il "at all," and he did not engage					

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(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 679	with television or m "doesn't see" and s searches or other p she was unsure if cactivities had been activities staff would AA-B stated R45 "w "likes to sleep." AA "does some stuff w frequency provided activity participation On 9/3/20, at 10:19 very quiet man and LPN-C stated R45 listen to the radio b now. LPN-C stated engage him," and fi have seen activities	usic. AA-B further stated R45 taff cannot give him word paper activities. AA-B stated of the sensory stimulation offered to R45. AA-B stated dtalk with R45 about his life. Wants to be in bed" and he ab stated restorative staff ith him" but was unsure of the when asked about other a a.m. LPN-C stated R45 was a didn't like to attend activities. liked to lay down, and used to but was too hard of hearing and used to but was too hard of hearing are talking with R45 in PN-C stated restorative.	F 6	79			
	in restorative therand could call that an activities R45 would expect staff to Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of Care is a applies to all treatmost facility residents. Bacassessment of a rethat residents received.	c.m. the DON stated R45 was by, and stated, "I guess you ctivity." The DON stated she he activities department about was in. The DON stated she to offer R45 activities. care fundamental principle that then and care provided to eased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of	F 6	84		10/7/20	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245495	B. WING			C 09/04/2020	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE EME	ERALDS AT GRAND I	RAPIDS LLC			801 SOUTH HIGHWAY 169		
				G	RAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	care plan, and the	rehensive person-centered residents' choices.	F 6	884			
	by: Based on observareview, the facility fineel boots were apreviewed for quality. Findings include: R17's Admission R R17's Care Area As 6/12/20, indicated I impairment. R17's care plan date a history of scratch be applied in the medema. R17's care boots to be put on in bed for cushion. R17's treatment addated 9/4/20, direct applied in the a.m. further directed blubed, and when up in the control of the cont	ecord dated 9/4/20, indicated acluded dementia. ssessment (CAA) dated R17 had severe cognitive ted 7/10/20, indicated R17 had ing and directed Ace wraps to forning (a.m.) to legs for e plan further directed blue when up in the wheelchair and liministration record (TAR) ted Ace wraps to legs to be and off in the p.m. The TAR e boots to both feet while in			F684: Quality of Care Immediate Corrective Action: R17's needs were reassessed. Here were discontinued, and ace wraps applied. Action as it Applies to Others: Care Planning policy was reviewed remained current. All residents requiring ace wraps at boots will be reassessed to ensure interventions are appropriate and collanned. All nurses and NARs will be re-edu on ensuring resident wraps and here boots are applied per care plan. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by: Observation audit of 5 residents received by: A weeks then monthly x2 to assure heel boots and ace wraps applied per care plan. The results of audits will be shared with the facility committee for input on the need to increase, decrease, or discontinue audits. Corrections will be monitored by: DON/Nurse Managers/Designee	and nd heel these are cated el quiring ed months s of these	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245495		B. WING		C 09/04/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		104/2020
(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 CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	On 9/3/20, at 11:01 (LPN)-F stated R17 on during the day, while in bed and in stated the nurses a morning, and the nurses a morning, and the nurse stated resident care resident's care plar supposed to have I wheelchair and in the On 9/3/20, at 2:51 put R17's Ace wraps to put them on late she signed R17's TR17's Ace wraps at were not on. On 9/4/20, at 4:41 (DON) stated she was resident's plan of contract the treatment was a The DON further signed the treatment was a The DON further signed could lead pressure injuries. The facility policy of directed care plan interdisciplinary teasure interdisciplinary teasure in the plant interdisci	a.m. licensed practical nurse was to have her Ace wraps and her blue heel boots on the wheelchair. LPN-F further apply the Ace wraps in the ursing assistants apply the a.m. nursing assistant (NA)-P e was directed by the n. NA-P verified R17 was blue boots on when up in the bed. p.m. LPN-F stated she did not on that morning, and planned in the day. LPN-F verified TAR and indicated she had put and blue boots on, and they p.m. the director of nursing would expect staff to follow the are, and further stated be signed off on the TAR after completed, and not before. Itated the concern for heel wraps not being applied as to worsening edema and care Planning revised 6/19, lent will have a person	F 6	84		
F 689 SS=D	psychosocial, and t		F 68	39		10/7/20

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F 689	CFR(s): 483.25(d) §483.25(d) Accided The facility must en §483.25(d)(1) The as free of accident §483.25(d)(2)Each supervision and as accidents. This REQUIREME by: Based on observate review, the facility is smoking assessmeresidents (R30) rev Findings include: R30's Admission Rincluded quadriples injury. R30's quarterly Mir 7/2/20, identified in total assistance for including locomotion MDS further identified in total assistance for including locomotion MDS further identified in R30's care plan da a self care deficit re R30's care plan for indicated he currer care plan indicated assist with smoking	nts. nsure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced tion, interview and document failed to ensure an appropriate ent was completed for 1 of 1 viewed for smoking. Record indicated diagnosis that gia, and a traumatic brain nimum Data Set (MDS) dated tact cognition, and required ractivities of daily living (ADLs) on on and off the unit. The fied R30 had upper extremity	F 689	F689: Free of Accidents Hazards/Supervision/Devices Immediate Corrective Action: R30 was given a new adaptive devismoking. Action as it Applies to Others: Smoking policy was reviewed and remained current. All residents that smoke were reass for safe smoking and new intervent put in place as needed. Nurse Managers will be re-educated completing resident smoking evaluation and putting appropriate intervention place. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by: Observation audit of 5 smokers to eat they are smoking safely and have appropriate interventions in place with a way and the seal of these audits will be shared the facility QAPI committee for input the need to increase, decrease, or discontinue the audits. Corrections will be monitored by:	sessed ions d on ations s in ensure reekly The d with		

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	been outside smo assistant (NA) well that R30 had cauged device he had rigg not get it off. The phad not gone outshimself." R30's Smoking Exhe was currently sloss and a dexterindicated R30 requextension/holder, R30 smoking. R30 that the activities oup. The assessment eded staff to lighis arms, hands a smoke independe R30's Smoking Exheritated he was a cognitive loss and assessment identificated he cigaret arms, hands and a independently. On 8/31/20, at 4:1 outside smoking a right hand was wrightly was sticking The stylus was us phone and tablet.	ress note indicated R30 had king, and when the nursing nt outside to get him, she found ght his cigarette on the adaptive ged to try to smoke, and could progress note indicated, "if NA ide he [R30] could have burnt valuation dated 5/6/20, indicated moking, and identified cognitive ty problem. The assessment uired the use of a cigarette and indicated writer observed 0 needed adaptive equipment department was going to pick ent further indicated R30 ht the cigarette, then could use nd adaptive equipment to		9	

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F 689	outside smoking a his cigarette, he was cigarette butt on the On 9/3/20, at 8:35 awas interviewed an R30's family membecause he had to on him when he waneeded staff to assigarette, stated stall had this thing on his cigarette and he do R30 could ask whe would call the facili when he was outside or out of the building she thought they clay when outside follow family member. On 9/3/20, at 1:51 rehabilitation (DOR cuff to use his phor and used a clothes stated R30 was about the cigarette to his he could get rid of R30 disposed of his DOR stated they had to assist R30 with a previous day but had The DOR stated he was smoking, but he cigarette he was smoking he cigarette he he was smoking he cigarette he cigarette he he cigarette	is p.m. R30 was observed cigarette. When R30 finished as observed to drop the still lit e grass next to his chair. a.m. nursing assistant (NA)-A and stated a few days prior, where had called the facility and her staff were not checking as outside. NA-A stated R30 sist him with lighting his aff took R30 outside, and R30 his hand, and we light the west it that way." NA-A stated an he wanted a cigarette, and the hewanted a cigarette, and the head on R30 every hour wing the phone call from his p.m. the director of and his IPad with a stylus, pin to smoke. The DOR are and his IPad with a stylus, pin to smoke. The DOR are the cigarette. The DOR stated as cigarette on the ground. The and ordered something different smoking and it had arrived the and not been implemented yet. It had been outside when R30 and not assessed him, and nursing to determine if	F 6	89		

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F 689	At 9:45 a.m. the direct stated she would ty residents were safe smoking apron was light the cigarette w R30 needed assist was able to "ash" the disposed of his cigareted and said "to using, it's plastic arfurther stated R30 on every 30 minute felt once he was out him. At 1:37 p.m. register initially she did not RN-A stated physical clothes pin that wa RN-A stated R30 was cigarette in an ashifus usually completed said in regard to Richtespin, they [the At 2:19 p.m. the Didepartment did "rig could smoke, but so a formal assessment of the nurse manager watched residents smoke independent criteria for safe, income being able to hold and properly disposed in the nurse manager watched residents smoke independent criteria for safe, income and properly disposed in the nurse manager watched residents smoke independent criteria for safe, income and properly disposed in the nurse manager watched residents smoke independent criteria for safe, income and properly disposed in the nurse manager watched residents smoke independent criteria for safe, income and properly disposed in the nurse manager watched residents smoke independent criteria for safe, income and properly disposed in the nurse manager watched residents smoke independent criteria for safe, income and properly disposed in the nurse manager watched residents smoke independent criteria for safe, income and properly disposed in the nurse manager watched residents smoke independent criteria for safe, income and properly disposed in the nurse manager watched residents smoke independent criteria for safe, income and properly disposed in the nurse manager watched residents and properly disposed in the nurse manager watched residents and properly disposed in the nurse manager watched residents and properly disposed in the nurse manager watched residents and properly disposed in the nurse manager watched residents and properly disposed in the nurse manager watched residents and properly disposed in the nurse manager watched residents and properly disposed in the nurse m	rector of social services (DSS) //pically go out and see if e to smoke, whether or not a s needed, or if assistance to //as needed. The DSS stated ance to light a cigarette and he cigarette appropriately, but arette butts on the ground. The smoking device had been //we don't like that clip he's hd it could melt." The DSS was supposed to be checked es while outside, because he if there staff did not check on ered nurse (RN)-A stated think R30 was safe to smoke. Hall therapy rigged up the s connected to R30's hand. //as not able to dispose of his tray. RN-A further stated she the smoking assessments and 30, "I did not rig up the erapy] did so" OR confirmed that the therapy " up the clothes pin so R30 tated therapy did not complete	F 68	9		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	X3) DATE SURVEY COMPLETED	
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F 697 SS=D	undated, directed to residents with the sepossible, and to proceach resident requithree smoking cate independently without an apron to smoke smoking supervision to identify the critical Pain Management CFR(s): 483.25(k) §483.25(k) Pain Mathematical The facility must en provided to resident consistent with proting the comprehensive and the residents' (and the residents' (and the residents' (and the residents') and the facility for management for 1 for pain. This result when her pain was Findings include:	desident Smoking Agreement the purpose of providing safest smoking environment ovide the smoking supervision res. The policy identified gories: able to smoke out an apron, requirement of safely, and resident requiring on to be safe. The policy dideria for the smoking categories. Anagement. Insure that pain management is the swho require such services, person-centered care plan, goals and preferences. Note that pain management is the swho require such services, person-centered care plan, goals and preferences. Note that pain management is the swho require such services, person-centered care plan, goals and preferences. Note that pain management is the swho require such services, person-centered care plan, goals and preferences. Note that pain management is the swho require such services, person-centered care plan, goals and preferences. Note that pain management is the swho require such services, person-centered care plan, goals and preferences. Note that pain management is the swho require such services, person-centered care plan, goals and preferences. Note that pain management is the swho require such services, person-centered care plan, goals and preferences. Note that pain management is the swho require such services, person-centered care plan, goals and preferences. Note that pain management is the swho require such services, person-centered care plan, goals and preferences. Note that pain management is the swho required to the swho requir	F 69	F697: Pain Management Immediate Corrective Action: R260 was seen on 9/9/20 by nurse practitioner for confusion and pain. orders to increase Mobic and continusing Tylenol. Foley catheter was a discontinued as MD noted it was caresident pain. Action as it Applies to Others:	nue Iso uusing
	diagnoses which in pubis, fracture of ri hip bone), and anx	admitted on 8/14/20, with cluded fracture of the right ght ischium (lower posterior ety disorder. Minimum Data Set (MDS)		Pain Assessment & Management p was reviewed and remains current All residents reviewed for proper pamanagement interventions to ensur is controlled. All nurses educated on recognizing	nin re pain

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F 697	completed on 9/1/2 severely cognitively indicated she recei medications (PRN) constantly, the pair and limited her day indicated she rated one to ten. R260's Care Area / 8/30/20, indicated pair Staff were directed ordered, to monitor medication, and do Administration Recindicated R260 state help her. R260's care plan in staff should use pathe medical doctor of pain, and encound discomfort. R260's Order Sum through 9/3/20, ind Percocet (narcotic milligrams (mg) on hours as needed (F8/21/20, acetamino give 650 mg by moordered on 8/27/20 anti-inflammatory on mg by mouth one and 9/3/20. On 9/2/20, at 9:25 and NA-L were obstated in the second sec	age 37 20, indicated R260 was y impaired. R260's MDS ved as needed pain of had pain present almost in made it difficult to function, it to day activities. R260's MDS in her pain a nine on a scale of the pain and problem. It is administer medications as informed for formed for the pain medication and for the pain medication did intitated on 8/17/20, indicated in medication as ordered by (MD), document effectiveness rage the resident to verbalize mary Report with active orders icated R260 had an order for pain medication) tablet 5-325 in the two times a day for pain, in medicated (in necessary), meloxicam (a non-steroidal drug used to relieve pain) 7.5 in day with food, ordered on the pain medication, ordered on the pain medication as sistents (NA)-K served attempting to assist and dressing. The NAs asked	F 697	responding/following up on pof residents. NARs were edunotifying nurse immediately complaints (verbal or non-versor for follow-up. Date of Compliance: 10/7/20 Reoccurrence will be prever of 5 residents using pain meconducted weekly x 4 weeks x2 months to assure pain in are effective. The results of will be shared with the facility committee for input on the nincrease, decrease, or discoundits. Corrections will be monitore DON/Nurse Managers/Designations.	ucated on of any erbal) of pain 020 oted by: Audit edication is then monthly terventions these audits y QAPI eed to ontinue the d by:	

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F 697	R260 if she could see they attempted to reason to sitting on the edg saying it hurt too mere R260 back down of stated, "It's the fraction forgotten that she had been been side to side, and her. During reposition of pain, and deshooting. R260 did have any cares corout of bed. -at 1:18 p.m. NA-Ke R260 for a clinic apprepating, "Ow" and attempts at dressin layed back down of her rest briefly, and and NA-C had R260 her quickly to the were R260 continued to at 1:49 p.m. NA-Ke R260 usually compers from laying to sitting informed registered painat 1:59 p.m. RN-Ce the NAs had informed morning, and did need to give continued not to give continued to give continued not to give continued to give continued not to give continued not to give continued to give continued not to giv	sit up, she agreed, but when move her from lying in her bed ge of her bed, R260 resisted, luch. NA-K and NA-L layed in her bed sideways. R260 cture," and said she had had a fracture. The NAs rolled and placed a lift sheet under ioning, R260 said she was in escribed the pain as sharp and not want to get dressed or impleted after attempting to get and NA-C entered to dress oppointment. R260 kept de "It hurts." R260 resisted and getting out of bed, and in the bed. NA-K and NA-C let decontinued dressing her. NA-K so stand up, and transferred wheelchair. During the transfer,	F 69	77			

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F 697	back into her bed f clinic. R260 stated she left for the app she was back in be-at 3:04 p.m. RN-A she did not see R2 clinic. RN-A stated you want her to do would expect staff assessment on R2 On 9/2/20, the phyclinic visit indicated confused, in a lot of the bed, and stated she was-at 10:05 a.m. NA-when she was ass morning, R260 had stated she could of the bed, and stated she could of the bed, and stated she could not accorpain. NA-A stated s R260's pain, and a not get out of bed. try again laterat 10:34 a.m. licer was interviewed. L was last medicated had not seen if stated she would no complete a pain as-at 1:50 p.m. R260 of bed. LPN-D wer get R260 back into	following her return from the she had been in pain since ointment. R260 stated once ed, the pain was less. It was interviewed, and stated 160 when she returned from the pain something." RN-A stated she to complete a pain 160 every shift. It is is always like this when something." RN-A stated she to complete a pain 160 every shift. It is is is note from orthopedic the resident was alert, of pain, and refusing meals. It is a.m. R260 was resting in bed, is "hurting today." A was interviewed. NA-A stated isting R260 with cares in the dicalled out "Ow, ow." NA-A nly get R260 to sit on the edge and long enough to pull up her lanned to get R260 out of bed, implish this because of R260's she informed the nurse of lso told the nurse R260 would NA-A was told by the nurse to the sed practical nurse (LPN)-D PN-D did not know when R260 the pain assessment on R260, R260 move yet today. LPN-D eed to see R260 move to	F 69	97 		

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F 761 SS=E	medication was giv-at 2:30 p.m. the dirinterviewed. The Diexpected staff to predict appointment of the control	en on 9/3/20, at 12:27 a.m. rector of nursing (DON) was ON stated she would have be-medicate R260 prior to her on 9/2/20. It is note by nurse practitioner apain was controlled with a seesament and ed 3/15, defined pain be process of alleviating the level that is acceptable to the sed on his or her clinical olished treatment goals. The led the following: otential for pain; inizing the presence of pain; the resident should be set and movement for ehavioral (non-verbal) signs of the was described as a behavior of limitations in his or her level be presence of pain, guarding, a particular part of the body, oss of appetite. and Biologicals th)(1)(2) If of Drugs and Biologicals als used in the facility must be note with currently accepted oles, and include the	F 69			10/7/20

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F 761	§483.45(h)(1) In active Federal laws, the fabiologicals in locket temperature contropersonnel to have a §483.45(h)(2) The locked, permanent storage of controlle the Comprehensive Control Act of 1976 abuse, except whe package drug distriquantity stored is more readily detected. This REQUIREMED by: Based on observative review, the facility families were labeled with administration for 20 observed for insuling the facility failed to ointments and creative prevent cross contained for medical findings include: R37's Admission R R37's diagnoses in R37's Order Summers	cordance with State and acility must store all drugs and d compartments under proper ols, and permit only authorized access to the keys. Ifacility must provide separately by affixed compartments for ed drugs listed in Schedule II of a Drug Abuse Prevention and and other drugs subject to in the facility uses single unit libution systems in which the ininimal and a missing dose can burner to a resident or a resident of a resident (R37, R58) in administration. In addition, ensure topical treatments are were stored separately to amination for 9 residents (R38, 20, R23, R44, R112, and R16) action storage.	F 76	F761: Label/Store Drugs & Immediate Corrective Action R37 & R58 insulin pens are labeled with current medica administration. R112 discharged from facil R38, R261, R33, R34, R261, R33, R34, R261, R38, R261, R39, R34, R261, R39, R39, R39, R39, R39, R39, R39, R39	on: e now correctly ation orders for lity on 9/14/20.), R23, R44, d ointments are sing staff are e amount into a the resident's cup so as not to ers: Topical Cream policies current	
	- insulin Aspart Fle	ed physician orders for: xPen Solution Pen-injector, itaneously three times a day		All insulin pens were review appropriate labels. All med ointments/creams are now	licated	

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NAME OF	PROVIDER OR SUPPLIE	R	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP (•	7 11 20 20
THE EM	ERALDS AT GRAND	RAPIDS LLC		2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
F 761	and, - insulin Aspart so scale; if 150-199 250-299=6 units; subcutaneously the control of the control of the change in change in change in change in change in direction of the change in the	plution, inject as per sliding =2 units; 200-249=4 units; 300-349=8 units; 350+=10 units, hree times a day. 40 p.m. registered nurse (RN)-D nister insulin Aspart to R37, and on the insulin pen, per the dication Administration Record macy label with administration I's insulin Aspart pen, directed to e times daily, and per sliding fied the pharmacy label did not ent medication orders on the ed she would go by the orders ney were the current orders. I's insulin pen should have a consisticker on it to alert nurses orders, and proceeded to return to the medication cart without e-in-directions sticker on the	F7	administered per the single stated above. Nurses & TMAs were educt labeling of insulin pens and administration/storage of or creams. Date of Compliance: 10/7/2 Reoccurrence will be preve of 5 resident insulin pens or weekly x 4 weeks then mor to assure pens are labeled Observation audit of 5 resident administered ointments/creconducted weekly x 4 week x2 months to assure ointmecreams are being administed appropriately. The results will be shared with the facili committee for input on the increase, decrease, or discaudits. Corrections will be monitored DON/Nurse Managers/Designature.	ated on proper interest and 2020 ented by: Audit onducted on the proper ams appropriately. Dents being eams as then monthly ents and ered & stored of these audits ity QAPI need to continue the	

STATEMENT OF D		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	COM	E SURVEY PLETED
		245495	B. WING				C 04/2020
	IDER OR SUPPLIER			2801 \$	ET ADDRESS, CITY, STATE, ZIP CODE SOUTH HIGHWAY 169 ND RAPIDS, MN 55744	1 09/	04/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
R58	B's diagnoses incomes of 9/3/20, indicated and part Flexibility of 18/3/20. Sulin Aspart soluting scale: if 2018-350=6 units; 358 provider, subcuted 8/5/20. Sulin detemir soluting administration of 14 als and per sliding and per sliding ers on the MAR armacy label was 18/3/20, at 3:36 pulin pharmacy label was 18/3/20, at 3	ecord printed 9/3/20, indicated cluded diabetes. ary Report with active orders ted R58 had orders for: Pen Solution Pen-injector; utaneously three times a day, tion pen injector; inject per -250-2 units; 251-300=4 units; 51-400=8 units; 401-600=MD taneously four times a day, ution pen-injector; inject 44 ly in the morning for diabetes, a.m. LPN-G was observed on of insulin to R58. R58's macy label was noted to direct units three times a day with a scale. R58's physician directed to inject 16 units an addition, R58's Levemir is noted to direct administration neously daily, and R58's the MAR directed to inject 44	F 7	61			

NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT GRAND RAPIDS LLC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 761 Continued From page 44 On 9/3/20, at 4:14 p.m. DON verified pharmacy labels should match physician orders on the MAR. R38's Admission Record printed 9/3/20, indicated R38's diagnoses included psoriasis, cellulitis (infection of the skin tissues), and a history of severe sepsis (body's extreme life threatening reaction to an infection). R38's Order Summary Report with active orders		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		TE SURVEY MPLETED C
THE EMERALDS AT GRAND RAPIDS LLC (X4) ID PREFIX TAG (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) F 761 Continued From page 44 On 9/3/20, at 4:14 p.m. DON verified pharmacy labels should match physician orders on the MAR. R38's Admission Record printed 9/3/20, indicated R38's diagnoses included psoriasis, cellulitis (infection of the skin tissues), and a history of severe sepsis (body's extreme life threatening reaction to an infection). R38's Order Summary Report with active orders STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY) F 761			245495	B. WING		09	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 761 Continued From page 44 On 9/3/20, at 4:14 p.m. DON verified pharmacy labels should match physician orders on the MAR. R38's Admission Record printed 9/3/20, indicated R38's diagnoses included psoriasis, cellulitis (infection of the skin tissues), and a history of severe sepsis (body's extreme life threatening reaction to an infection). R38's Order Summary Report with active orders			RAPIDS LLC		2801 SOUTH HIGHWAY 169		10-1/2020
On 9/3/20, at 4:14 p.m. DON verified pharmacy labels should match physician orders on the MAR. R38's Admission Record printed 9/3/20, indicated R38's diagnoses included psoriasis, cellulitis (infection of the skin tissues), and a history of severe sepsis (body's extreme life threatening reaction to an infection). R38's Order Summary Report with active orders	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
as of 9/3/20, included orders for triamcinolone acetonide ointment 0.1% (used to treat the itching, redness, dryness, crusting, scaling, inflammation, and discomfort of various skin conditions to right hand topically twice daily for psoriasis.) On 9/2/20, at 7:39 a.m. R38's door was closed, a contact precautions for special enteric precautions sign was posted on R38's door. R261's Admission Record printed 9/3/20, indicated R261's diagnoses include heart failure and diabetes. R261's Order Summary Report with active orders as of 9/3/20, included orders for Nystatin cream to infection area topically as needed for infection; and triamcinolone acetonide cream 0.1% to rash topically as needed three times daily. R33's Admission Record printed 9/3/20, indicated R33's diagnoses included chronic respiratory failure with hypoxia, history of pneumonia, dependence on a respirator, and tracheostomy.	F 761	On 9/3/20, at 4:14 labels should match MAR. R38's Admission R R38's diagnoses in (infection of the ski severe sepsis (bod reaction to an infection of a severe sepsis (bod reaction to an infection of an infection of a severe sepsis (bod reaction to an infection of a severe sepsis (bod reaction to an infection, redness, drinflammation, and conditions to right hipsoriasis.) On 9/2/20, at 7:39 contact precautions precautions sign with R261's Admission indicated R261's diand diabetes. R261's Order Sum as of 9/3/20, included to infection area to and triamcinolone at topically as needed. R33's Admission R R33's Admission R R33's diagnoses in failure with hypoxia.	p.m. DON verified pharmacy h physician orders on the ecord printed 9/3/20, indicated cluded psoriasis, cellulitis n tissues), and a history of y's extreme life threatening tion). The proof of the pro		61		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	CON	TE SURVEY MPLETED
		245495	B. WING _			C / 04/2020
	PROVIDER OR SUPPLIER ERALDS AT GRAND F	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP C 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 761	month, Asper-Flex salicylate) to knee to pain, to be kept in rapply; clotrimazole medicated cream) to day to rash; Euceridaily for dry skin; at 1% to G-tube site to R33's undated Pocwas on contact and a resistive organism R34's Admission RR34's diagnoses in rhythm), stroke, and R34's Order Summas of 9/3/20, includoxide ointment 0.44 (reddened) areas to triamcinolone acetorash as needed unter R20's Admission RR20's diagnoses in lower leg amputation Resistant Staphylocinfection (bacteria to commonly-used an and history of respiration, and rednessitic triangles	e morning on the 10th of each Cream 10% (trolamine opically as needed for knee esident room for nurse to cream 1% (antifungal to rash topically three times an cream to feet topically twice and silver sulfadiazine cream opically in the morning. Ret Care Plan indicated R33 droplet precautions related to an in the sputum. Becord printed 9/3/20, indicated cluded bradycardia (slow heart dracheostomy. Beary Report with active orders and orders for menthol-zinc 1-20.6% to erythematous opically twice daily; and onide cream 0.025% to facial ill clear. Becord printed 9/3/20, indicated cluded diabetes, bilateral ons, tracheostomy, a Methicillin coccus Aureus (MRSA) that is resistant to some tibiotics), cardiac pacemaker,	F 76			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	CON	E SURVEY MPLETED
		245495	B. WING			/ 04/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 761	R23's diagnoses in respiratory failure, pacemaker, and haeruginosa (organincluding pneumor R23's Order Summas of 9/3/20, included clotrimazole-betanrash topically twice cream to dry skins. R23's undated Powas on contact prowas on contact prowounds. R44's Admission FR44's diagnoses in failure, diseases on pulmonary embolisarrest, and trached R44's Order Summas of 9/3/20, includinsertion of trach ocalmoseptine ointregions topically the cream 1% to skin Desitin cream 13% topically every 6 homuscle pain four to ointment 4.7-1.2-2 (camphor-eucalypfingernail/toenails needed for pain; and including pains in the content of the content	Record printed 9/3/20, indicated included acute and chronic diabetes, MRSA, cardiac istory of pseudomonas ism that causes infections, is mary Report with active orders ded orders for inethasone cream 1-0.05% to endaily as needed; and Eucerin is needed for dry skin. Coket Care Plan indicated R23 ecautions due to MRSA in her included chronic respiratory if the bronchus, history of sm, history of sudden cardiac costomy. Mary Report with active orders ded orders for Lidocaine gel for during changing every month, ment 0.44-20.6% to decubitus incree times daily; clotrimazole topically twice daily for yeast; if (zinc oxide) to bottom ours prn rash and skin irritation; alicylate Ointment to skin ours as needed for joint and times daily; Vicks VapoRub 1.6%	F 76			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		TE SURVEY MPLETED C
		245495	B. WING		09	/ 04/2020
	PROVIDER OR SUPPLIER ERALDS AT GRAND F	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP C 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 761	indicated R112's diadue to MRSA, resp cancer, and celluliti R112's Order Summas of 9/3/20, include skin surrounding fe cream 1% (used or itching and irritation one time daily; lidoo topically as needed daily, and Nystating topically two times of R112's undated Powas on contact presputum. R16's Admission RR16's diagnoses infailure, history of preseudomonas aeru R16's Order Summas of 9/3/20, include G tube site topically rash/back/side topic daily, and triamcing 0.025% to around the R16's undated Poowas on contact and	Record printed 9/3/20, agnoses included pneumonia iratory failure, history of oral s. mary Report with active orders ed orders for barrier cream to eding tube, hydrocortisone in the skin to treat swelling, it to feeding tube side topically caine gel 2% to coccyx for moderate pain three times cream to feeding tube site daily for site breakdown. Cocket Care Plan indicated R112 cautions for MRSA in her Decord printed 9/3/20, indicated cluded chronic respiratory neumonia, cardiac arrhythmia, ginosa, and tracheostomy. Ary Report with active orders ed orders for A&D ointment to a twice daily and to cally as needed for rash twice blone acetonide cream rach site topically twice daily. Exet Care Plan indicated R16 droplet precautions for	F 7	61		
	(CRPA) in his sputu	ant pseudomonas aeruginosa im. o.m. both medication carts				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	СОМ	E SURVEY IPLETED
		245495	B. WING _			C 04/2020
	PROVIDER OR SUPPLIER	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 761	revealed several to tubes/containers w drawer, without any treatments stored to included: -R38's triamcinolor-R261's triamcinolor-R261's triamcinolor-R33's sports crear sulfadiazine cream-R34's triamcinolor-R20's capsaicin-R23's Asper-crear Topical treatments cart included: -R44's calmoseptina A&D, clotrizole creand R112's and R1 baggies, but in contreatments. On 9/3/20, at 3:36 cross-contamination treatments together ooms during application of the cross-contamination treatments together of the cross-contamination treatment together of the cross-contamination tr	nedication storage and spical treatment ere stored together in a y separation. Topical ogether in the first cart he acetonide one acetonide and Nystatin in (Asper-cream) and silver he acetonide had	F 76			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	`́сом	E SURVEY IPLETED
		245495	B. WING			04/2020
	PROVIDER OR SUPPLIER ERALDS AT GRAND I	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP CO 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 812	Continued From particles Food Procurement CFR(s): 483.60(i) food sathe facility must -	Store/Prepare/Serve-Sanitary	F 8 F 8			10/7/20
	approved or considerate or local author (i) This may include from local produce and local laws or refull (ii) This provision of facilities from using gardens, subject to safe growing and for (iii) This provision of the constant of the con	e food items obtained directly rs, subject to applicable State				
	serve food in accor standards for food This REQUIREMED by: Based on observareview, the facility f was clean by ensure preparation area are components were forevent food contafacility failed to ensure close proximity to a the ice machine was Findings include: On 8/31/20, at 3:01 tour with the culinare food tour with the constant of the contagency of th	e, prepare, distribute and dance with professional service safety. NT is not met as evidenced tion, interview, and record failed to ensure the kitchening ceiling tiles over the food and the oven hood and its free of dust and debris to mination. In addition, the ure dirty dishware was not in a clean dish drying rack, and as free from rusted bolts. p.m. during the initial kitchen ry services director (CSD)-A, dishes were parked within		F812: Food Procurement, Store/Prepare/Serve-Sanital Immediate Corrective Action Kitchen tiles over the food p area, as well as the oven ho cleaned. Clean dish cart wa away from the dirty area in t Rusty bolt in ice machine wa Action as it Applies to Other Dishwasher policy was revie remains current Dietary staff educated on dis policy and storing clean dish dirty dishes. Date of Compliance: 10/7/20	rocurement rocurement sod, were s relocated he kitchen. as removed. s: ewed and shwasher nes away from	

CLIVILING FOR WILDICANL & N	VILDICAID SLIVICES			<u> </u>	MD NO.	0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	COMI	SURVEY PLETED
	245495	B. WING			09/0)4/2020
NAME OF PROVIDER OR SUPPLIER			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
			2	801 SOUTH HIGHWAY 169		
THE EMERALDS AT GRAND RAPI	IDS LLC			GRAND RAPIDS, MN 55744		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
p.m. a staff member wa additional dirty dishes in stacking them atop a ro- dish drying rack. The di- clean items including gi- water carafe. The dryin and had multiple worn a rust. CSD-A confirmed confirmed the dirty and close in proximity to ea machine was noted to lead underside, with a visible down from the screw in ice. No rust was observed the ice machine month. CSD confirmed screw and orange drip rust." During kitchen too dust were observed on sprinkler system, direct where food was being paccumulation was observed above the oven hood a the oven hood was profevery 6 months, and cleavery month. CSD-A condust and stated, "I see was done in March so to CSD-A confirmed the paceiling tiles and fire spranged food preparation area and dust." Food was being in dusty ceiling.	dish drying rack. At 3:05 as observed bringing nto the kitchen, and olling cart near the clean lrying rack held various lasses, meal trays, and and rack was made of metal, areas with considerable the presence of rust, and I clean areas were too ach other. The lid of the ice have a rusty screw on the e orange drip line leading nto the area that held the ved on the ice. CSD-A was cleaned once per I the presence of the rusty and stated, "It looks like our, copious amounts of the oven hood and the tly above the stovetop prepared. Dusty erved on the electrical box and its piping. CSD-A stated fessionally cleaned once eaned by maintenance confirmed the presence of a little dust, not a lot, it they should be coming." oresence of dust on the rinkler directly above the	F 8	312	Reoccurrence will be prevented by Weekly observation audit of the dishwashing area x 4 weeks then rx2 months to ensure clean dishes a stored away from the dirty dishes, of tiles, and oven hood are clean. The results of these audits will be share the facility QAPI committee for inputhe need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Of Services Director/Designee	nonthly are ceiling e ed with ut on	

(X3) DATE SURVEY COMPLETED	
C 09/04/2020	
03/04/2020	
(X5) COMPLETION DATE	
10/7/20	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG		COMPLETED	
		245495	B. WING		09	C 0/ 04/2020
	PROVIDER OR SUPPLIER ERALDS AT GRAND F	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 842	professional standamust maintain medithat are- (i) Complete; (ii) Accurately docu (iii) Readily accessi (iv) Systematically (iv) Systematical on the forecords, except who (iv) To the individual representative where (iv) Required by Law (iv) For treatment, properations, as permoved in the system of the	records. cordance with accepted ards and practices, the facility lical records on each resident mented; ible; and organized acility must keep confidential ained in the resident's records, orm or storage method of the en release is, or their resident re permitted by applicable law; w; bayment, or health care nitted by and in compliance	F8	42		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		245495	B. WING				04/2020
	PROVIDER OR SUPPLIEF			280	REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 842	there is no require (iii) For a minor, 3 legal age under Si §483.70(i)(5) The (i) Sufficient inform (ii) A record of the (iii) The comprehe provided; (iv) The results of and resident revie determinations co (v) Physician's, nu professional's pro- (vi) Laboratory, ra- services reports a This REQUIREME by: Based on intervie facility failed to en records for 3 of 5 reviewed for unne Findings include: R11's Admission R11's diagnoses in hypokalemia (low disorder, atrial fibr chronic kidney dis disorder, osteoarth hypertension. R11's medical rec- consultant pharma and 11/19.	the date of discharge when the ment in State law; or years after a resident reaches tate law. medical record must containation to identify the resident; resident's assessments; ensive plan of care and services any preadmission screening we evaluations and inducted by the State; rse's, and other licensed gress notes; and diology and other diagnostics required under §483.50. ENT is not met as evidenced we and document review, the sure proper retention of medical residents (R11, R23, R33)	F 8		F842: Resident Records-Identifial Information Immediate Corrective Action: Pharmacy recommendations are resident residents' medical record Action as it Applies to Others: Records Retention Schedule was reviewed and remains current DON and Medical Records Director educated on Record Retention schand uploading pharmacy recommendations into the resident medical record. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by Weekly audit of 3 resident pharmareviews x 4 weeks then monthly x months to ensure pharmacy recommendations are being retain	oow of d. or were nedule ts' ccy 2	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245495	B. WING				04/2020
NAME OF I	PROVIDER OR SUPPLIER	२	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	
THE EM	ERALDS AT GRAND	RAPIDS LLC			801 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	Continued From p	page 54 ated irregularities were	F8	342	uploaded to the residents medical	record.	
	identified. The factorsultant pharmal identification of the recommendations follow-up to the irrespondent of the irrespondent	cility was unable to provide the acist's Consultation Report with e specific irregularities and s, or evidence of the physician's egularities.			The results of these audits will be swith the facility QAPI committee for on the need to increase, decrease, discontinue the audits. Corrections will be monitored by: MRecords Director/Designee	shared r input or	
	Review dated 2/14 physician order fo millequivelants ex a day for hypokale identified this as a requested confirm was the correct do calendar day. R1 Review had a han records staff, indicate the records of the calendar day.	macist Prospective Medication 4/20, indicated R11 had a r Potassium Cl 50 tended release by mouth twice emia. the consultant pharmacist high dose of potassium and nation by the physician that it ose by midnight of the next 1's Prospective Medication and written note by the medical cating the original potassium was written on 4/23/18.					
	of R11's potassiur	ord lacked evidence of a review morder by a physician by 2/15, irected by the consultant					
	4/20, indicated irrefacility was unable pharmacist's Conidentification of the	charmacist Summary Report for egularities were identified. The e to provide the consultant sultation Report with e specific irregularities and s, or evidence of the physician's egularities.					
		pharmacist Summary Report for irregularities were identified.					
	6/20, indicated irre	pharmacist Summary Report for egularities were identified. The to provide the consultant					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245495	B. WING _			C / 04/2020	
	PROVIDER OR SUPPLIER	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP C 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 842	pharmacist's Considentification of the recommendations, follow-up to the irred R11's consultant pharmacist's consultant pharmacist's considentification of the recommendations. On 9/4/20, at 2:50 pverified they were used to the pharmacist's considentification of the recommendations. The facility policy Morevised 5/19, direct would provide a write of each residential with the physician of the facility Records 11/14, directed Medical Provides a write of the physician of the physician of the facility Records 11/14, directed Medical Provides a write of the physician of the physician of the facility Records 11/14, directed Medical Provides a write of the physician of th	ultation Report with specific irregularities and or evidence of the physician's gularities. narmacist Summary Report for gularities were identified. narmacist Summary Report for gularities were identified. The to provide the consultant ultation Report with specific irregularities and o.m. director of nursing (DON) mable to locate the remaining and physician follow-up for records were requested. Iledication Regimen Reviews ed the consultant pharmacist tten copy of all medication nich would be maintained as nt's permanent record, along	F 84				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245495	B. WING _		09	C 09/04/2020	
	PROVIDER OR SUPPLIER	APIDS LLC		STREET ADDRESS, CITY, STATE, ZIP COD 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	•	104/2020	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 842	indicated R23's diagon respirator (ventil acute respiratory failure widisorder, chronic pasyndrome. R23's medical recoconsultant pharmacand 11/2019. R33's Admission Reindicated R33's diagrespiratory failure wirespirator (ventilatostatus. R33's medical recoconsultant pharmacand 11/19, and 2/20. In pharmacist review ireport was found. On 9/4/20, at 4:06 pinterviewed and verto keep medical recoperiod. On 9/4/20, at 4:15 pwas interviewed and been monthly medithe stated that he to	ecord printed on 9/4/20, gnoses included dependence ator) status, anxiety disorder, stress syndrome, chronic with hypoxia, major depressive ain, and restless legs and lacked evidence of sist reviews for 9/19, 10/19, gnoses included chronic with hypoxia, dependence on any status, and tracheostomy and lacked evidence of sist reviews for 9/19, 10/19, gnoses included chronic with hypoxia, dependence on any status, and tracheostomy and lacked evidence of sist reviews for 9/19, 10/19, addition the 3/20, consultant dentified irregularities, no a.m. the administrator was iffied the facility was required cords for a specified time a.m. the consultant pharmacist diverified there should have cation reviews in R23's record. The property is any	F 84	42			
	pharmacist in Dece Infection Prevention CFR(s): 483.80(a)(§483.80 Infection C	n & Control 1)(2)(4)(e)(f)	F 88	30		10/7/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG) COM	(X3) DATE SURVEY COMPLETED		
		245495	B. WING _			C / 04/2020	
	PROVIDER OR SUPPLIER	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP C 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 880	infection prevention designed to provide comfortable enviror development and to diseases and infection program. The facility must est and control program a minimum, the followed to providing services arrangement based conducted according accepted national services for the but are not limited to (i) A system of surverpossible communication accepted in the facility when and to who communicable diseases in the facility when and to who communicable diseases in the facility when and to who communicable diseases in the facility when and to who communicable diseases in the facility when and to who communicable diseases in the facility when and to who communicable diseases in the facility when and to who communicable diseases in the facility when and the provided in the facility when and how resident; including (A) The type and displays the facility when and how resident; including (A) The type and displays the facility when and how resident; including (A) The type and displays the facility when and how resident; including (A) The type and displays the facility when and how resident; including (A) The type and displays the facility of the facility when and how resident; including (A) The type and displays the facility of the facility when and the facility when and how resident; including (A) The type and displays the facility of the facility o	stablish and maintain an and control program a safe, sanitary and ament and to help prevent the ransmission of communicable tions. In prevention and control stablish an infection prevention in (IPCP) that must include, at owing elements: In the for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual diupon the facility assessmenting to §483.70(e) and following standards; I we standards, policies, and program, which must include, one eillance designed to identify table diseases or ey can spread to other ity; som possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a	F 88				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245495	B. WING			C 04/2020
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP C 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE
F 880	least restrictive pocircumstances. (v) The circumstanust prohibit emptises or infected contact with reside contact will transmove (vi) The hand hygiby staff involved in §483.80(a)(4) A sidentified under the corrective actions §483.80(e) Linens Personnel must he transport linens sinfection. §483.80(f) Annual The facility will consider the prevention will consider the facility will consider the facility will consider the facility after direct contact environmental surrooms and subset of 25 residents (Fand R21) reviewed failed to ensure the prevention and consurveillance of all comprehensive a surveillance data;	that the isolation should be the ossible for the resident under the nessible for the resident under the nessible for the resident under the nessible for the resident under the disease with a communicable of skin lesions from direct ents or their food, if direct ents or their food, if direct nit the disease; and ene procedures to be followed in direct resident contact. System for recording incidents are facility's IPCP and the taken by the facility. Solution as to prevent the spread of	F8	F880:Infection Prevention & Immediate Corrective Action Staff were educated on perhygiene in between room trackion as it Applies to Other Facility policy on Infection Program policy was remains current. Infection Control Nurse/ADG educated on proper infection tracking including surveillan potential infections; ongoing comprehensive analysis of	n: forming hand ays. rs: Prevention and reviewed and ON and DON n control ace of all	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245495	B. WING			09/0) 14/2020	
NAME OF	PROVIDER OR SUPPLIEF	₹	l	S1	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/1	7-1/2020	
THE EMI	ERALDS AT GRAND	RAPIDS LLC			301 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROFICIENCY)) BE	(X5) COMPLETION DATE	
F 880	prevent potential rithe facility. This has residents residing survey. Findings include: R46's Admission IR46's diagnoses in obstructive respiral diabetes. R57's Admission IR57's diagnoses is kidney disease. R110's Admission indicated R110's of following joint replaying to following joint replaying the properties of	Record printed 9/3/20, indicated ncluded COPD and chronic Record printed 9/3/20, indicated ncluded at printed 9/3/20, indicated ncluded at physema, and Record printed 9/3/20, indicated ncluded at physema, and Record printed 9/3/20, indicated ncluded at physema, and physema	F8	880	surveillance data, and demonstrate investigation of developed infection help prevent potential recurrence of spread within the facility. Handwashing/Hand Hygiene policy reviewed and remains current. All nurses and NARs were educate performing hand hygiene in betwee trays. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by Weekly observation audit of 5 staff assure they are completing hand happropriately after direct contact were sidents, high touch surfaces, high environmental services, and meal x 4 weeks then monthly x2 months results of these audits will be share the facility QAPI committee for input he need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/Nurse Managers/Designee	ns to or / was ed on en room /: f to nygiene with gh touch delivery s. The ed with ut on		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245495	B. WING				C 04/2020
	PROVIDER OR SUPPLIER	APIDS LLC		STREET ADDRESS, CITY, STATE, ZIP C 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	CODE	1 001	7-112020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD	BE	(X5) COMPLETION DATE
F 880	a quarantine sign p R12's Admission Re R12's diagnoses incody's extreme, life infection), COPD, d failure, history of pr (problems swallowing R12's room door h on it. On 8/31/20, at 5:45 (NA)-M was serving from a cart with ind and a faceshield on R46's room, left the and/or sanitize hanc cart and served it to R110, and left the re and/or sanitizing ha from the cart, broug positioned R57 in h table, and with the s R11's door, brought without wearing a g room without sanitiz NA-M picked up an sanitizing or changi After passing a tray NA-M verified she h gloves from room to environment, and w room" without wear	p.m. nursing assistant g meal trays to each room,	F 8	.80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG	CON	(X3) DATE SURVEY COMPLETED C		
		245495	B. WING			/04/2020	
	PROVIDER OR SUPPLIER ERALDS AT GRAND F	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP CO 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	a tray and touched During the same tir fluids to each room between each room glove changes. On 8/31/20, at 6:13 they should have be changes, between On 9/3/20, at 4:14 verified there was a when gloves aren't washed or sanitized passing meal trays The facility policy a Handwashing/Hand directed staff to use soap and water beforesident with meals gloves, before and residents or contain On 9/1/20, at 12:03 delivered meals to the room, and with took another meal to R59. NA-B then was in quarantine. hygiene, NA-B deliversident R210. NA-on R210's bedside and soda can. NA-perform hand hygiener hygiener hand hygien	his belongings. me, NA-N picked delivered . NA-N changed gloves n, but did not sanitize between s p.m. NA-M and NA-N verified een sanitizing between glove each resident. p.m. director of nursing (DON) a risk of cross-contamination changed and hands are not d between each resident while . nd procedure for d Hygiene revised 8/19, e an alcohol-based hand rub or fore and after assisting a s, handling food, after removing after direct contact with ninated equipment. s p.m. nursing assistant (NA)-B residents R48 and R56, exited but performing hand hygiene from the cart and delivered it delivered a meal to R211, who Without performing hand wered a meal to quarantined .B touched and moved items table including a water glass B exited the room, did not ene, and pushed the food cart brought a meal tray into R21's	F8	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		245495	B. WING		09	/04/2020	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CO 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	•		
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	On 9/1/20, at 12:3 and stated she did passing meal trays spaced it, I am us hygiene." On 9/3/20, at 10:2 (LPN)-A was intergoing in and out oh hand sanitizer prodoing proper hand on 9/3/20, at 2:17 staff was going froshe would expect hygiene. On 9/3/20, the last control line listings from the infection nurse (RN)-B. The reviewed and idense separated by each The facility Antibio 6/4/20, to 6/25/20, identified line listing within the facility. Various items trac resident names, resymptoms, onset results, antibiotic of the separate of the	O p.m. NA-B was interviewed I not sanitize her hands while is. NA-B stated, "I must have ually really good about hand a a.m. licensed practical nurse viewed and stated if staff were if rooms they should be using perly and they should should be hygiene. p.m. the DON stated when om resident to resident rooms they would perform hand it twelve months infection is were requested for review control preventionist/registered in provided information was stiffied the following data in month. Itic Tracking Sheets, dated and 7/2/20, to 7/31/20, igs used to record infections. The data collected included ked including, but not limited to, noom numbers, infection types, dates, laboratory or organism.	F 8	30			
	by Resident Days 2020, tracked a br	ated Infection Summary Report dated June 2020, and July reakdown of specific infections ry tract infections [UTIs], skin,					

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245495	B. WING			C 09/04/2020		
	PROVIDER OR SUPPLIER	RAPIDS LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	1 03/	04/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 880	ventilator associated days, which when comonth's total infect form identified an a "Actions Taken." JUNE 2020: The line listing (out of 12 resident infect units (unit 2, unit 3, - Unit 2 had an ider specimen had been onset of 6/4/20, how not identify the organtibiotics had been onset of 6/4/20, how not identified units (unit 3) had identified UTI, pneumonia, upskin infection, along identified as, "Othe specimen had been onset of 6/17/20, how failed to identify the of antibiotics had be pneumonia infection culture obtained affidentified extended (ESBL, an enzyme antibiotics from bein The upper respirate culture was obtained 6/23/20, however, for the specimen had been onset of 6/17/20, however, for the upper respirate culture was obtained 6/23/20, however, for the upper respi	codstream, other, and ad pneumonia) and resident calculated indicated the ion rate. The bottom of the irea for "Specific Trends" and lined above) identified a total stions between three listed and unit 4): Intified UTI which listed a urine in collected after symptom wever, the tracking sheet did anism for which seven days of	F 8	380				
	administeredUnit 4 had identifie	ed a single skin infection and						

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG			
		245495	B. WING		09	C / 04/2020	
	PROVIDER OR SUPPLIER ERALDS AT GRAND F	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP CO 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	•	70472020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	five UTI. All five UT different symptoms for two of the UTI ic bacteria) with symp 6/19/20, respective identified escherich one further identifie of 6/22/20, and 6/23. The line listing faile dates for three of the of reported wound infections, and furth the infections listed line listing did not in residents had been treated infections (i cold symptoms). The infection summedated June 2020, ic infections with a tot series of equations the facility had an in (percent). The "Sp"Unit 2- 1 UTI, Unit 3 - 1 pneumonia. The listed: "Hand washi wing. Different orgasummary report fail a comprehensive a June 2020. JULY 2020: The line listing (outlier).	Il were each identified to have listed, however, urine cultures dentified proteus mirabilis (a stom onsets of 6/4/20, and ly. Two of the other UTI ia coli (a bacteria), in which id ESBL, with symptom onsets 3/20, respectively. Id to indicate antibiotic end he resident infections, results cultures for the two skin her failed to identify when all of had resolved symptoms. The indicate or identify any tracked for non-antibiotic in e.e. viral infections, common in the indicate of 4.89 % were listed which identified infection rate of 4.89 % ecific Trends" section listed: 4 - 5 UTI, Unit 4 - skin 1, Unit is "Actions Taken" section in gaudits in place for each anisms." The infection led to show documentation of inalysis of the infections for	F 8	80			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245495	B. WING		C 09/04/20		
	PROVIDER OR SUPPLIE			2801 SOL	ADDRESS, CITY, STATE, ZIP CO UTH HIGHWAY 169 RAPIDS, MN 55744	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S ROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	- Unit 2 had identified to have urine culture for sreported to be obwith no other symenterococcus aviresident's urine conset of 7/30/20, bacteria). Anothe identified eschericonset of 7/30/20. identify the organ infection indicated emergency departing indicate results of occurred on 7/27/2/2-Unit 3 had identified infection, one presingle infection lisurine culture was of 7/22/20, however organism for which administered. -Unit 4 had identified in UTI, and two UTI indicated a urine culture reportant in additional in	ified four UTI and one ur of the UTI were each different symptoms listed. One ymptom onset of 7/9/20, tained per the resident's request ptoms indicated, identified um (a bacteria) and another ulture obtained for symptom identified enteroccus faecalis (a rurine culture obtained chia coli with ESBL for symptom One urine culture failed to ism result. The pneumonia of the resident was seen in the tement but the line listing did not if the x-ray report listed to have 120. Ified one skin infection, one ear eumonia, and one UTI, with a sted as "Other." The UTI listed a completed for symptom onset ver, failed to identify the 12th three days of antibiotics were 15th three days of antibiotics were 15th one pneumonia infection, infections listed as "Other." One of the culture obtained after 17/22/20, which identified the escherichia coli and ESBL. A 12th of the UTI. This was not 15th one of the UTI. This was not	F	380			

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		245495	B. WING				C 09/04/2020	
	PROVIDER OR SUPPLIER			2801 SOU	DDRESS, CITY, STATE, ZIP CODE TH HIGHWAY 169 RAPIDS, MN 55744	09/	04/2020	
(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 SHOUL OSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 880	antibiotic reassess antibiotic stewards listing failed to iden listed had resolved not indicate or iden tracked for non-antitracked for non-antitracked for non-antitracked July 2020, id infections with a to series of equations the facility had a in "Specific Trends" strends." The "Actio total infections. 3 residents with cellur The infection summer.	ment performed in regards to hip processes. Further, the line stify when all of the infections symptoms. The line listing did tify any residents had been sibiotic treated infections. nary report (outlined above) entified a total of 11 facility tal of 1729.00 resident days. A were listed which identified fection rate of 6.36%. The ection listed: "no specific ins Taken" section listed: "11 esidents with pneumonia. 2 clitis. 6 residents with UTI's." nary report failed to show a comprehensive analysis of	F8	80				
	demonstrating the comprehensive and infections to determ identified were potentially or having had multiple causative organism. Further, there was facility had correlat with staff illnesses infections were related not provide document a system for tracking infections. On 9/3/20, at 10:06 interviewed. RN-B	provide documented evidence facility had conducted a alysis of the facility acquired nine if any of the infections entially related and/or spread respective unit(s), despite infections with the same as throughout the facility. no provided evidence the ed the resident' infection data to determine if any of the ated. In addition, the facility did ented evidence the facility had no non-antibiotic treated						

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		245495	B. WING				04/2020
	PROVIDER OR SUPPLIER			280	REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	OULD BE COMPLÉTIC	
F 880	she works, and mantibiotics, which is listing. The DON is the line listings are trends and to see Both the DON and analysis was docudata being brough (Quality Assurance Improvement) concompleted during kept with the infect was kept with the the DON nor RN-E analysis which maor during the QAP comprehensive into the DON in the listing that required antib non-antibiotic infections are sidents. Research to the plan was " addresses detection fections among policy further directions among policy further directions, and definifection control in the sisting that recording their nuroutbreaks and epinifections, and definifection control in the sisting that recording their nuroutbreaks and epinifections, and definifection control in the sisting that recording their nuroutbreaks and epinifections, and definifection control in the sisting that recording their nuroutbreaks and epinifection control in the sisting that recording their nuroutbreaks and epinifection control in the sisting that recording their nuroutbreaks and epinifection control in the sisting that recording their nuroutbreaks and epinifection control in the sisting that recording their nuroutbreaks and epinifection control in the sisting that recording their nuroutbreaks and epinifection control in the sisting that recording their nuroutbreaks and epinifection control in the sisting that recording their nuroutbreaks and epinifection control in the sisting that recording their nuroutbreaks and epinifection control in the sisting that recording the sisting that recording their nuroutbreaks and epinifection control in the sisting that recording the sisting the sisting that recording the si	onitors every resident who is on she then adds to a monthly line stated at the end of the month e reviewed to see if there are if staff education was required. I RN-B denied a comprehensive mented prior to the infection to the facility monthly QAPI and Performance mittee. Any analysis the QAPI committee was not tion control reports, however, QAPI meeting minutes. Neither 3 offered to provide any y have been completed prior to I meetings to show support of a fection analysis process. p.m. a follow-up interview was N-B in which she stated the is were only for those infections iotic treatment. RN-B explained citions were placed on a "24 ch nursing staff would chart on N-B confirmed she did not	F 8	880			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245495	B. WING			C 09/04/2020	
	PROVIDER OR SUPPLIER ERALDS AT GRAND F	L		STREET ADDRESS, CITY, STATE, ZIF 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		104/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 880	included in the facil which surveillance is used to inform the issues and trends. infection prevention nursing units, categories, and recorded to infections. The policy guidance on how investigated to reduvate to ensure a completed. Furth information on how non-antibiotic treater	ity surveillance activities, in data and reporting information e committee of potential The policy identified the list collected data from the porized each infection by body the absolute number of cy lacked any direction or lentified infections would be ace the risk of recurrence or comprehensive analysis was to ther, the policy lacked any the program would track and infections or if/when the infections would be done.	F 8	80			



Protecting, Maintaining and Improving the Health of All Minnesotans

DIRECTED PLAN OF CORRECTION

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

TRACKING AND TRENDING INFECTION CONTROL PROGRAM

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

• The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review and revise policies for infection surveillance as needed.
- Develop and implement an infection control program sign and symptom tracking tool to monitor all residents and staff for communicable, respiratory infection, according to the CDC guidelines.
- Ensure that the charge nurse for each shift documents all resident and employee infections on the facility's shared infection tracking log. Compliance and review of the infection control log will be completed by the Infection Preventionist daily. The data will be analyzed for possible trends/outbreaks. The Infection Preventionist will investigate any potential outbreaks and follow up as appropriate.
- Conduct rounds throughout the facility to ensure staff is exercising appropriate use of personal protective equipment and to ensure infection control procedures are followed on each unit. Ad hoc education will be provided to persons who are not correctly utilizing equipment and/or infection prevention/control practices. Such monitoring will continue until the facility has been infection free for at least four weeks.
 - Review infection prevention tracking and trending. Any unexpected increases in infection must be reported to the Medical Director, Public Health Department, and the state survey agency in order to obtain further assistance to control infection.

TRAINING/EDUCATION:

• As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, nursing leadership/management, and facility administration. The training must cover standard infection control practices, active surveillance, tracking and trending for a comprehensive infection control program. The facility may use

training resources made available by the Centers for Disease Control and Prevention or a program developed by well-established centers of geriatric health services education, such as schools of medicine or nursing, centers for aging, and area health education centers with established programs in geriatrics.

- Include documentation of the training completed with a timeline for completion.
- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.
- Tier three or four concerns (harm or IJ) training must be provided by a contracted outside infection prevention consultant.
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

CDC RESOURCES:

- Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic.
 - https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
- Infection Control Guidance for Healthcare Professionals about Coronavirus (COVID-19) https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html

CMS RESOURCES:

• CMS & CDC Offer a specialized, online Infection Prevention and Control Training For Nursing Home Staff in the Long-Term Care Setting

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforR CA.pdf

MDH RESOURCES:

- Infection Prevention and Control Guidelines https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/guidelines.html
- Infection Control Precautions https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/index.html
- National Healthcare Safety Network (NHSN) https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/nhsn.html
- COVID-19 Toolkit: Information for Long-term Care Facilities (PDF) https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf
- Responding to and Monitoring COVID-19 Exposures in Health Care Settings (PDF) https://www.health.state.mn.us/diseases/coronavirus/hcp/response.pdf
- COVID-19 Infection Prevention and Control and Cohorting in Long-term Care (PDF) https://www.health.state.mn.us/diseases/coronavirus/hcp/ltcipchohort.pdf

MONITORING/AUDITING:

Monitoring of approaches to ensure infections are controlled will include:

• The Infection Preventionist and Director of Nursing, each day and more often as necessary, will review infection prevention tracking and trending logs and data analysis. Any unexpected increases in infection will result in communication with the Medical Director, Public Health Department and the state survey agency in order to obtain further assistance to control

infection.

• The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

EQUIPMENT/ENVIRONMENT

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.
- The director of housekeeping, director of maintenance, and director of nursing must review policies and procedures regarding disinfecting multiuse/shared equipment/items and/or environmental disinfection to ensure they meet the CDC guidance for disinfection in health care facilities and follow disinfectant product manufacturer directions for use including contact time.

TRAINING/EDUCATION:

- The Director of Housekeeping/Maintenance, and/or Director of Nursing, or Infection
 Preventionist must train all staff responsible for resident care equipment and environment on
 the facility policies/practices for proper disinfection, including following manufacturer direction
 for use. Each staff person must demonstrate competency at the conclusion of the training.
 Training and competency testing must be documented. The Minnesota Department of Health
 (MDH), Center for Disease Control (CDC), and Environmental Protection Agency have education
 materials that may be used for training.
 - CDC: Infection Control Guidelines and Guidance Library. https://www.cdc.gov/infectioncontrol/guidelines/index.html/eic in HCF 03.pdf
 - MDH COVID-19 Toolkit. https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf
 - EPA: List N: Disinfectants for Use Against SARS-CoV-2 (COVID-19) https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html CDC: Isolation Precautions Guideline:

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/

Healthcare Infection Prevention and Control FAQs for COVID-19:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html

MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf

Interim Guidance on Facemasks as a Source Control Measure (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf

Interim Guidance on Alternative Facemasks (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf

Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf

Droplet Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

Airborne Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

• The Director of Nursing, the Infection Preventionist, and/or other facility leadership will conduct audits for proper cleaning and disinfection of resident use equipment/environmental cleaning, on all shifts every day for one week, then may decrease frequency as determined by compliance.

HAND HYGIENE

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

• The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

• Review hand hygiene policies and procedures to ensure they meet CDC guidance, and revise as needed.

TRAINING/EDUCATION:

• As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the

Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions and adequately caring for and disinfecting shared medical equipment. Findings of the RCA should also be incorporated into staff training.

- The Infection Preventionist, Director of Nursing and Clinical Education Coordinator must implement competency assessments for staff on proper hand hygiene and develop a system to ensure all staff have received the training and are competency
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

https://www.health.state.mn.us/people/handhygiene/ (MDH)

Hand Hygiene (MDH) https://www.health.state.mn.us/people/handhygiene/index.html

Hand Hygiene for Health Professionals (MDH)

https://www.health.state.mn.us/people/handhygiene/index.html

Cleaning Hands with Hand Sanitizer (MDH)

https://www.health.state.mn.us/people/handhygiene/clean/index.html

CDC: Guideline for Hand Hygiene in Health-Care Settings (CDC)

https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm

WHO Guidelines on Hand Hygiene in Health Care (WHO)

590E49844880F6F3E1D8F22F0841?sequence=1

Hand Hygiene in Outpatient and Home-based Care and Long-term Care Facilities (WHO)

https://www.who.int/gpsc/5may/hh_guide.pdf

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html

CDC: Isolation Precautions Guideline: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings

(2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/

Healthcare Infection Prevention and Control FAQs for COVID-19:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC AA refVal=https%3A%2F%2Fwww.cdc.gov%2F

coronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html

MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings

(PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf

Interim Guidance on Facemasks as a Source Control Measure (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf

Interim Guidance on Alternative Facemasks (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf

Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf

Droplet Precautions: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

Airborne Precautions: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

• The Director of Nursing, the Infection Preventionist and other facility leadership will conduct audits on all shifts, every day for one week, then may decrease the frequency based upon compliance. Audits should continue until 100% compliance is met.

The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed on or after that date. The effective date is not a deadline for completion of the DPOC. However, a revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To demonstrate that the facility successfully completed the DPOC, the facility must provide all of the following documentation. Documentation should be uploaded as attachments through ePOC.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Item	Checklist: Documents Required
	for Successful Completion of the Directed Plan
1	Documentation of the RCA and intervention or corrective action plan based on the results with signatures of the QAPI Committee members.
2	Documentation that the interventions or corrective action plan that resulted from the RCA was fully implemented
3	Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any other materials used or provided to staff for the training
4	Names and positions of all staff that attended and took the trainings
5	Staff training sign-in sheets
6	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
7	Documentation of efforts to monitor and track progress of the interventions or corrective action plan

In order to speed up our review, identify all submitted documents with the number in the "Item" column.

Attach all items into ePOC.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 24, 2020

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

Re: State Nursing Home Licensing Orders

Event ID: ZR7711

Dear Administrator:

The above facility was surveyed on August 31, 2020 through September 4, 2020 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 <u>only a suggestion</u> 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.

The Emeralds At Grand Rapids Llc September 24, 2020 Page 2

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:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us

Phone: (218) 302-6151

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				B. WING			С	
		00299		D. WING		09/	04/2020	
NAME OF	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE			
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	****ATTEI	NTION*****						
	NH LICENSING CORRECTION ORDER							
	144A.10, this correspursuant to a surver found that the deficiency herein are not correspond to corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation ha	n issued tion, it is s cited n violation ordance y rule of s been e tag I below. lure to nsidered e upon t rule will if the item					
	that may result fron orders provided tha the Department wit	hearing on any asse n non-compliance w it a written request is hin 15 days of receil ent for non-complian	ith these s made to ot of a					
	Department's staff the following correct Please indicate in y correction that you	rs: h 9/4/20, surveyors ovisited the above protion orders are issurtour electronic plan of have reviewed these e when they will be or	ovider and ed. of e orders,					
	epartment of Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESEI	NTATIVE'S SIGN	ATURE	TITLE		(X6) DATE	

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

Electronically Signed 09/25/20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					OATE SURVEY COMPLETED	
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	column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. The findings which are in after the statement, evidence by." Follow	umber appears in the far left Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the his column also includes the n violation of the state statute n "This Rule is not met as wing the surveyors findings Method of Correction and rection.				
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2 265	MN Rule 4658.0085 Resident Health Sta	5 Notification of Chg in atus	2 265			10/7/20
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death.	ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious At a minimum, the director of and the medical director or an				

Minnesota Department of Health

STATE FORM 5899 ZR7711 If continuation sheet 2 of 63

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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2 265	Continued From pa	ge 2	2 265			
	attending physician development of the	must be involved in the se policies. The policies must address at least the				
		involving the resident which I has the potential for requiring on;				
	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;					
	D. a decision t resident from the ne	to transfer or discharge the ursing home; or				
	E. expected an	d unexpected resident deaths.				
	by: Based on observati review, the facility for care provider was rigained and edema (R18) reviewed for R18's Admission Reference in the control of the care of th	ecord printed 9/4/20, indicated cluded hypertension, and		F580: Notification of Change Immediate Corrective Action: R18 physician was notified of weig and edema on 9/4/20. Action as it Applies to Others: Change in a Resident's Condition Status policy was reviewed and recurrent. All residents were reviewed for we gain/edema to ensure that MD has	or mains ight	
		ta Set (MDS) dated 8/19/20, cognitively intact, required		notified. All nurses were re-educated on Re		

Minnesota Department of Health

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S	
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2 265	Continued From pa	ge 3	2 265			
	dressing, personal lextensive assistance	vith bed mobility, transfers, hygiene, and required se with toileting.		Condition or Status policy to include MD notification of a resident change weight of +/- 5 lbs or per MD order Date of Compliance: 10/7/2020 Reoccurrence will be prevented by	ge in r.	
	weights: On 8/12/20, weight On 8/17/20, weight	was 117 pounds (lbs) was 116 lbs was 123.4 lbs (7.4 lbs. weight ays)		of 5 residents with a change in columbial be conducted weekly x 4 week monthly x2 months to assure physical notified of resident changes in coron The results of these audits will be with the facility QAPI committee from the need to increase, decrease	ndition ks then sician is ndition. shared or input	
	physician or nurse	rd lacked indication the practitioner (NP) was notified me of R18's 7.4 lbs weight		discontinue the audits. Corrections will be monitored by: DON/Nurse Managers/Designee		
	On 8/27/20, a progr no edema.	ress note indicated R18 had				
		parate progress notes edema to the left foot and				
	On 8/30/20, a progredema to the left fo	ress note indicated R18 had ot and lower leg.				
	On 8/31/20, a progredema to the foot.	ress note indicated R18 had				
	On 9/1/20, a progre edema in left foot.	ss note indicated R18 had				
	R18's progress note was notified of R18	es lacked indication the MD 's edema.				
	and toes were obse stated she told licer	a.m. the top of R18's left foot erved to be swollen. R18 used practical nurse (LPN)-C ollen, she was gaining weight,				

Minnesota Department of Health

STATE FORM 5899 ZR7711 If continuation sheet 4 of 63

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)	
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2 265	Continued From pa	ge 4	2 265				
	removes excess flu had gained over 7 I concerned her left to On 9/2/20, at 7:30 a propelling herself in	ave a diuretic (medication that aid) ordered. R18 stated she bs in a week, and was foot and toes were swollen. a.m. R18's was observed at the hallway in her wheelchair r leg was observed to be					
	unaware R18 had a week prior to that d medical record lack was notified of R18 edema prior to 9/2/	a.m. LPN-F stated she was a weight gain of 7.4 lbs in a ay. LPN-F verified R18's sed indication R18's physician 's 7.4 lbs weight gain, and 20. LPN-F stated a physician of a weight gain of five lbs or					
	reviewed resident v she was aware of F 8/24/20. LPN-C sta of R18's weight gai was already on the 8/24/20. LPN-C sta not seen by the NP stated she added F 9/2/20, because of stated the NP shou immediately of R18	a.m. LPN-C stated she veights weekly. LPN-C stated R18's weight gain the week of ted she did not notify the NP n and edema because R18 NP's schedule to bee seen on ated was unsure why R18 was on 8/24/20, or 8/26/20. LPN-C R18 to the NP's schedule on her weight gain. LPN-C ld have been notified l's weight gain and edema, and C should have followed up 9/2/20.					
	responsible for kee schedule. LPN-I sta a resident to be see add the resident to	o.m. LPN-I stated she was ping the NP rounding ated the nurses would request en by the NP, and LPN-I would the NP's schedule and the LPN-I stated R18 was					

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					0000	
		00299	l		09/0	4/2020
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S TH HIGHWA	STATE, ZIP CODE		
THE EME	RALDS AT GRAND F	RAPIDSTIC	APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTIES OF THE A	.D BE	(X5) COMPLETE DATE
2 265	visit after her admis stated the NP was and R18 was resch LPN-I stated R18 w 8/26/20. LPN-I verif schedule, the reason 8/24/20, and 8/2 and weight gain wa NP did not see R18 On 9/4/20, at 3:51 p (DON) stated she et to be notified of any either by fax or phowas discovered. The gain of 7.4 lbs woul underlying medical. The facility policy Cor Status revised 5/2 the resident's physi resident's medical/r SUGGESTED MET The Director of Nurdevelop, review, an procedures to ensure representatives are condition or treatmet The Director of Nurdeducate all approprincedures. The Director of Nurdevelop monitoring compliance.	en on 8/24/20, for an initial NP ssion to the facility. LPN-I running out of time that day, eduled to be seen on 8/26/20. As not seen by the NP on fied according the NP's on listed R18's was to be seen 66/20, was for an initial visit, as also listed. LPN-I verified the until 9/2/20. The director of nursing expected the physician or NP weight gain over five lbs are the day the weight increase the DON further stated a weight do be a concern of changes in conditions. The directed to promptly notify cian of changes in the mental condition and/or status. THOD OF CORRECTION: sing or designee could d/or revise policies and re residents/family notified of a change in	2 265			

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Minneso	a Department of Health					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00299	B. WING		C 09/04/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EME	ERALDS AT GRAND F	RAPIDS LLC	JTH HIGHWA RAPIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 695	Continued From pa	ige 6	2 695			
2 695	MN Rule 4658.0470 and Retrieval; Rete	0 Subp. 1 Retention, Storage, ention	2 695			10/7/20
		on. A resident's records must period of at least five years or death.				
	This MN Requirement	ent is not met as evidenced				
	Based on interview facility failed to ens	and document review, the ure proper retention of medical esidents (R11, R23, R33) essary meds.		F842: Resident Records-Identifiab Information Immediate Corrective Action: Pharmacy recommendations are i	now	
	Findings include:			being retained and uploaded to the individual residents' medical recor		
	R11's diagnoses ind hypokalemia (low p disorder, atrial fibril	ootassium), major depressive lation (irregular heart rhythm), ease, bipolar disorder, anxiety		Action as it Applies to Others: Records Retention Schedule was reviewed and remains current DON and Medical Records Directe educated on Record Retention sol and uploading pharmacy recommendations into the residen medical record. Date of Compliance: 10/7/2020	hedule	
		rd lacked evidence of cist reviews for 9/19, 10/19,		Reoccurrence will be prevented by Weekly audit of 3 resident pharma reviews x 4 weeks then monthly x months to ensure pharmacy	асу	
	dated 12/19, indica identified. The faci consultant pharmadidentification of the recommendations, follow-up to the irre			recommendations are being retain uploaded to the residents medical The results of these audits will be with the facility QAPI committee for on the need to increase, decrease discontinue the audits. Corrections will be monitored by: I Records Director/Designee	record. shared or input e, or	
		nacist Prospective Medication /20, indicated R11 had a Potassium Cl 50				

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NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT GRAND RAPIDS LLC (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 695 Continued From page 7 millequivelants extended release by mouth twice a day for hypokalemia. the consultant pharmacist identified this as a high dose of potassium and requested confirmation by the physician that it was the correct dose by midnight of the next calendar day. R11's Prospective Medication Review had a hand written not by the medical records staff, indicating the original potassium order at this dose was written on 4/23/18. R11's medical record lacked evidence of a review of R1's potassium order by the medical records staff, indicating the original potassium order this dose was written on 4/23/18. R11's consultant pharmacist Summary Report for 4/20, indicated irregularities were identified. The facility was unable to provide the consultant pharmacists Consultation Report with identification of the specific irregularities and recommendations, or evidence of the physician's follow-up to the irregularities. R11's consultant pharmacist Summary Report for 5/20, indicated in irregularities were identified. R11's consultant pharmacist Summary Report for 6/20, indicated in irregularities were identified. R11's consultant pharmacist Summary Report for 6/20, indicated in irregularities were identified. The facility was unable to provide the consultant pharmacist Summary Report for 6/20, indicated irregularities were identified. The facility was unable to provide the consultant pharmacist Summary Report for 6/20, indicated irregularities were identified. The facility was unable to provide the consultant pharmacist Summary Report tor 6/20, indicated irregularities were identified. The facility was unable to provide the consultant pharmacist Summary Report for 6/20, indicated irregularities were identified.		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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CALID CALI	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 695 Continued From page 7 millequivelants extended release by mouth twice a day for hypokalemia. the consultant pharmacist identified this as a high dose of potassium and requested confirmation by the physician that it was the correct dose by midnight of the next calendar day. R11's Prospective Medication Review had a hand written note by the medical records staff, indicating the original potassium order at this dose was written on 4/23/18. R11's medical record lacked evidence of a review of R11's potassium order by a physician by 2/15, at 11:59 p.m. as directed by the consultant pharmacist. R11's consultant pharmacist Summary Report for 4/20, indicated irregularities were identified. The facility was unable to provide the consultant pharmacist's Consultation Report with identification of the specific irregularities and recommendations, or evidence of the physician's follow-up to the irregularities. R11's consultant pharmacist Summary Report for 5/20, indicated irregularities were identified. R11's consultant pharmacist Summary Report for 5/20, indicated irregularities were identified. The facility was unable to provide the consultant pharmacist Summary Report for 6/20, indicated irregularities were identified. The facility was unable to provide the consultant pharmacist Summary Report for 6/20, indicated irregularities were identified. The facility was unable to provide the consultant pharmacist Summary Report for 6/20, indicated irregularities were identified. The facility was unable to provide the consultant pharmacist Summary Report for 6/20, indicated irregularities were identified. The facility was unable to provide the consultant pharmacist Summary Report for 6/20, indicated irregularities were identified.	THE EM	ERALDS AT GRAND F	RAPIDS LLC				
millequivelants extended release by mouth twice a day for hypokalemia. the consultant pharmacist identified this as a high dose of potassium and requested confirmation by the physician that it was the correct dose by midnight of the next calendar day. R11's Prospective Medication Review had a hand written note by the medical records staff, indicating the original potassium order at this dose was written on 4/23/18. R11's medical record lacked evidence of a review of R11's potassium order by a physician by 2/15, at 11:59 p.m. as directed by the consultant pharmacist. R11's consultant pharmacist Summary Report for 4/20, indicated irregularities were identified. The facility was unable to provide the consultant pharmacist's Consultation Report with identification of the specific irregularities and recommendations, or evidence of the physician's follow-up to the irregularities. R11's consultant pharmacist Summary Report for 5/20, indicated no irregularities were identified. R11's consultant pharmacist Summary Report for 5/20, indicated irregularities were identified. R11's consultant pharmacist Summary Report for 6/20, indicated irregularities were identified. The facility was unable to provide the consultant	PRÉFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI	OULD BE	COMPLETE
identification of the specific irregularities and recommendations, or evidence of the physician's follow-up to the irregularities. R11's consultant pharmacist Summary Report for 7/20, indicated irregularities were identified. R11's consultant pharmacist Summary Report for 9/20, indicated irregularities were identified. The	2 695	millequivelants extera day for hypokaler identified this as a lifequested confirmation was the correct dost calendar day. R11' Review had a hand records staff, indicated order at this dose with the records staff, indicated in the records at this dose with the records at the r	ended release by mouth twice nia. the consultant pharmacist nigh dose of potassium and ation by the physician that it se by midnight of the next s Prospective Medication written note by the medical ating the original potassium was written on 4/23/18. Indexed evidence of a review order by a physician by 2/15, ected by the consultant Inarmacist Summary Report for gularities were identified. The to provide the consultant ultation Report with specific irregularities and or evidence of the physician's gularities. Inarmacist Summary Report for regularities were identified. Inarmacist Summary Report for gularities were identified. The to provide the consultant ultation Report with specific irregularities and or evidence of the physician's gularities were identified. The to provide the consultant ultation Report with specific irregularities and or evidence of the physician's gularities. Inarmacist Summary Report for gularities were identified. Inarmacist Summary Report for gularities were identified.	2 695			

Minnesota Department of Health

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		00299	B. WING		I	C 04/2020
	PROVIDER OR SUPPLIER ERALDS AT GRAND F	PAPIDS LLC 280°	ET ADDRESS, CITY, I SOUTH HIGHWA	AY 169		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 695	pharmacist's Constidentification of the recommendations. On 9/4/20, at 2:50 preserved they were used they were derecommendations are sidents for whom. The facility policy Morevised 5/19, direct would provide a writegimen reports, where they will be the physician of the facility Records 11/14, directed Mediconsultant reports for the facility Records 11/14, directed Mediconsultant re	ultation Report with specific irregularities and o.m. director of nursing (Donable to locate the remained physician follow-up for records were requested. It ledication Regimen Reviewed the consultant pharmace the copy of all medication in the would be maintained ant's permanent record, alo	ws cist as ng ated			

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ZR7711 If continuation sheet 9 of 63

Minnesota Department of Health

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00299	B. WING		I	0 4/2020
	PROVIDER OR SUPPLIER	PAPIDS LLC 2801 SO	DDRESS, CITY, S UTH HIGHWA RAPIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 695	11/19, and 2/20. In pharmacist review i report was found. On 9/4/20, at 4:06 pinterviewed and verto keep medical reciperiod. On 9/4/20, at 4:15 pwas interviewed and been monthly medithe stated that he to pharmacist in Deceniary or designee could opolicies and procedures and procedures and appropriate procedures. The Director of Nurdeducate all appropriate procedures. The Director of Nurdevelop monitoring compliance.	cist reviews for 9/19, 10/19, addition the 3/20, consultant dentified irregularities, no co.m. the administrator was rified the facility was required cords for a specified time co.m. the consultant pharmacist diverified there should have cation reviews in R23's record reviews in R23's record rock over the role of consultant mber of 2019. THOD OF CORRECTION: sing, medical record director, levelop, review, and/or revise ures to ensure appropriate				
2 830	Proper Nursing Car	O Subp. 1 Adequate and re; General general. A resident must	2 830			10/7/20
	receive nursing car custodial care, and	e and treatment, personal and supervision based on d preferences as identified in				

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE S	
			7. BOILDING.		c	;
		00299	B. WING			4/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
THE EM	ERALDS AT GRAND F	RAPIDS LLC	TH HIGHWA APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	plan of care as des 4658.0405. A nursi of bed as much as written order from t	resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830			
	by: Based on observati review, the facility for smoking assessme residents (R30) rev Findings include: R30's Admission Reincluded quadripleg injury. R30's quarterly Min 7/2/20, identified intotal assistance for including locomotio MDS further identific impairment to both R30's care plan data a self care deficit rere R30's care plan for indicated he curren care plan indicated assist with smoking	ecord indicated diagnosis that ita, and a traumatic brain imum Data Set (MDS) dated fact cognition, and required activities of daily living (ADLs) n on and off the unit. The ed R30 had upper extremity		F689: Free of Accidents Hazards/Supervision/Devices Immediate Corrective Action: R30 was given a new adaptive desembly and serviewed and remained current. All residents that smoke were reast for safe smoking and new interver put in place as needed. Nurse Managers will be re-educat completing resident smoking evaluand putting appropriate intervention place. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by Observation audit of 5 smokers to they are smoking safely and have appropriate interventions in place 4 weeks then monthly x2 months. results of these audits will be shart the facility QAPI committee for input the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/Nurse Managers/Designee.	ed on uations ons in y: ensure weekly x The red with	

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STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
,	o. oo.u.20o		A. BUILDING:				
		00299	B. WING		09/0	<i>4</i> /2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE EME	ERALDS AT GRAND F	PAPINS LLC:	ITH HIGHWA RAPIDS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 11	2 830				
	been outside smok assistant (NA) went that R30 had caugh device he had rigge not get it off. The pi	ess note indicated R30 had ing, and when the nursing t outside to get him, she found at his cigarette on the adaptive ed to try to smoke, and could rogress note indicated, "if NA de he [R30] could have burnt					
	he was currently sn loss and a dexterity indicated R30 requiextension/holder, a R30 smoking. R30 that the activities de up. The assessmen needed staff to ligh	aluation dated 5/6/20, indicated noking, and identified cognitive problem. The assessment ired the use of a cigarette and indicated writer observed needed adaptive equipment epartment was going to pick at further indicated R30 the cigarette, then could use diadaptive equipment to tly.					
	indicated he was cu cognitive loss and a assessment identifi extension/holder, a to light the cigarette	aluation dated 8/31/20, urrently smoking, and had a a dexterity problem. The ed the use of a cigarette and indicated R30 required staff a and was then able to use his daptive equipment to smoke					
	outside smoking a right hand was wra stylus was sticking The stylus was use phone and tablet. C hand, a yellow plas	p.m. R30 was observed cigarette independently. R30's pped in a bandage, and a out the top of the bandage. d to aide R30 in use of his on the left side of R30's right tic clothes pin was sticking out e clothes pin was stained a peared burnt.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: CON	PLETED
00299 B. WING 09/	C 04/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
On 9/2/20, at 12:46 p.m. R30 was observed outside smoking a cigarette. When R30 finished his cigarette, he was observed to drop the still lit cigarette butt on the grass next to his chair. On 9/3/20, at 8:35 a.m. nursing assistant (NA)-A was interviewed and stated a few days prior, R30's family member had called the facility because he had told her staff were not checking on him when he was outside. NA-A stated R30 needed staff to assist him with lighting his cigarette, stated staff took R30 outside, and R30 "had this thing on his hand, and we light the cigarette and he does it that way." NA-A stated R30 could ask when he wanted a cigarette, and would call the facility if he needed something when he was outside, but could not get himself in or out of the building independently. NA-A stated she thought they checked on R30 every hour when outside following the phone call from his family member. On 9/3/20, at 1:51 p.m. the director of rehabilitation (DOR) stated R30 had a universal cuff to use his phone and his IPad with a stylus, and used a clothes pin to smoke. The DOR stated R30 was able to use the clothespin to get the cigarette to his mouth, and when he was done he could get rid of the cigarette. The DOR stated R30 disposed of his cigarette on the ground. The DOR stated they had ordered something different to assist R30 with smoking and it had arrived the previous day but had not been implemented yet. The DOR stated he had been outside when R30 was smoking, but had not assessed him, and stated it was up to nursing to determine if residents could smoke safely.	

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NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT GRAND RAPIDS LLC (X4) ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 13 residents were safe to smoke, whether or not a smoking apron was needed, or if assistance to light the cigarette was needed. The DSS stated R30 needed assistance to light the eigarette was needed. The DSS stated R30 needed assistance to light the eigarette was needed. The DSS stated a new smoking device had been ordered and said "we don't like that clip he's using, it's plastic and it could melt." The DSS further stated R30 was supposed to be checked on every 30 minutes while outside, because he felt once he was out there staff did not check on him. At 1:37 p.m. registered nurse (RN)-A stated initially she did not think R30 was asafe to smoke. RN-A stated physical therapy rigged up the clothes pin that was connected to R30's hand. RN-A stated R30 was not able to dispose of his cigarette in an ashtray. RN-A further stated she usually completed the smoking assessments and said in regard to R30," I did not rig up the clothespin, they [therapy] did so" At 2:19 p.m. the DOR confirmed that the therapy department did "rig" up the clothese pin so R30		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT GRAND RAPIDS LLC (X4) ID PREFIX (EACH DERICHENCY MUST BE PRECEDED BY FULL TAG) PREFIX TAG COntinued From page 13 2 830 Continued From page 13 residents were safe to smoke, whether or not a smoking apron was needed, or if assistance to light the cigarette was needed. The DSS stated R30 needed assistance to light the cigarette butts on the ground. The DSS stated and was able to "ash" the cigarette butts on the ground. The DSS stated and was able to "ash" the cigarette butts on the ground. The DSS stated and was one there are will be considered and said "we don't like that clip he's using, it's plastic and it could melt." The DSS further stated R30 was supposed to be checked on every 30 minutes while outside, because he felt once he was out there staff did not check on him. At 1:37 p.m. registered nurse (RN)-A stated initially she did not think R30 was safe to smoke. RN-A stated physical therapy rigged up the clothes pin that was connected to R30's hand. RN-A stated gas was not able to dispose of his cigarette in an ansthray. RN-A further stated she usually completed the smoking assessments and said in regard to R30," did not rig up the clothespin, they [therapy] did so" At 2:19 p.m. the DOR confirmed that the therapy department did "rig" up the clothese pin so R30				71. 501251110.			
THE EMERALDS AT GRAND RAPIDS LLC 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 CALL DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PRE			00299	B. WING			
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 830 Continued From page 13 2 830 residents were safe to smoke, whether or not a smoking apron was needed, or if assistance to light the cigarette was needed. The DSS stated R30 needed assistance to light a cigarette and was able to "ash" the cigarette appropriately, but disposed of his cigarette butts on the ground, The DSS stated a new smoking device had been ordered and said "we don't like that clip he's using, it's plastic and it could melt." The DSS further stated R30 was supposed to be checked on every 30 minutes while outside, because he felt once he was out there staff did not check on him. At 1:37 p.m. registered nurse (RN)-A stated initially she did not think R30 was safe to smoke. RN-A stated physical therapy rigged up the clothes pin that was connected to R30's hand. RN-A stated physical therapy rigged up the clothes pin that was connected to R30's hand. RN-A stated R30 was not able to dispose of his cigarette in an ashtray. RN-A further stated she usually completed the smoking assessments and said in regard to R30," I did not rig up the clothespin, they [therapy] did so" At 2:19 p.m. the DOR confirmed that the therapy department did "rig" up the clothesp pin so R30	NAME OF	PROVIDER OR SUPPLIER					
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 13 residents were safe to smoke, whether or not a smoking apron was needed, or if assistance to light the cigarette was needed. The DSS stated R30 needed assistance to light a cigarette and was able to "ash" the cigarette appropriately, but disposed of his cigarette butts on the ground. The DSS stated a new smoking device had been ordered and said "we don't like that clip he's using, it's plastic and it could melt." The DSS further stated R30 was supposed to be checked on every 30 minutes while outside, because he felt once he was out there staff did not check on him. At 1:37 p.m. registered nurse (RN)-A stated initially she did not think R30 was safe to smoke. RN-A stated physical therapy rigged up the clothes pin that was connected to R30's hand. RN-A stated R30 was not able to dispose of his cigarette in an ashtray. RN-A further stated she usually completed the smoking assessments and said in regard to R30," I did not rig up the clothespin, they [therapy] did so" At 2:19 p.m. the DOR confirmed that the therapy department did "rig" up the clothes pin so R30	THE EM	ERALDS AT GRAND F	RAPIDSTIC				
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could smoke, but stated therapy did not complete a formal assessment. At 3:32 p.m. the director of nursing (DON) stated the nurse manager or social services department watched residents to make sure they were safe to smoke independently. The DON stated the criteria for safe, independent smoking included being able to hold a cigarette, not drop hot ashes, and properly dispose of the cigarette in the canister. The DON stated she had not observed R30 smoking. The facility policy Resident Smoking Agreement	2 830	residents were safe smoking apron was light the cigarette w R30 needed assists was able to "ash" the disposed of his cigaretted and said "vusing, it's plastic and further stated R30 won every 30 minute felt once he was outhim. At 1:37 p.m. register initially she did not RN-A stated physic clothes pin that was RN-A stated R30 wo cigarette in an ashtusually completed the said in regard to R3 clothespin, they [the At 2:19 p.m. the D0 department did "rig could smoke, but so a formal assessme At 3:32 p.m. the direction that the nurse manager watched residents as smoke independent criteria for safe, individually completed that said in regard to R3 clothespin, they [the R4 2:19 p.m. the D0 department did "rig could smoke, but so a formal assessme R4 3:32 p.m. the direction of the safe, individually safe, i	e to smoke, whether or not a se needed, or if assistance to was needed. The DSS stated ance to light a cigarette and ne cigarette appropriately, but arette butts on the ground. The smoking device had been we don't like that clip he's not it could melt." The DSS was supposed to be checked as while outside, because he at there staff did not check on the ered nurse (RN)-A stated think R30 was safe to smoke. The ered nurse to dispose of his ray. RN-A further stated she the smoking assessments and 30, "I did not rig up the erapy] did so" DR confirmed that the therapy "up the clothes pin so R30 tated therapy did not complete ent. The correction of nursing (DON) stated to make sure they were safe to the lependent smoking included a cigarette, not drop hot ashes, se of the cigarette in the stated she had not observed	2 830			

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						X3) DATE SURVEY COMPLETED	
	00299				09/0	; 4/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
THE EMERAL DS AT GRAND RAPIDS LLC			TH HIGHWA APIDS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 830	undated, directed the residents with the spossible, and to propose ach resident requitation there independently without an apron to smoke smoking supervision not identify the crite. Based on observation review, the facility for pain. This result when her pain was findings include: R260's Admission findicated she was a diagnoses which in pubis, fracture of righip bone), and anxious R260's admission from the pain was resident on 9/1/2 severely cognitively indicated she received indicated she received in the pain and limited her day indicated she rated one to ten. R260's Care Area A 8/30/20, indicated properties of the pain and limited her day indicated she rated one to ten.	the purpose of providing safest smoking environment ovide the smoking supervision ares. The policy identified gories: able to smoke out an apron, requirement of safely, and resident requiring on to be safe. The policy dideria for the smoking categories. John to the smoking categories of 3 residents (R260) reviewed are actual harm to R260 not relieved. Record printed on 9/3/20, admitted on 8/14/20, with cluded fracture of the right ght ischium (lower posterior	2 830				

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE		ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
THE EMERALDS AT GRAND RAPIDS LLC 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 ID PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)		00299					_
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			RAPIDS LLC 2801 SOL	JTH HIGHWA	Y 169		
2 920 Continued From page 45	PRÉFIX (E	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	COMPLETE
indicated R260 stated the pain medication did help her. R260's care plan initiated on 8/17/20, indicated staff should use pain medication as ordered by the medical doctor (MD), document effectiveness of pain, and encourage the resident to verbalize discomfort. R260's Order Summary Report with active orders through 9/3/20, indicated R260 had an order for Percocet (narcotic pain medication) tablet 5-325 milligrams (mg) one tablet by mouth every six hours as needed (PRN) for pain ordered on 8/21/20, acetaminophen (Tylenol) tablet 325 mg, give 650 mg by mouth two times a day for pain, ordered on 8/27/20, meloxicam (a non-steroidal anti-inflammatory drug used to relieve pain) 7.5 mg by mouth one a day with food, ordered on 9/3/20. On 9/2/20, at 9:25 a.m. nursing assistants (NA)-K and NA-L were observed attempting to assist R260 with cares and dressing. The NAs asked R260 if she could sit up, she agreed, but when they attempted to move her from lying in her bed to sitting on the edge of her bed, R260 resisted, saying it hurt too much. NA-K and NA-L layed R260 back down on her bed sideways. R260 stated, "It's the fracture," and said she had forgotten that she had a fracture. The NAs rolled her side to side, and placed a lift sheet under her. During repositioning, R260 said she was in lots of pain, and described the pain as sharp and shooting. R260 did not want to get dressed or have any cares completed after attempting to get out of bed. -at 1:18 p.m. NA-K and NA-C entered to dress	indicate help help help help help help help hel	dicated R260 starely her. 260's care plan in aff should use particle medical doctor finance from painting and encounting and encounting and encounting and encounting as needed (Figure 650 mg by mouth one and pay a	ted the pain medication did nitiated on 8/17/20, indicated in medication as ordered by (MD), document effectiveness rage the resident to verbalize mary Report with active orders icated R260 had an order for pain medication) tablet 5-325 to tablet by mouth every six PRN) for pain ordered on ophen (Tylenol) tablet 325 mg, buth two times a day for pain, reloxicam (a non-steroidal drug used to relieve pain) 7.5 to day with food, ordered on the served attempting to assist and dressing. The NAs asked sit up, she agreed, but when move her from lying in her bed ge of her bed, R260 resisted, uch. NA-K and NA-L layed in her bed sideways. R260 cture," and said she had had a fracture. The NAs rolled did placed a lift sheet under ioning, R260 said she was in scribed the pain as sharp and not want to get dressed or impleted after attempting to get	2 830			

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Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			B. WING		C 09/04/2020	
		00299	b. WING		09/0	4/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE EM	ERALDS AT GRAND F	RAPIDS LLC	TH HIGHWA APIDS, MN			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
2 830	Continued From pa	ige 16	2 830			
2 830	repeating, "Ow" and attempts at dressin layed back down or her rest briefly, and and NA-C had R26 her quickly to the w R260 continued to at 1:49 p.m. NA-K R260 usually comp from laying to sitting informed registered pain. -at 1:59 p.m. RN-C the NAs had informed morning, and did not dressed. RN-C states scheduled acetamin tried not to give cor RN-C stated she sh R260 prior to her clafternoon. -at 2:39 p.m. R260 pain as she was as back into her bed for clinic. R260 stated she left for the apposhe was back in be at 3:04 p.m. RN-A she did not see R20 clinic. RN-A stated, you want her to do would expect staff to assessment on R20 On 9/2/20, the physicinic visit indicated confused, in a lot or confused.	d "It hurts." R260 resisted g and getting out of bed, and he the bed. NA-K and NA-C let I continued dressing her. NA-K 0 stand up, and transferred rheelchair. During the transfer, say "Ow." was interviewed. NA-K stated lained of pain when going g in bed. NA-K stated she I nurse (RN)-C about R260's was interviewed. RN-C stated led her R260 was in pain in the lot want to get up or get led she had given R260 mophen (Tylenol), and she infused residents narcotics. Inould have pre-medicated linic appointment this was observed crying out in sisted from the wheelchair collowing her return from the she had been in pain since lointment. R260 stated once led, the pain was less. was interviewed, and stated 60 when she returned from the "She is always like this when something." RN-A stated she to complete a pain 60 every shift. sician's note from orthopedic the resident was alert, f pain, and refusing meals.	2 830			
	confused, in a lot o	f pain, and refusing meals. a.m. R260 was resting in bed,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
				С		
	00299	B. WING		09/0	4/2020	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE			
THE EMERALDS AT GRAND RA	APIDS LLC	TH HIGHWA				
	GRAND R	APIDS, MN	55744			
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTY)	D BE	(X5) COMPLETE DATE	
2 830 Continued From pag	ge 17	2 830				
-at 10:05 a.m. NA-A when she was assist morning, R260 had of stated she could only of the bed, and stand pants. NA-A had plat but could not accompain. NA-A stated she R260's pain, and als not get out of bed. Not try again laterat 10:34 a.m. licens was interviewed. LPI was last medicated thad not completed a land had not seen R2 stated she would necomplete a pain assistated she would necomplete a pain assistated. LPN-D went get R260 back into be so bad." LPN-D state medication was give at 2:30 p.m. the direction was give at 2:30 p.m. the direction appointment of line appointment as the resident's pain to a line resident, and is based.	was interviewed. NA-A stated ting R260 with cares in the called out "Ow, ow." NA-A y get R260 to sit on the edge d long enough to pull up her nned to get R260 out of bed, plish this because of R260's in informed the nurse of so told the nurse R260 would IA-A was told by the nurse to sed practical nurse (LPN)-D N-D did not know when R260 for pain. LPN-D stated she in pain assessment on R260, 260 move yet today. LPN-D ed to see R260 move to essment. Was observed trying to get out to get another staff to help bed. R260's last PRN pain en on 9/3/20, at 12:27 a.m. ector of nursing (DON) was bN stated she would have expendicate R260 prior to her in 9/2/20. Is note by nurse practitioner pain was controlled with an Assessment and d 3/15, defined pain process of alleviating the evel that is acceptable to the ed on his or her clinical ished treatment goals. The	2 830				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
		00299	B. WING	09	C /04/2020
	PROVIDER OR SUPPLIER	PAPIDS LLC 2801 SOU	DRESS, CITY, S ITH HIGHWA APIDS, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	The policy indicated observed during resphysiological and be pain. Resisting care to monitor, as were of activity due to the rubbing or favoring difficulty eating or loss UGGESTED MET. The director of nursed develop or revise pappropriate smokin completed. In additional develop or related to manager. The DON or design implementation of the DON or design audits to ensure control of the policy indicates the	nizing the presence of pain; d the resident should be st and movement for ehavioral (non-verbal) signs of e was described as a behavior limitations in his or her level e presence of pain, guarding, a particular part of the body, oss of appetite. THOD OF CORRECTION: sing (DON) or designee, could olicies/procedures to ensure g assessments were tion, the DON or designee vise policies/procedures nent of pain. Inee, could train staff in the policies and plan of care. There is no pain to the policies and plan of care. There is no pain to the policies and plan of care. There is no pain to the policies and plan of care. There is no pain to the policies and plan of care. There is no pain to the policies and plan of care.	2 830		
2 920	Subp. 6. Activities comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,	2 920		10/7/20
	by:	ent is not met as evidenced		F677: ADL Care Provided for Dependent	

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00299	B. WING		09/0	4/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
THE EMERALDS AT GRAND RAPIDS LLC 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
revirem R2² (AE ass Find R2² fract low R2² f	nove facial hair for 15, R45) reviewed DLs) and who we sistance. dings include: 1's Admission Rough and the T11- rer part of the T11- rer part of the sponsor on Gamma and the served on the T11- distance of the T11- distance on the T11- distance on the sponsor on Gamma and Ingerved to have long factor on the served to have long from	ailed to provide nail care and or 3 of 8 residents (R21, ed for activities of daily living are dependent on staff for ADL ecord dated 9/4/20, indicated cluded wedge compression T12 vertebrae (fracture of the ine). Inimum Data Set (MDS) dated R21 was cognitively intact, and with personal hygiene needs. Med 6/30/20, directed staff to of one for personal hygiene. Inspections indicated R45 had had his nails trimmed since 20. a.m. R21 was interviewed of own clippers and has asked ernails and beard. R21 was ong, jagged fingernails on both cial hair. a.m. R21 was observed in bed, cial hair remained long and a.m. R21 put his call light on assistant (NA)-D if he could D stated R21's bath was	2 920	Residents Immediate Corrective Action: Nail Care and Facial Hair Care was completed for residents R21, R21 R45. Action as it Applies to Others: ADL Assistance per Care Plan por reviewed and remained current. All residents were offered/received assistance with nail care/facial haremoval. All nurses and NARs were educat providing nail care and removal of hair for residents based on reside preference. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by Observation audit of 5 residents conducted weekly x 4 weeks then x2 months to ensure facial hair is and nail care is provided. The resithese audits will be shared with th QAPI committee for input on the rincrease, decrease, or discontinuated audits. Corrections will be monitored by: DON/Nurse Managers/Designee	5, & licy was d ir ed on f facial nt y: monthly trimmed ults of e facility need to	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
		A. BUILDING:			_	
	00299	B. WING			C 04/2020	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE EMERALDS AT GRAND RA	PIDS LLC	JTH HIGHWA RAPIDS, MN				
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
was interviewed and a bath as scheduled last ON 9/3/20, at 11:03 at (LPN)-F stated if a rewas to document refusinspection sheet, and nurse. R21 reviewed inspection sheet date with a line drawn through did not get his shower heard staff did not hat R21 his shower. LPN and get his shower completed in the still had not it was important to his fingernails and factory of the still had not gevening as scheduled shaving was completed as needed. NA-I stat had not been shaved weeks. On 9/3/20, at 3:56 p.r (DON) stated resident shaved and nails trim the DON further stat cares, it was expected three times, have a document of the refusal. The DON to get done, it was expected three times.	hair remained long. R21 stated he did not get his st evening. a.m. licensed practical nurse sident refused a bath, staff usals on a weekly skin I report the refusal to the I R21's weekly skin of 9/2/20, and noted a zero ough, which indicated R21 or. R21 further stated she eve time last evening to give N-F stated staff should try completed that day. m. R21 was interviewed and a been offered a shower, and m to get a shower, and m to get a shower and hair trimmed. m. nursing assistant (NA)-I get a bath/shower last d. NA-I stated nail care and led on bath/shower day and led it looked like R21's had or nails trimmed in several m. the director of nursing lits should be offered to be a med on bath/shower day. ed if a resident declined d to reproach the resident					

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
			A. BUILDING:		С		
		00299	B. WING		09/04/2020		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE EMERALDS AT GRAND RAPIDS LLC 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 920	Continued From pa	ige 21	2 920				
	R215's Admission Record dated 9/4/20, indicated R21's diagnoses included a wedge compression fracture of second lumbar vertebral (fracture of the spine).						
	R215's admission MDS dated 9/1/20, indicated R21's cognition was moderately impaired, and required extensive assistance with personal hygiene.						
		ated 8/28/20, indicated R21 groomed, and bathed.					
	R215's weekly skin inspection dated 8/28/20, indicated R21 received assistance with a bed bath, R21 was not shaved, and fingernails and toenails were not trimmed.						
	On 8/31/20, at 5:39 p.m. R215 was observed to have dark facial hairs on the upper lip, and long jagged fingernails with a brown debris underneath and along the sides of the nails on both hands.						
	her room and had j fingernails remaine	p.m. R215 was observed in ust finished with lunch. R21's d long with a brown debris ails. R215 continued to have ove upper lip.					
	long and dirty dirty, the upper lip. R215	a.m. R215's nails remained and facial hairs noted above 5 was interviewed and stated ve her nails shorter, and facial					
	(LPN)-F verified R2 and fingernails were	o.m. licensed practical nurse 215's facial hair to upper lip e long and dirty. LPN-F asked ike to have her fingernails					

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE	SURVEY	
,			A. BUILDING:			
		00299	B. WING			C 0 4/2020
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
THE EMI	ERALDS AT GRAND R	RAPINS LLC	OUTH HIGHWA RAPIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 920	Continued From pa	age 22	2 920			
		ed, and her hair removed from tated R215 stated "yes."				
	should be offered s	p.m. the DON stated residents shaving and nail care each mented on the weekly skin	5			
		ecord dated 9/3/20, indicated cluded visual loss and muscle	2			
	had intact cognition he had severely imp	dated 7/30/20, indicated R45 n. R45's MDS further indicated paired vision, and required ce with personal hygiene.				
	required extensive	ted 7/29/20, indicated R45 assistance grooming. R45's staff to shave R45 as needed.				
	8/26/20, and 8/31/2	eekly skin inspections dated 20, indicated shaving t documented on 8/26/20.				
	On 8/31/20, at 5:13 have long facial hai	p.m. R45 was observed to ir.				
	and NA-G were obscares and transferre electric razor was n	a.m. nursing assistant (NA)-F served to perform personal red R45 to his wheelchair. An noted on a table near R45's NA-G did not offer to shave				
	he stated his prefer R45 stated, "I like s	p.m. R45 was interviewed and rence was to be clean shaven smoothe skin." R45 stated his be shaven every few days, an ven now.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00299		B. WING		09/0	; 4/2020
NAME OF I	PROVIDER OR SUPPLIER		I.	STATE, ZIP CODE	1 03/0	4/2020
THE EM	ERALDS AT GRAND F	RAPIDS LLC	TH HIGHWA			
0(4) ID	CHIMMA DV CTA		APIDS, MN	PROVIDER'S PLAN OF CORRECTION	ON	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 23	2 920			
	needed staff assista R45 did not have th NA-I stated he belie R45 was observed the presence of face	o.m. NA-I confirmed R45 ance with shaving. NA-I stated he dexterity to shave himself. eved R45 was legally blind. with NA-I, and NA-I confirmed hair. NA-I stated he hair was present "a day or				
	and stated R45 was himself. NA-H state assistance, and sta NA-H stated R45 w NA-H confirmed R4 was "a little longer" NA-H stated he was	o.m. NA-H was interviewed so blind, however, shaved and R45 required set up off placed a gown over him. It was very precise and particular. It had facial hair and stated it than a five o'clock shadow. It is unaware when R45 was last of stated R45 was shaved on				
	needed staff assista	a.m. LPN-B stated R45 ance with shaving. LPN-B ved R45, and stated he was				
	(DON) stated R45 i	o.m. the director of nursing needed staff assistance with stated staff were expected to				
	Assistance revised resident/resident re assessment and cabe provided to any Some examples we	Ionarch Healthcare ADL 5/18, directed based upon presentative desires, are plan, ADL assistance will residents deemed necessary, buld be shaving males and , and fingernails and toenails nmed.				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
		00299	B. WING		C 9/04/2020
	PROVIDER OR SUPPLIER	STREET AD 2801 SOL	DRESS, CITY, S JTH HIGHWA RAPIDS, MN	STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	The director of nurs review and/or revise personal hygiene pensure nail care an maintained. The DON or design appropriate staff on The DON or design system to ensure or	THOD OF CORRECTION: sing (DON) or designee could the the current grooming and colicies and procedures to d hygiene is completed and the could educate the the policies/procedures. the could develop a monitoring	2 920		
21015	Requirements- San Subp. 7. Sanitary procedures and conthe operation of the times.	O Subp. 7 Dietary Staff nitary conditi conditions. Sanitary nditions must be maintained in edietary department at all ent is not met as evidenced	21015		10/7/20
	review, the facility fivas clean by ensur preparation area ar components were five prevent food contain facility failed to ensure close proximity to a the ice machine was Findings include: On 8/31/20, at 3:01	on, interview, and record ailed to ensure the kitchen ing ceiling tiles over the food and the oven hood and its ree of dust and debris to mination. In addition, the ure dirty dishware was not in clean dish drying rack, and s free from rusted bolts. p.m. during the initial kitchen ry services director (CSD)-A,		F812: Food Procurement, Store/Prepare/Serve-Sanitary Immediate Corrective Action: Kitchen tiles over the food procurement area, as well as the oven hood, were cleaned. Clean dish cart was relocated away from the dirty area in the kitchen. Rusty bolt in ice machine was removed. Action as it Applies to Others: Dishwasher policy was reviewed and remains current Dietary staff educated on dishwasher policy and storing clean dishes away fro dirty dishes.	m

Minneso	<u>ota Department of He</u>	alth					
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUF IDENTIFICATION		1 ' '	E CONSTRUCTION	(X3) DATE S	
		00299		B. WING		09/0	; 4/2020
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EM	ERALDS AT GRAND F	RAPIDS LLC		ITH HIGHWA APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDEL SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	Continued From parthree carts of dirty of three feet of the clep.m. a staff member additional dirty dish stacking them atop dish drying rack. The clean items includir water carafe. The clean items includir water carafe. The clean dish ad multiple worder confirmed the dirty close in proximity to machine was noted underside, with a vidown from the screice. No rust was obstated the ice mach month. CSD confirms crew and orange or rust." During kitched dust were observed sprinkler system, diwhere food was bein accumulation was cabove the oven hood was every 6 months, an every month. CSD-dust and stated, "I swas done in March CSD-A confirmed the ceiling tiles and fire food preparation ar dust." Food was bedusty ceiling. On 8/31/20, at 5:59	dishes were parker and dish drying rater was observed be es into the kitcher a rolling cart neamed drying rack helping glasses, meal drying rack was morn areas with connect the presence and clean areas with connect the presence drip and stated, "I have a rusty so sible orange drip with the area the served on the ice and the presence drip and stated, "I have a rusty so be a cleaned med the presence drip and stated, "I have a rusty so be a little dust, and and its piping, professionally cleaned by main a confirmed the presence of drip and stated, "I have a little dust, and stated, "I have and stated, "L ing prepared directly in the prep	ck. At 3:05 pringing an, and ar the clean ld various trays, and a nade of metal, nsiderable of rust, and were too a lid of the ice screw on the line leading nat held the a. CSD-A once per a of the rusty t looks like mounts of od and the stovetop selectrical box CSD-A stated eaned once intenance presence of not a lot, it a coming." ust on the above the ooks like ctly below the	21015	Date of Compliance: 10/7/2020 Reoccurrence will be prevented by Weekly observation audit of the dishwashing area x 4 weeks then x2 months to ensure clean dishes stored away from the dirty dishes, tiles, and oven hood are clean. The of these audits will be shared with facility QAPI committee for input oneed to increase, decrease, or distinguished the audits. Corrections will be monitored by: Services Director/Designee	monthly are ceiling the results the on the scontinue	
	On 8/31/20, at 5:59 food was observed immediately outside	splattered on the	ceiling tile				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00299	B. WING		09/0) 4/2020
NAME OF I			<u>I</u>		1 09/0	4/2020
	PROVIDER OR SUPPLIER	2801 SQU	TH HIGHWA	STATE, ZIP CODE Y 169		
THE EMERALDS AT GRAND RAPIDS LLC GRAND I			APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21015	Continued From pa	ige 26	21015			
		a.m. dust remained on the sprinkler directly above the ea.				
	was empty, and a r placed on one of th poles. Dietary aide towels to dry her ha remained on the ce above the food pre prepared directly be dried food remained	a.m. the paper towel dispenser oll of paper towels had been to empty clean drying rack (DA)-A used these paper ands after washing. The dust billing tiled and sprinkler directly paration area. Food was being elow this area. At 09:49 A.M. d on the ceiling tile to of the kitchen doors.				
	presence of dust of above the food pre- still dust up there, it DCS-A also confirm outside of the kitch- sure what that is or	o.m. the DCS-A confirmed the name the ceiling and sprinkler properties and stated, "There is a can fall in the food." The ned food splatter on the ceiling en doors and stated, "I am not how it even got up there."				
	revised October 20	ood Receiving and Storage 17, directed food services, or aff, will maintain clean food times.				
	The dietary manage and/or revise the continuous policies and cleanliness of the far and service areas where contamination of food The dietary manage the appropriate star The dietary manage.	rhod of correction: er, or designee could review urrent kitchen and food service d procedures to ensure ans over the food preparation were cleaned to prevent od. er or designee could educate ff on the policies/procedures. er or designee could develop a to ensure ongoing compliance.				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	_ETED
					_	.
		00000	B. WING		00/0	
		00299	B: Wiite		09/0	4/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		2801 SOU	TH HIGHWA	Y 169		
THE EME	ERALDS AT GRAND F	PAPINS LLC:	APIDS, MN			
(X4) ID		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROF		DATE
IAO		,	IAO	DEFICIENCY)		
21015	Continued From pa	ge 27	21015			
	TIME DEDIOD FOR	CORRECTION: Twenty one				
		R CORRECTION: Twenty-one				
	(21) days.					
21375	MN Rule 4658.0800	0 Subp. 1 Infection Control;	21375			10/7/20
	Program	•				
	· ·					
	Subpart 1. Infection	on control program. A nursing				
		sh and maintain an infection				
		signed to provide a safe and				
	sanitary environme					
	Samuary Crivilonino	iii.				
	This MN Requireme	ent is not met as evidenced				
	-	ent is not met as evidenced				
	by:	ion intensions and decomment		E000-Infaction Drawantian 9 Contr	_1	
		ion, interview, and document		F880:Infection Prevention & Contro	OI .	
		ailed to perform hand hygiene		Immediate Corrective Action:		
		with residents and high touch		Staff were educated on performing	hand	
		aces in quarantined residents		hygiene in between room trays.		
	rooms and subsequ	uently passing meal trays for 6		Action as it Applies to Others:		
	of 25 residents (R4	8, R56, R59, R211, R2100,		Facility policy on Infection Preventi	on and	
	and R21) reviewed	for dining. Further, the facility		Control Program policy was review	ed and	
		ir comprehensive infection		remains current.		
		trol program (IPCP) included		Infection Control Nurse/ADON and	I DON	
		otential infections; ongoing,		educated on proper infection contr		
		alysis of all collected		tracking including surveillance of a		
	•	•				
	surveillance data; a			potential infections; ongoing,	otod	ļ
		leveloped infections to help		comprehensive analysis of all colle		ļ
		currence and/or spread within		surveillance data, and demonstrate		ļ
		the potential to affect all 64		investigation of developed infection		ļ
	_	n the facility at the time of the		help prevent potential recurrence of	or	
	survey.			spread within the facility.		ļ
				Handwashing/Hand Hygiene policy	/ was	ļ
	Findings include:			reviewed and remains current.		ļ
				All nurses and NARs were educate	ed on	ļ
	R46's Admission Re	ecord printed 9/3/20, indicated		performing hand hygiene in betwee	en room	ļ
		cluded dementia, chronic		trays.		ļ
		ory disease (COPD), and		Date of Compliance: 10/7/2020		ļ
	diabetes.	, (- 21 =),		Reoccurrence will be prevented by	<i>r</i> :	ļ
				Weekly observation audit of 5 staff		ļ
				vvoorily observation addit of 3 stan	i.o	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
		00299	B. WING		09/0	2 4/2020
	PROVIDER OR SUPPLIER ERALDS AT GRAND F	RAPIDS LLC 2801 SOU	DRESS, CITY, ITH HIGHWA APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21375	R57's Admission R R57's diagnoses in kidney disease. R110's Admission F indicated R110's dia following joint replat COPD. R R11's Admission Ro R11's diagnoses ind (irregular heart rhytheart failure, and hitheart failure, rheumatoid disease. R111 was on quara new admission to the quarantine sign pure R12's Admission R12's diagnoses in body's extreme, life infection), COPD, of failure, history of problems swallowing R12's room door hitheart failure, and hitheart failure, rheumatoid disease.	ecord printed 9/3/20, indicated cluded COPD and chronic Record printed 9/3/20, agnoses included aftercare cement, emphysema, and ecord printed 9/3/20, indicated cluded atrial fibrillation hm), diabetes, congestive istory of cancer. iated 6/10/20, indicated R11 cautions for e Staphylococcus Aureus esistive to some antibiotics). Record printed 9/3/20, and I urinary tract infection, heart arthritis, and chronic kidney antine precautions related to the facility, and room door had osted on it. ecord printed 9/3/20, indicated cluded a history of sepsis (the e-threatening response to an diabetes, acute respiratory neumonia and dysphagia	21375	assure they are completing har appropriately after direct contarresidents, high touch surfaces, environmental services, and m x 4 weeks then monthly x2 moresults of these audits will be s the facility QAPI committee for the need to increase, decrease discontinue the audits. Corrections will be monitored b DON/Nurse Managers/Designer	ct with high touch eal delivery nths. The hared with input on e, or	

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					c	>
		00299	B. WING		09/0	4/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EMI	ERALDS AT GRAND F	RAPIDSTIC	TH HIGHWA			
(V4) ID	SLIMMADV STA	ATEMENT OF DEFICIENCIES	APIDS, MN	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ige 29	21375			
	(NA)-M was serving meal trays to each room, from a cart with individual trays.					
	(NA)-M was serving from a cart with ind and a faceshield or R46's room, left the and/or sanitize hand cart and served it to R110, and left the mand/or sanitizing has from the cart, broug positioned R57 in hable, and with the R11's door, brough without wearing a groom without sanitizing or changi After passing a tray NA-M verified she has gloves from room to environment, and wroom" without wear	is p.m. nursing assistant g meal trays to each room, lividual trays. NA-M had gloves in. NA-M brought a tray into e room, did not remove gloves ds, got another tray from the portion, moved a glass for room, without removing gloves ands. NA-M got another tray ght the tray into R57, his wheelchair up to the tray same gloves, knocked on the tray from the cart, gown, left R11's "precautions" in a tray from the cart without in gloves, delivered it to R12. If to R12, when questioned, had been wearing the same to room, touched resident's event into R11's "precautions ing a gown, or changing ght into R12's room to deliver his belongings.				
	fluids to each room	me, NA-N picked delivered . NA-N changed gloves n, but did not sanitize between				
		p.m. NA-M and NA-N verified een sanitizing between glove each resident.				
	verified there was a	p.m. director of nursing (DON) a risk of cross-contamination changed and hands are not				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00299	B. WING			C 04/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
THE EME	THE EMERALDS AT GRAND RAPIDS LLC 2801 SO GRAND					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
	The facility policy ar Handwashing/Hand directed staff to use soap and water beforesident with meals gloves, before and residents or contamination on 9/1/20, at 12:03 delivered meals to rethe room, and without took another meal of the room, and without took another meal of the room, and without and sand resident R210. NA-B delivered meals to rethe room, and without and soda can. NA-B deliversident R210. NA-B on R210's bedside and soda can. NA-B perform hand hygie down the hall, and be room, who was quared on 9/1/20, at 12:30 and stated she did a passing meal trays. Spaced it, I am usual hygiene." On 9/3/20, at 10:23 (LPN)-A was intervisioning in and out of hand sanitizer proportioning proper hand be on 9/3/20, at 2:17 pastaff was going from	In determined the second of th				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			c	
		00299	B. WING			04/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE EMI	ERALDS AT GRAND F	RAPIDS LLC	ITH HIGHWA RAPIDS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
21375	Continued From party hygiene. On 9/3/20, the last control line listings from the infection on the infection of the reviewed and identification of the facility Antibiotic 6/4/20, to 6/25/20, a identified line listing within the facility. To various items track resident names, rosymptoms, onset does needed/used. Healthcare Associated by Resident Days of 2020, tracked a bree (respiratory, urinary gastrointestinal, bloventilator associated days, which when comonth's total infections.	twelve months infection were requested for review control preventionist/registered provided information was ified the following data month. Ic Tracking Sheets, dated and 7/2/20, to 7/31/20, gs used to record infections he data collected included ed including, but not limited to, om numbers, infection types, ates, laboratory or organism sage and if	21375				
	"Actions Taken." JUNE 2020:						
	• ,	lined above) identified a total tions between three listed and unit 4):					
		ntified UTI which listed a urine n collected after symptom					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:		
	C	
00299 B. WING 09/04/20	020	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
THE EMERALDS AT GRAND RAPIDS LLC 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COI	(X5) OMPLETE DATE	
onset of 6/4/20, however, the tracking sheet did not identify the organism for which seven days of antibiotics had been administered. -Unit 3 had identified a single infection each for UTI, pneumonia, upper respiratory infection and skin infection, along with a single infection identified as, "Other." The UTI listed a urine specimen had been collected after symptom onset of 6/17/20, however, the tracking sheet failed to identify the organism for which six days of antibiotics had been administered. The pneumonia infection sputum (coughed up mucus) culture obtained after symptom onset of 6/17/20 identified extended-spectrum beta-lactamase (ESBL, an enzyme that prevents certain antibiotics from being able to kill the bacteria). The upper respiratory infection listed a sputum culture was obtained for symptom onset of 6/23/20, however, failed to identify the organism for which seven days of antibiotics were administered. -Unit 4 had identified a single skin infection and five UTI. All five UTI were each identified to have different symptoms listed, however, urine cultures for two of the UTI identified proteus mirabilis (a bacteria) with symptom onsets of 6/4/20, and 6/19/20, respectively. Two of the other UTI identified escherichia coli (a bacteria) in which one further identified ESBL, with symptom onsets of 6/22/20, and 6/23/20, and 6/23/20, respectively. The line listing failed to indicate antibiotic end dates for three of the resident infections, results of reported wound cultures for the two skin infections, and further failed to identify when all of the infections listed had resolved symptoms. The line listing did not indicate or identify any residents had been tracked for non-antibiotic		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			c	
		00299	B. WING		I	04/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
THE EM	ERALDS AT GRAND F	RAPIDS LLC	ITH HIGHWA APIDS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
21375	Continued From pa	ige 33	21375				
	treated infections (i cold symptoms).	.e. viral infections, common					
	dated June 2020, ic infections with a tot series of equations the facility had an ir (percent). The "Sp "Unit 2- 1 UTI, Unit 3 - 1 pneumonia. T listed: "Hand washi wing. Different orga summary report fail a comprehensive a June 2020.	nary report (outlined above) dentified a total of seven facility al of 1432.00 resident days. A were listed which identified infection rate of 4.89 % ecific Trends" section listed: 4 - 5 UTI, Unit 4 - skin 1, Unit he "Actions Taken" section ing audits in place for each anisms." The infection led to show documentation of nalysis of the infections for					
		lined above) identified a total tions between three listed and unit 4):					
	pneumonia. All four identified to have di urine culture for syr reported to be obta with no other symplenterococcus avium resident's urine cultionset of 7/30/20, id bacteria). Another uidentified escherich onset of 7/30/20. Oidentify the organis infection indicated the emergency department.	ed four UTI and one of the UTI were each ifferent symptoms listed. One inptom onset of 7/9/20, ined per the resident's request toms indicated, identified in (a bacteria) and another ture obtained for symptom dentified enteroccus faecalis (a urine culture obtained in a coli with ESBL for symptom one urine culture failed to im result. The pneumonia the resident was seen in the inent but the line listing did not the x-ray report listed to have 0.					

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00299	B. WING		09/0	2 4/2020
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/0	-1/2020
THE EM	ERALDS AT GRAND F	PAPINS LLC:	TH HIGHWA			
	OLIMANA DV. OTA		APIDS, MN			0.5
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 34	21375			
	infection, one pneu single infection liste urine culture was co of 7/22/20, howeve organism for which administered. -Unit 4 had identified one UTI, and two in UTI indicated a uring symptom onset of organisms to be esturine culture report practitioner note ful diagnosed with ESI	ed one skin infection, one ear monia, and one UTI, with a ed as "Other." The UTI listed a completed for symptom onset r, failed to identify the three days of antibiotics were ed one pneumonia infection, affections listed as "Other." One he culture obtained after 7/22/20, which identified the cherichia coli and ESBL. A dated 7/23/20, with a nurse other indicated the resident BL also had evidence of ion to the UTI. This was not ting form.				
	residents tracked for antibiotic reassess antibiotic stewards listing failed to iden listed had resolved not indicate or iden tracked for non-ant. The infection summedated July 2020, identifications with a tot series of equations the facility had a infections." The "Action total infections. 3 residents with cellu The infection summer.	d to identify two of the or UTI and "Other" had an ment performed in regards to hip processes. Further, the line tify when all of the infections symptoms. The line listing did tify any residents had been ibiotic treated infections. The line listing did tify any residents had been ibiotic treated infections. The report (outlined above) entified a total of 11 facility all of 1729.00 resident days. A were listed which identified fection rate of 6.36%. The ection listed: "no specific his Taken" section listed: "11 esidents with pneumonia. 2 litis. 6 residents with UTI's." hary report failed to show comprehensive analysis of				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		00299	B. WING		09/0	2 4/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EME	ERALDS AT GRAND F	PAPIDS LLC 2801 SOL	TH HIGHWA	Y 169		
		GRAND R	APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 35	21375			
	the infections for Ju	ıly 2020.				
	demonstrating the fit comprehensive and infections to determ identified were poted within the facility or having had multiple causative organism. Further, there was facility had correlated with staff illnesses to infections were related to the provide documents.	crovide documented evidence facility had conducted a alysis of the facility acquired nine if any of the infections entially related and/or spread respective unit(s), despite infections with the same as throughout the facility. In a provided evidence the ed the resident' infection data to determine if any of the atted. In addition, the facility didented evidence the facility had any non-antibiotic treated				
	interviewed. RN-B selectronic health syshe works, and moantibiotics, which slisting. The DON stathe line listings are trends and to see if Both the DON and analysis was documed to being brought (Quality Assurance Improvement) composed during the kept with the infection was kept with the Cothe DON nor RN-B analysis which may or during the QAPI	a.m. the DON and RN-B were stated she reviewed the stem "dashboard" each day nitors every resident who is on he then adds to a monthly line ated at the end of the month reviewed to see if there are staff education was required. RN-B denied a comprehensive mented prior to the infection to the facility monthly QAPI and Performance mittee. Any analysis he QAPI committee was not on control reports, however, the part of the provide any where the provide any where the provide any where the provide any where the provide and performents to show support of a pection analysis process.				

Minnesota Department of Health STATE FORM

On 9/3/20, at 3:32 p.m. a follow-up interview was

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER	/SUPPLIER/CLIA TION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY
,	0. 0020	.52		A. BUILDING:			
		00299		B. WING			C 0 4/2020
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			2801 SOU	TH HIGHWA	Y 169		
THE EMI	ERALDS AT GRAND F	RAPIDS LLC	GRAND R	APIDS, MN	55744		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRIES OF THE AP	ULD BE	(X5) COMPLETE DATE
21375	Continued From pa	ae 36		21375			
	conducted with RN monthly line listings that required antibid non-antibiotic infect hour board" in which those residents. RN track non-antibiotic	B in which she were only for otic treatment. tions were plath nursing staful-	those infections RN-B explained ced on a "24 f would chart on				
	The facility Infection Program policy date of the plan was " addresses detectio infections among repolicy further direct for recognizing the recording their numoutbreaks and epid infections, and deteinfection control important included in the facil which surveillance is used to inform the issues and trends. Infection prevention nursing units, categories, and recorded infections. The policy didance on how investigated to reduvate to ensure a completed. Furth information on how non-antibiotic treate investigations into the SUGGESTED MET. The director of nursidevelop or revise the related to infection surveillance.	ed 8/19/20, direction is comprehensive, prevention is esidents and ped surveillance occurrence of ober and frequenics, monito ecting unusual plications. Cultiplications. Cultiplications and report of antibiotic usaity surveillance data and report of ecommittee of the policy identified infections of the policy identified infections of the program of the program of the program of the program of the policy infections of the policy of the program of the pr	rected the scope we in that is and control of personnel." The e tools are used infections, pency, detecting oring employee pathogens with ture reports, age reviews are e activities, in rting information of potential ntified the data from the effection by body umber of direction or ions would be recurrence or e analysis was to a lacked any would track or if/when would be done. ORRECTION: designee, could d procedures				

Minnesota Department of Health

Minneso	ta Department of He	eaim				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00299	B. WING		C 09/04/2020	
		00299			09/0	4/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		2801 SQU	TH HIGHWA	Y 169		
THE EME	ERALDS AT GRAND F	RAPINS LLC:	APIDS, MN			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
04075	O	27	21375			
21375	Continued From pa	ige 37	213/5			
	The DON or design	nee could provide education to				
	all involved staff.	•				
	The DON or design	nee could develop a monitoring				
		ngoing compliance and report				
		Qualify Assurance Committee.				
	· ·	, and the second se				
	TIME PERIOD FOR	R CORRECTION: Twenty-one				
	(21) days.	•				
	, , ,					
21435	21435 MN Rule 4658.0900 Subp. 1 Activity and		21435			10/7/20
	Recreation Program; General					10/1/20
		, ••				
	Subpart 1. Genera	al requirements. A nursing				
		an organized activity and				
		. The program must be				
		vidual resident's interests,				
		ds, and must be designed to				
		mental, and psychological				
		resident, as determined by the				
		ident assessment and				
		n of care required in parts				
		58.0405. Residents must be				
		ties to participate in the				
		opment of the activity and				
	recreation program					
	This MN Requireme	ent is not met as evidenced				
	by:					
		ion, interview, and document		F679: Activities Meet Interests/Nee	eds of	
	review, the facility fa	ailed to ensure meaningful		Each Resident		
		ided for 4 of 4 residents (R111,		Immediate Corrective Action:		
	R16, R28, and R45	i) reviewed for activities.		R111, R16, R28, & R45 were reass	sessed	
				including family interviews to assur	e all	
	Findings include:			activities planned were sufficient,		
				meaningful, and additional activitie	s added	
		Record printed 9/4/20,		if indicated.		
		s included chronic pain, heart		Action as it Applies to Others:		
	failure, and chronic	c kidney disease.		Activity Programs policy was review	wed and	

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE S COMPL	
		00299	B. WING		09/0	4/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EM	TO A L DC AT CDAND	2801 SOU	TH HIGHWA	Y 169		
INE EIVII	ERALDS AT GRAND R	GRAND R	APIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	Continued From pa	ge 38	21435			
21433	R111's care plan ini was at risk for incre related to decrease guidelines while ma Interventions includ social isolation, and independent activiti wishes. R111's care R111's Activity Parti 8/31/20, indicated F staff and his own in and would participa choosing. R111's fa accomplishments, a watching TV, exerc short stories, trivia, roommate. R111's including needs, str determined to rema per R111's care pla Review did not addi actually attended or The facility Activity I undated, indicated I the Daily Chronicle, any one to one visit activities, and provimaterials, such as I On 9/1/20, at 10:28 sitting in his room, and no in his door, and no in his room. R111's	tiated 8/31/20, indicated R111 ased depression and anxiety d socialization due to federal maging Coronavirus-19. ed assessments for risk of provide appropriate es per resident likes and e plan lacked identification of vity needs and preferences. cipation Review dated and entities of his avorite activities, special and/or new interests included ises, the daily chronicles, and visiting with staff and his activity-related focuses engths and preferences was in appropriate and current as n. R111's Activity Participation ress activities R111 had a participated in. Record of Participation R111 had been provided with but lacked documentation of s, participation in any sion of independent activity pooks or magazines. a.m. R111 was observed a quarantine sign was hanging activity materials were visible TV was turned toward his cated there were no activities	21400	remained current. All residents will be reassessed to activities planned are meaningful a sufficient. Activity Department staff will be re-educated on the process for as and planning for sufficient and me activities for those residents required activity set up. Date of Compliance: 10/7/2020 Reoccurrence will be prevented by of 5 residents requiring activities are conducted weekly x 4 weeks then x2 months to assure activities are sufficient and meaningful via verbal response. The results of the audits will be shared with the facilic committee for input on the need to increase, decrease, or discontinue audits. Corrections will be monitored by: A Director/Designee	sessing aningful ring y: Audit et up monthly ell or non ese ty QAPI	

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUF IDENTIFICATION		` ′	E CONSTRUCTION		E SURVEY PLETED
		00299		B. WING			C 04/2020
	PROVIDER OR SUPPLIER ERALDS AT GRAND F	RAPIDS LLC	2801 SOL	DRESS, CITY, S JTH HIGHWA' RAPIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIEN / MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21435	Continued From particles of the particle	o.m. R111 was obvith the door mostly materials, and to roommate. o.m. R111 was sittle and just returned atted there was not a quarantine sign of the worse than being door to read to read, but coure adding materials a.m. R111 was in the worse than being door to read to	ting in his from othing to do. on his door do in here?" in prison. Idn't see very in his room, ual activity istant (NA) -G and she had stated she r residents. It citical nurse ny activities, ted R111 went day, and I no staff do an dropping of nursing e-to-one happening.				
	The facility policy A directed the activitic support the well-be	ctivity Programs r es program was p	provided to				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00299	B. WING		09/0) 4/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EMI	ERALDS AT GRAND R	RAPIDSTIC	JTH HIGHWA			
		GRAND R	RAPIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	Continued From pa	ge 40	21435			
	assessment and re included facility-org independent individudindividual activities. programs were des interests of the resi	ive resident-centered sident preferences, and anized group activities, ual activities and assisted The policy indicated activity igned to meet the needs and dents and activity participation ted in the resident's medical				
	indicated he was se and required extens of daily living (ADLs	ange MDS dated 8/12/20, everely cognitively impaired, sive assistance for all activities a). The activity preference DS was not completed.				
	dated 8/30/20, indic or pleasure in doing R16 was dependen engaging him in act confined to his roor further indicated sta room visits, and ind	sessment (CAA) for Activities sated R16 showed little interest things. The CAA indicated to no staff for setting up and civities, and indicated R16 was no related to infection. The CAA aff were to provide one to one icated R16 liked watching to classical music, and liked r fresh air.				
	dependent on staff activities due to cog limitations. The card converse with R16 the window for freshindicated R16 liked with family on the IF music. R16's care pincreased depression decreased socialization.	ed 8/30/20, indicated he was for setting up and engaging in gnitive deficits and physical e plan directed staff to while providing care, and open air. The care plan also to watch television, converse Pad, and listen to classical plan further indicated a risk for on and anxiety related to ation.				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00299	B. WING		1	4/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EMI	ERALDS AT GRAND F	SADING LIP	JTH HIGHWA RAPIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	indicated R16 enjoy stories, tons of pundon of pundon on 9/1/20, at 9:07 and his room. At 10:14 his eyes open and 10:16 a.m. activity a resident room hand AA-A left the unit word on 9/2/20, at 8:33 and his back in bed his room. At 9:39 a R16 was laying on and not engaged in On 9/3/20, at 8:28 alying in bed with no had awakened R16 shifting around in the Facility documents 9/2/20, included a lidentified the follow 7/17/20, R16 watch 7/21/20, activity log computer and indication the activi 7/22/20 - 7/27/20, pthe same as 7/21/27/28/20, activity log 7/28/20, activity l	yed the Daily Chronicles, short s, and staff reading to him. a.m. R16 was observed lying with no television or radio on in a.m. R16 remained in bed with no television or radio on. At aide (AA)-A was in another ding out the Daily Chronicles. ithout stopping in R16's room. a.m. R16 was observed laying with no television or radio on in .m. R16's television was on, the bed with his eyes closed, a the program. a.m. R16 was again observed television or radio on. Staff or prior to 7:30 a.m. R16 was ne bed and appeared restless. titled Wing 3 dated 7/17/20 - ist of residents on the unit and ring: ned television I was pre-filled out on a stated independent activity, visits with staff and Daily utes. The log lacked any ties were completed. The log lacked any ties was left blank.	21435			
	again provided but completed.	0, the pre-filled activity log was no indication activities were activity attendance was				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00299	B. WING			C 04/2020	
	PROVIDER OR SUPPLIER ERALDS AT GRAND F	PAPIDS LLC 2801 SOU	DRESS, CITY, S ITH HIGHWA APIDS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
21435	8/20/20, R16 had a the weather, and cu 8/24/20, indicated I R16. 8/27/20, staff sat widay. 9/1/20, R16 had a v 9/2/20, indicated da The activity logs lad activity programmir On 9/3/20, at 11:28 stated R16 watched he wanted to use it got up in his chair, R28's admission M he was severely corequired assistance MDS indicated loco occurred during the MDS further indicated to do his favorite activity with staff. Tinform R28 of scheefforts for attendan A facility document 9/2/20, included a lidentified the follow 7/17/20, no activity 7/21/20, activity log computer and indicated indicated indicated indicated the follow 7/17/20, no activity gocomputer and indicated indicated indicated indicated indicated the follow 7/17/20, no activity 10g computer and indicated indicated indicated indicated indicated the follow 7/17/20, no activity 10g computer and indicated in	one to one visit talking about urrent events were read to him. Daily Chronicles were read to him. Daily chronicles. Sked evidence of weekending. a.m. nursing assistant (NA-)-Jid television and had an IPad if NA-J stated sometimes R16 and sometimes not. DS dated 6/30/20, indicated gnitively impaired, and he from staff to transfer. The motion off the unit had not assessment period. R28's red it was somewhat important civities, go outside and get to music. Ded 7/17/20, indicated R28 of activity involvement, and participate in one to one he care plan directed staff to duled activities, and praise or of hallway activities. Description of the unit and ing:	21435				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00299	B. WING		09/0) 4/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	<u>I</u>	STATE, ZIP CODE	1 00.0	
THE EM	ERALDS AT GRAND F	RAPINS LLC:	TH HIGHWA APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	Chronicles 10 minut the activities were of 7/22/20 - 7/24/20, a attendance log provactivities were com 7/28/20, copy of chinterested in library and he accepted th 7/30/20, 7/31/20, provided with no incompleted. 8/1/20 - 8/17/20, no provided. 8/18/20, Daily Chron 8/21/20, Daily Chron 8/21/20, Enjoying to but R28 was tired a 8/29/20, Daily Chron 7/2/20, Daily Chron 7/2/20, Daily Chron 1/2/20, at 9/2/20, Daily Chron 1/2/20, at 9/2/20, at 7/2/20, at 11/2/20,	Intes. There was no indication completed. Ind 7/27/20, Pre-filled vided, but no indication the pleted. In ronicle, R28 was not cart but showed him items are different items. In re-filled attendance sheet dication activity was activity attendance was anicles. In incles. In incles. In incles. In icles. In icles.	21435			

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Millinesc	ita Department of He	eaun				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						:
		00299	B. WING		1	4/2020
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
THE EM	ERALDS AT GRAND F	RAPIDSTIC	TH HIGHWA			
		GRAND R	APIDS, MN	55744		
(X4) ID	-	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
17.0		,	17.0	DEFICIENCY)		
21125	Cantinuad Francis	no 44	21.125			
21435	Continued From pa	ge 44	21435			
	activities staff did a	ctivities. NA-J stated R28 got				
	papers from activity	staff, but did not know if he				
	participated.					
	0 0/0/00 1 0 54					
		o.m. the administrator stated				
	,	was new. The administrator arted, someone from another				
		ne guide based on previous				
	assessments (the guide referred to the activity log that was pre-filled out). The administrator stated the direct care staff did activities with residents,					
	but they were "prob	ably" not documented. The				
	administrator stated	d when the activity director first				
		st of the activities, but stated				
		ost of the activities were one				
		dministrator stated the Daily				
		and out that described what				
		irring each day, and				
		er things like a word search. tated the activity department				
		residents, and went over it				
		ninistrator stated R16 had an				
		ngs, and had a bird feeder				
	•	The administrator stated				
	activities staff would	d go in and chat with R16 in				
		it was difficult to have him				
		ue to infection control				
		inistrator stated he did not				
		said if something was written				
	down for an activity	, it was probably done.				
	R15's Admission D	ecord dated 9/3/20, indicated				
		cluded visual loss, muscle				
	weakness, and hea					
	R45's annual MDS	dated 7/30/20, indicated R45				
		, had severely impaired vision,				
		aired hearing. R45's activity				
		dicated he enjoyed being				
		ne outdoors, and keeping up				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						;
		00299	B. WING		09/0	4/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EM	ERALDS AT GRAND F	RAPIDSTIC	TH HIGHWA APIDS, MN			
0/4) ID	CLIMMA DV CTA				ON .	()/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	Continued From page 45		21435			
	with the news. R45's activity self-assessment lacked indication he enjoyed listening to music and reading books, newspapers or magazines.					
	was dependent on stimulation, social i R45's care plan fur independently purs listen to a transisto	viewed 7/29/20, indicated R45 staff for activities, cognitive nteractions, and well-being. ther indicated he ued activities, and he liked to r radio or the television. R45 de or attend group activities.				
	R45's Care Conference form dated 8/3/20, indicated R45 relied on staff for activities, and participated in one-on-one activities with staff. The form further indicated R45 did not have interest in activities due vision and hearing loss.					
	activities were docu - Delivered mail and occurrence. - Watched televisio - Listened to transis occurrences.	d "talked a bit" on one n on one occurrence.				
	activities were docu - Visited with staff a occurrence The Daily Chronic - Visited by staff "al occurrence Chatted about fall on one occurrence Verbal interactions-R45 refused to wa	and "current events" on one cles on five occurrences. bout his needs" on one and "reviewed today's events"				

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winnesc	ita Department of He	eaim				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		(X3) DATE :	
7.110 1 15.11	or contraction	is Errin is an errit moniser.	A. BUILDING:			
		00299	B. WING		09/0	; 4/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		2801 SOL	JTH HIGHWA			
THE EME	ERALDS AT GRAND F	GRAND F	APIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
21435	Continued From pa	ge 46	21435			
	sitting in a wheelchale bedside table in from off in the room. R45 wall. The television radio was observed used to enjoy fishin television. On 8/31/20, at 6:00 sitting in a wheelchale eating dinner. R45 wall. The television On 9/2/20, at 8:22 a assist R45 with more a wheelchair, and pof him. The TV was activities assistant (and placed a mug of the exited the room a.m., R45 was seat forward toward a woff. At 12:43 p.m. Find wheelchair facing for television remained observed to walk passeveral resident's reopportunity to attendid not enter R45's p.m. R45 was obseappeared to be award to ward to be award to be aw	p.m. R45 was observed air in his room. R45 had a nt of him, and the lights were was facing forward toward a was noted to be off, and no in R45's room. R45 stated he g, reading, and watching p.m. R45 was observed air in his room. R45 was was facing forward toward a was noted to be off. a.m. NA-F was observed to rning cares, transferred him to placed a bedside table in front anoted to be off. At 8:47 a.m. (AA)-B entered R45's room on his bedside table. AA-B m. From 9:29 a.m. to 10:17 and in a wheelchair and facing all. R45's television remained R45 was seated in a prward toward a wall. R45's ast R45's room and entered pooms and offered them and an exercise activity. AA-A room. At 1:42 p.m. At 2:14 erved lying in bed and ake. NA-I entered R45's room was "just kind of laying				
	anything." R45 state keep himself comfo	o.m. R45 stated, "I don't do ed he was "bored" and tried to ortable by lying in bed most of sion was noted to be off.				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00299	B. WING			C 04/2020	
	PROVIDER OR SUPPLIER ERALDS AT GRAND F	2801 SOL	DRESS, CITY, S JTH HIGHWA RAPIDS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
	eating breakfast in was observed to be television was note observed in the roo On 9/3/20, at 8:54 a listen to the radio, but did not know if there right now. NA-D statended activities. assisted R45 to pla provided "a daily shappened to him. his roommates tele "found peace" with stated R45 barely to factivities were provided to activities activities were provided to activities activities were provided to activities activit	a.m. NA-D stated R45 liked to but not often. NA-D stated he e was a radio in R45's room ated he did not know if R45 NA-F stated in the past, staff y bingo. NA-D stated staff eet" and was "pretty sure" NA-D stated R45 listened to vision. NA-D stated R45 "peace and quiet." NA-D alked. When asked what types ovided to R45, NA-D stated					
	in his room facing fitelevision was noted. On 9/3/20, at 9:12 a "have much going of unable to see and his stated there was no being blind and har believed music was was just "living day. R45's activity partice restorative staff profon 9/3/20, at 9:41 a and offered him the On 9/3/20, at 9:46 a unable to hear well	orward toward a wall. R45's d to be off. a.m. NA-E stated R45 didn't on." NA-E stated R45 was had hearing issues. NA-E of much for R45 to do due him d of hearing. NA-E stated he provided in the past, and R45-to-day." When asked about ipation, NA-E stated vided R45 with exercises.					

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
ANDFLAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		OOIVII EE	
		00299	B. WING		09/0	2 4/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TUE EMI	EDALDE AT CDAND I	2801 SOU	TH HIGHWA	Y 169		
	ERALDS AT GRAND F	GRAND R	APIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	Continued From pa	ige 48	21435			
	"doesn't see" and searches or other persons and searches or other persons activities had been activities staff would AA-B stated R45 "very description of activity participation of 9/3/20, at 10:19 very quiet man and LPN-C stated R45 listen to the radio be now. LPN-C stated engage him," and fenave seen activities	staff cannot give him word paper activities. AA-B stated other sensory stimulation offered to R45. AA-B stated d talk with R45 about his life. wants to be in bed" and he -B stated restorative staff ith him" but was unsure of the when asked about other n. I a.m. LPN-C stated R45 was a didn't like to attend activities. liked to lay down, and used to ut was too hard of hearing, "I don't know what they do to urther stated, "I can't say I is over here talking with R45 in LPN-C stated restorative				
	in restorative theral could call that an all would have to ask to other activities R45 would expect staff. SUGGESTED MET The Activity Director review, and/or revisensure resident's high program that meets The Activity Director all appropriate staff procedures. The Activity Director and the Activity Director all appropriate staff procedures.	o.m. the DON stated R45 was by, and stated, "I guess you ctivity." The DON stated she the activities department about was in. The DON stated she to offer R45 activities. THOD OF CORRECTION: or or designee could develop, see policies and procedures to ave an indivdualized activity is their needs. For or designee could educate on the policies and or or designee could develop is to ensure ongoing				

Minneso	ta Department of He	alth				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00299	B. WING		09/0	; 4/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
THE EME	ERALDS AT GRAND R	PAPIDSTIC	ITH HIGHWA RAPIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
21435	Continued From pa	ge 49	21435			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21620	MN Rule 4658.1345	5 Labeling of Drugs	21620			10/7/20
	Drugs used in the n in accordance with	oursing home must be labeled part 6800.6300.				
	by: Based on observati review, the facility fa were labeled with of administration for 2 observed for insulin the facility failed to o ointments and crea prevent cross conta R261, R33, R34, R3 reviewed for medica Findings include: R37's Admission Re R37's Admission Re R37's diagnoses inc R37's Order Summ as of 9/3/20, include insulin Aspart Flex inject 5 units subcur and, insulin Aspart solu scale; if 150-199=2	ecord printed 9/3/20, indicated cluded diabetes. ary Report with active orders ed physician orders for: Pen Solution Pen-injector, taneously three times a day attion, inject as per sliding units; 200-249=4 units; 200-349=8 units; 350+=10 units,		F761: Label/Store Drugs & Biologi Immediate Corrective Action: R37 & R58 insulin pens are now clabeled with current medication or administration. R112 discharged from facility on 9. R38, R261, R33, R34, R20, R23, R112, and R16 creams and ointmestored separately and nursing stafnow squeezing a single use amoudisposable cup to take into the restroom, then dispose of the cup so a cross contaminate. Action as it Applies to Others: Storage of Medications & Topical Application of Ointment & Cream pwere reviewed and remain current All insulin pens were reviewed for appropriate labels. All medicated ointments/creams are now being administered per the single use mestated above. Nurses & TMAs were educated on labeling of insulin pens and proper administration/storage of ointment creams.	orrectly ders for /14/20. R44, ents are f are nt into a sident's as not to colicies ethod	
		p.m. registered nurse (RN)-D ster insulin Aspart to R37, and		Date of Compliance: 10/7/2020 Reoccurrence will be prevented by	/: Audit	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE :	
		A. BUILDING.			
	00299	B. WING			4/2020
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
THE EMERALDS AT GRAND R	RAPIDS LLC	TH HIGHWA APIDS, MN			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
orders on the Medic (MAR). The pharm directions on R37's inject 7 units three the scale. RN-D verified match R37's curren MAR. RN-D stated on the MAR, as the RN-D stated R37's change-in-directions of the change in order R37's insulin pen to applying a change-insulin pen. On 9/3/20, at 2:50 pm (LPN)-F verified R3 have a change-in-directions of the change in orders on R37's insulin pen structured pharmacy label directions on R37's insulin pen structured pharmacy label directions on 9/3/20, at 3:15 pm verified a change-inbeen placed on R33 a change in direction risk for giving the wmpharmacy label did orders on the MAR. R58's Admission Re R58's diagnoses in R58's Order Summas of 9/3/20, indicated the scale of R58	a the insulin pen, per the cation Administration Record acy label with administration insulin Aspart pen, directed to times daily, and per sliding at the pharmacy label did not at medication orders on the she would go by the orders y were the current orders. insulin pen should have a sticker on it to alert nurses ders, and proceeded to return the medication cart without in-directions sticker on the sticker on the dections did not match the attendance to the MAR. LPN-F verified hould have had a sticker on it. D.m. director of nursing (DON) dedirection sticker should have had a sticker on it. D.m. director of nursing (DON) dedirection sticker should have as a sticker on it. D.m. director of nursing (DON) dedirection sticker should have as a sticker on it. D.m. director of nursing (DON) dedirection sticker should have as a sticker on it. D.m. director of nursing (DON) dedirection sticker should have as a sticker on it.	21620	of 5 resident insulin pens conduct weekly x 4 weeks then monthly x2 to assure pens are labeled appropriately administered ointments/creams of weekly x 4 weeks then monthly x2 to assure ointments and creams a administered & stored appropriate results of these audits will be shall the facility QAPI committee for inthe need to increase, decrease, of discontinue the audits. Corrections will be monitored by: DON/Nurse Managers/Designee	2 months priately. Deing onducted 2 months are being ely. The red with put on	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			,			;
		00299	B. WING			4/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
THE EME	RALDS AT GRAND F	PAPINS LLC	TH HIGHWA			
040.15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	APIDS, MN		ON	(2/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	Continued From pa	ge 51	21620			
	sliding scale: if 201 301-350=6 units; 38 call provider, subcut dated 8/5/20insulin detemir solu units subcutaneous dated 8/27/20. On 9/3/20, at 7:23 a during administration insulin Aspart pharm administration of 14					
	administration of 14 units three times a day with meals and per sliding scale. R58's physician orders on the MAR directed to inject 16 units three times daily. In addition, R58's Levemir pharmacy label was noted to direct administration of 40 units subcutaneously daily, and R58's physician orders on the MAR directed to inject 44 units subcutaneously daily.					
	insulin pharmacy la physician order dire stated she looked a medication orders v	o.m. LPN-H verified R58's bels did not match the ectives on R58's MAR. LPN-H at the MAR for the correct when administering H wrote "see MAR" on both				
		o.m. DON verified pharmacy n physician orders on the				
	R38's diagnoses in (infection of the skill	ecord printed 9/3/20, indicated cluded psoriasis, cellulitis n tissues), and a history of y's extreme life threatening tion).				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				71. 501251110.			c
		00299		B. WING			04/2020
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
THE EMI	ERALDS AT GRAND F	RAPIDS LLC		TH HIGHWA APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
21620	Continued From pa	nge 52		21620			
	as of 9/3/20, includ acetonide ointment itching, redness, dr inflammation, and o	ed orders for triamcing to the conders for triamcing to 1.1% (used to treat the conders, crusting, scaling discomfort of various stand topically twice dates.	olone he ng, skin				
	contact precautions	a.m. R38's door was s for special enteric as posted on R38's do					
		Record printed 9/3/20 agnoses include hear					
	as of 9/3/20, includ to infection area top	mary Report with actived orders for Nystatin pically as needed for in acetonide cream 0.1% I three times daily.	cream nfection;				
	R33's diagnoses in failure with hypoxia	ecord printed 9/3/20, cluded chronic respira , history of pneumonia espirator, and trached	atory a,				
	as of 9/3/20, includ trach insertion in the month, Asper-Flex salicylate) to knee to pain, to be kept in rapply; clotrimazole medicated cream) day to rash; Euceridaily for dry skin; at 1% to G-tube site to	nary Report with active ed orders for lidocaine e morning on the 10th Cream 10% (trolamin topically as needed for esident room for nurs cream 1% (antifungal to rash topically three in cream to feet topicand silver sulfadiazine opically in the morning	e gel for n of each ne r knee se to l times a ally twice cream				
	R33's undated Poc	ket Care Plan indicate	ea K33				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00299	B. WING			C 04/2020
	PROVIDER OR SUPPLIER ERALDS AT GRAND F	RAPIDS LLC 2801 SOU	DRESS, CITY, S TH HIGHWA APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21620	was on contact and a resistive organism. R34's Admission Re R34's diagnoses in rhythm), stroke, and R34's Order Summ as of 9/3/20, include oxide ointment 0.44 (reddened) areas to triamcinolone acetorash as needed unto R20's Admission Re R20's diagnoses includer leg amputation Resistant Staphyloc infection (bacteria to commonly-used and and history of respiratory of respiratory of respiratory failure, or pacemaker, and his aeruginosa (organis including pneumoni R23's Order Summ as of 9/3/20, include clotrimazole-betam rash topically twice	I droplet precautions related to in the sputum. ecord printed 9/3/20, indicated cluded bradycardia (slow heart ditracheostomy. ary Report with active orders ed orders for menthol-zinc 1-20.6% to erythematous opically twice daily; and onide cream 0.025% to facial ill clear. ecord printed 9/3/20, indicated cluded diabetes, bilateral ons, tracheostomy, a Methicillin coccus Aureus (MRSA) hat is resistant to some tibiotics), cardiac pacemaker, ratory failure. ary Report with active orders ed orders for betamethasone (reduces the swelling, is related to skin conditions) to every 12 hours as needed. ecord printed 9/3/20, indicated cluded acute and chronic diabetes, MRSA, cardiac story of pseudomonas is mithat causes infections, ita). ary Report with active orders	21620			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		DED.	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00299	В.	. WING		09/0	2 4/2020
	PROVIDER OR SUPPLIER	RAPINS LLC	STREET ADDRE 2801 SOUTH GRAND RAP	HIGHWA			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FI SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21620	Continued From pa	ige 54	2	21620			
	was on contact pre wounds. R44's Admission R R44's diagnoses in failure, diseases of pulmonary embolis arrest, and tracheo	ary Report with active	ndicated tory of ardiac				
	insertion of trach dicalmoseptine ointmander regions topically the cream 1% to skin to Desitin cream 13% topically every 6 ho Menthol-Methyl Saltopically every 6 homuscle pain four tire ointment 4.7-1.2-2. (camphor-eucalyptingernail/toenails to needed for pain; ar	us-menthol) to opically every 12 hours nd zinc oxide ointment ery 6 hours as needed	nonth, cubitus azole yeast; rritation; n t and Rub				
	indicated R112's di	Record printed 9/3/20, agnoses included pned iratory failure, history o s.					
	as of 9/3/20, includ skin surrounding fe cream 1% (used or itching and irritation	mary Report with active ed orders for barrier cr eding tube, hydrocortis in the skin to treat swell in) to feeding tube side caine gel 2% to coccyx	ream to sone ing, topically				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00299	B. WING		I	C 0 4/2020
NAME OF PROVIDE		2801 SOL	DRESS, CITY, S JTH HIGHWA RAPIDS, MN			
	ACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
topical daily, topical R112' was of sputured Pseudo R16's failured pseudo R16's as of G tuberash/b daily, 0.025 R16's was of Carba (CRP, On 9/ were reveal tubes, drawed treatm included R38's -R261 -R33's sulface -R34's -R20's	and Nystatinally two times of sundated Poon contact preme. Admission Rediagnoses in the history of premonas aerus of site topically pack/side topicand triamcine of the history of the site topically pack/side topicand triamcine of the history of the history of premonas aerus of the history of the	for moderate pain three times cream to feeding tube site daily for site breakdown. cket Care Plan indicated R112 cautions for MRSA in her ecord printed 9/3/20, indicated cluded chronic respiratory neumonia, cardiac arrhythmia, ginosa, and tracheostomy. ary Report with active orders ed orders for A&D ointment to ratice daily and to cally as needed for rash twice plone acetonide cream rach site topically twice daily. cket Care Plan indicated R16 droplet precautions for ant pseudomonas aeruginosa im. c.m. both medication carts nedication storage and pical treatment ere stored together in a reparation. Topical ogether in the first cart e acetonide ne acetonide and Nystatin in (Asper-cream) and silver	21620			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00299	B. WING		_	, 4/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EM	ERALDS AT GRAND F	ZAPINS I I C	JTH HIGHWA RAPIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	Continued From pa	ige 56	21620			
21620	Topical treatments cart included: -R44's calmoseptin A&D, clotrizole crea and R112's and R1 baggies, but in contreatments. On 9/3/20, at 3:36 pcross-contaminatio treatments together rooms during application of cross-contamination treatments together rooms during application of cross-contamination being stored together A policy for labeling provided. The facility policy for Ointment and Creatives for storing cross-contamination of cross-contamination of cross-contamination or consumplements of nurse develop and implementated to medication orders. The director of nurse complete staff train labels with current in the director of nurse perform random automatical cartion or complete staff train labels with current in the director of nurse perform random automatical cartions and cartions are cartiological cartions.	stored together in the second le, Desitin, antifungal spray, am 6's topical treatments were in intact with R44's topical o.m. RN-A verified the risk of in due to storing topical or that go into each resident's cation. o.m. the DON verified the risk tion with topical treatments iter. of medications was not or Topical Application of im dated 11/19, lacked g them separately to prevent in. THOD OF CORRECTION: sing (DON) or designee, could ment policies/procedures on labels with current sing (DON) or designee could ing related to medication	21620			
	(21) days.	A CORRECTION: Twenty-one				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			,
		00299	B. WING		09/0	4/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EMI	ERALDS AT GRAND F	PAPIDS LLC 2801 SOU	TH HIGHWA	Y 169		
	ENALDO AI ONAND I	GRAND R	APIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINED TO THE	D BE	(X5) COMPLETE DATE
21695	Continued From pa	ge 57	21695			
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance		21695			10/7/20
	provide housekeep necessary to maint comfortable interior	eping. A nursing home must ing and maintenance services ain a clean, orderly, and r, including walls, floors, ixtures, equipment, lighting,				
	by: Based on observatireview, the facility for was cleaned and in residents (R45) rev Findings include: R45's Admission Rerection R45's diagnoses in and muscle weakned R45's annual Minim 7/30/20, indicated Frequency R45's MDS further impaired vision, use extensive assistance R45's care plan data clean equipment who weekly. On 9/2/20, at 8:22 a was observed to ha crusted food debris	num Data Set (MDS) dated R45 was cognitively intact. indicated he had severely ed a wheelchair, and required		F584: Safe/Clean/Comfortable/Ho Environment Immediate Corrective Action: R45's wheelchair was cleaned on Action as it Applies to Others: All resident wheelchairs and cushi were cleaned. Nursing and maintenance staff ed on importance of cleaning wheelch monthly per schedule and when so Date of Compliance: 10/7/2020 Reoccurrence will be prevented by of 5 resident wheelchairs/cushions cleanliness will be conducted weel weeks then monthly x2 months to resident wheelchairs/cushions are The results of these audits will be with the facility QAPI committee for on the need to increase, decrease discontinue the audits. Corrections will be monitored by: Maintenance Supervisor/Designeed	9/4/20 ons ucated nairs biled. /: Audit s for kly x 4 assure clean. shared ir input , or	

Minnesota Department of Health

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPF IDENTIFICATION		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00299		B. WING			C 04/2020
	PROVIDER OR SUPPLIER ERALDS AT GRAND F	RAPIDS LLC	2801 SOL	DRESS, CITY, S JTH HIGHWA RAPIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCY MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21695	Continued From pay wheelchair and look NA-G then walked was observed to als NA-G and NA-F they wheelchair. R45 was oiled wheelchair. R45 was oiled wheelchair of the bed. R45's was oiled. On 9/2/20, at 10:25 being transferred, but the bed. R45's was oiled. On 9/2/20, at 10:30 and confirmed R45 soiled. NA-H stated residue on R45's was not notice the residue on R45's was not notice the residue and when spills occurred of National Wheelchair cushion. A wheelchair cushion A wheelchair cushion. A wheelchair cleani but not provided by SUGGESTED MET The Director of Nurdevelop, review, an procedures on wheelchair chair cleani appropriate staff on the DON or design appropriate staff on the DON or design systems to ensure of TIME PERIOD FOR	ked at the wheelch to R45's bathroom so look at R45's when transferred R45 as seated directly cushion. a.m., R45 was obey NA-H, from his wheelchair cushion a.m., NA-H was in so wheelchair cushion heelchair cushion a.m., NA-H was in so wheelchair cushion heelchair. NA-H stue when he got R4 leaning was compourred. b.m., the director of expected staff to clowhen it was dirty. In g schedule was referred the facility. THOD OF CORRESING (DON) or desing (DON) or desider revise policies elchair cleaning. The policies and plee could develop to going compliance could develop to going compliance.	and NA-F heelchair. To to his on top of the served wheelchair remained hterviewed ion was s egg ated he did 5 up. NA-H leted weekly f nursing ean a requested CTION: ignee could s and all procedures. monitoring ce.				

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Minnesota Department of Health STATE FORM

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		o.	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00299	B. WII	NG		09/0	2 4/2020	
	PROVIDER OR SUPPLIER ERALDS AT GRAND F	PAPIDS LLC 28	REET ADDRESS, 01 SOUTH HI RAND RAPIDS	GHWA				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	. PRE	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21695	Continued From pa	ge 59	2169	95				
21980	Subd. 3. Timing or reporter who has revulnerable adult is to or who has knowled has sustained a phyreasonably explains information to the cindividual is a vulne the individual is a vulne the individual is adreporter is not requimaltreatment of the to admission, unless (1) the individual was another facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this sas described above (c) Nothing in this known or suspected knows or has reason to be considered in the considerable of the considerable	of report. (a) A mandated eason to believe that a peing or has been maltred de that a vulnerable ad ysical injury which is not ed shall immediately reported to a facility, a manifed to a facility, a manifed to report suspected eindividual that occurred is: as admitted to the facility the reporter has reason to be a vulnerable adult as delenows or has reason to be a vulnerable adult as delenows or has reason to be a vulnerable adult as delenomediately in the reporter that is a controlled to report under ection may voluntarily received maltreatment, if the report to know that a report in the report of the report in the report of the report	eated, ult ort the nuse dated prior from to in the delieve defined (4). the port desired des	80			10/7/20	

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Minnesota Department of Health STATE FORM

Minnesota Department of Health

MILLIESC	ita Department of He	aitri					
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	_ETED	
					_	.	
			D WINC		C		
		00299	B. WING		09/0	4/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
			TH HIGHWA				
THE EME	ERALDS AT GRAND F	PAPINS LLC:	APIDS, MN				
	OUR MAA DV OTA						
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)		(X5) COMPLETE	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIES		DATE	
				DEFICIENCY)			
21000	Canting and Frame no		21000				
21980	Continued From pa	ge ou	21980				
	subdivision. If the r	reporter or a facility, at any					
		in investigation by a lead					
		ne or should determine that					
		vas not neglect according to					
		ection 626.5572, subdivision					
		clause (5), the reporter or					
		e to the common entry point or					
		agency information explaining					
		ts the criteria under section					
		on 17, paragraph (c), clause					
		ncy shall consider this					
		naking an initial disposition of					
	the report under su						
	the report under 3u	Daivision 50.					
	This MN Requireme	ent is not met as evidenced					
	by:	one is not mot as evidenced					
		and document review, the		F609: Reporting of Alleged Violation	ns		
		nediately report an allegation of		Immediate Corrective Action:	7110		
		agency (SA) for 1 of 2		R7 discharged from facility on 9/19	0/20		
	residents (R7) revie			Action as it Applies to Others:	7/20		
	residents (IVI) revie	ewed for abuse.		Abuse Prohibition/Vulnerable Adult	Plan		
	Findings include:			policy was reviewed and remained			
	i mamys molade.			current.			
	R7's quarterly Minir	num Data Set (MDS) dated		All staff educated on Abuse			
	, ,	she was severely cognitively		Prohibition/Vulnerable Adult Plan	olicy		
		ired extensive assistance for		with regards to immediately report			
		otal assistance for transfers.		suspected abuse to the DON &	ing any		
	bed mobility, and to	dai assistance for transfers.		Administrator.			
	On 8/6/20, an untitle	ed facility document indicated		Date of Compliance: 10/7/2020		ļ	
		nursing assistant (NA) went		Reoccurrence will be prevented by	. Δudit	ļ	
		she approached the doors she		of 5 staff members conducted wee		ļ	
	•	ont of the medication cart		weeks then monthly x2 months to		ļ	
		elling, "[R7], shut up and go to		staff know who to report any suspe		ļ	
						ļ	
		to bed, [R7], its time to go to		abuse to, how to report it, and whe		ļ	
		The document further		report it via verbal conversation. T		ļ	
		ported the incident to two		results of these audits will be share		ļ	
		old her to write a statement		the facility QAPI committee for inp		ļ	
	and place it in the D	DON'S INDOX.		the need to increase, decrease, or			
				discontinue the audits.			

Minnesota Department of Health STATE FORM

E FORM 2R7711 If continuation sheet 61 of 63

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00299	B. WING		09/0	; 4/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 03/0	4/2020
		2801 SQU	TH HIGHWA	•		
IHE EMI	ERALDS AT GRAND F	GRAND R	APIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 61	21980			
	nursing assistant (Not toward the wing four nurse through the cresident to, "Shut ur further indicated the but was not reporter."	report to the SA indicated a NA) reported she was walking in hallway, and could hear a doors loudly telling at a p and go to bed." The report is incident occurred on 8/6/20, indicated to the director of nursing hinistrator until the following		Corrections will be monitored by: Services Director/Designee	Social	
	four staff members but it was not repor	a.m. the administrator stated were aware of the incident, ted to him until the following ator stated it should have been nediately.				
	Adult Plan dated 7/residents in the fact abuse by anyone. I staff were responsite that was considered notify the administrallegations of abuse policy directed susp	buse Prohibition Vulnerable 5/19, directed to ensure ility were not subjected to The policy further directed all ble for reporting any situation d abuse or neglect, and to ator immediately of any e or suspected abuse. The pected abuse shall be reported nan two hours after forming a				
	The Administrator, Director of Nursing review, and/or revisensure immediate resident, and thorouglegations. The Administrator, Director of Nursing appropriate staff on The Administrator,	CHOD OF CORRECTION: Social Services Director, or designee could develop, se policies and procedures to reporting, protection of ugh investigation of abuse Social Services Director, or designee could educate all of the policies and procedures. Social Services Director, or designee could develop				

Minnesota Department of Health

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00299	B. WING		09/0	C 04/2020
	PROVIDER OR SUPPLIER ERALDS AT GRAND F	PAPIDS LLC 2801 SOU	DRESS, CITY, S TH HIGHWA APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21980	monitoring systems compliance.		21980			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245495	B. WING			09/	02/2020
	PROVIDER OR SUPPLIER ERALDS AT GRAND F	RAPIDS LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPIDEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ΓS	K 0	00			
	FIRE SAFETY						
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.					
	ONSITE REVISIT (CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departm Fire Marshal Division The Emeralds at Grampliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F	Survey was conducted by the nent of Public Safety, State on. At the time of this survey rand Rapids was found not in a requirements for participation at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), a Health Care.					
		E AN EPOC, A PAPER COPY CORRECTION IS NOT					
	PLEASE RETURN CORRECTION FOI DEFICIENCIES (K	R THE FIRE SAFETY					
LABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

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

Electronically Signed

09/25/2020

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

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION 01 - MAIN BUILDING 01	` '	SURVEY PLETED
		245495	B. WING			09/0	02/2020
	PROVIDER OR SUPPLIER ERALDS AT GRAND I	RAPIDS LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	By e-mail to: FM.HC.Inspections THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defic 2. The actual, or pr 3. The name and/oresponsible for corprevent a reoccurre The Emeralds at Gouilding with a part constructed at 4 difficulty did building was constructed at 4 difficulty did building with a part constructed at 4 difficulty did building with a par	RE INSPECTIONS SHAL DIVISION STREET, SUITE 145 01-5145, or @state.mn.us RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done	К	000			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245495 B. WING 09/02/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 THE EMERALDS AT GRAND RAPIDS LLC **GRAND RAPIDS, MN 55744** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 000 | Continued From page 2 K 000 of the west wing (special cares unit) which were determined to be Type II (111) construction and separated with 2-hour fire barriers. The building is divided into 8 smoke zones by 30-minute and 2-hour fire barriers. The facility is fully sprinkler protected and has a fire alarm system with smoke detection in the corridor system and in all sleeping rooms that is monitored for automatic fire department notification. The facility has a capacity of 93 beds and had a census of 64 at the time of the survey. The requirements at 42 CFR Subpart 483.70(a) are NOT MET. K 132 Multiple Occupancies - Contiguous Non-Health K 132 10/7/20 SS=D CFR(s): NFPA 101 Multiple Occupancies - Contiguous Non-Health Care Occupancies Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than 2-hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1

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(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

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(X3) DATE SURVEY

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(X2) MULTIPLE CONSTRUCTION

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245495 B. WING 09/02/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 THE EMERALDS AT GRAND RAPIDS LLC **GRAND RAPIDS, MN 55744** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 353 Continued From page 5 K 353 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 Based on observations and staff interview, the K353 automatic sprinkler system is not installed and 1. Wing 3 storage room sprinkler head maintained in accordance with NFPA 13 the with corrosion on the actuator and plug Standard for the Installation of Sprinkler Systems was replaced. Fast response sprinkler 2010 edition. The failure to maintain the sprinkler heads will be inspected onsite. system in compliance with NFPA 13 (10) could 9/30/2020 allow system being place out of service causing a 3. Maintenance Director decrease in the fire protection system capability in the event of an emergency that could affect 93 of 93 residents. Findings include: 1. On 09/02/2020, at 11:41 a.m., during the facility tour observations revealed that in the wing 3 storage room the sprinkler head had corrosion on the actuator and plug. 2. On 09/02/2020, at 12:06 a.m., during the facility tour observations revealed that the facility has 20 year old fast response sprinkler heads with a manufacture date of 2000 which the facility did not have a representative sample tested or replaced at the time of the inspection. This deficient condition was confirmed by a Maintenance Supervisor. K 363 Corridor - Doors K 363 10/7/20 CFR(s): NFPA 101 SS=E

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(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

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(X3) DATE SURVEY

AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245495 B. WING 09/02/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 THE EMERALDS AT GRAND RAPIDS LLC **GRAND RAPIDS, MN 55744** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 363 | Continued From page 7 K 363 This REQUIREMENT is not met as evidenced Based on observation and interview, the facility K363 had a corridor door that did not meet the 1. Latches for closet doors were requirements of NFPA 101 "The Life Safety replaced so that they positively latch into Code" 2012 edition, section 19.3.6.3. This the frame. deficient practice could affect 30 of 93 residents. 9/11/20 2. 3 Maintenance Director Findings include: On 09/02/2020, at 11:49 a.m., during the facility tour observations revealed that the storage closets located in the 300 wing corridor by resident room 310 and in the 400 wing corridor by resident room 406 have double doors that do not positively latch into the frame. This deficient condition was confirmed by a Maintenance Supervisor. K 712 Fire Drills K 712 10/7/20 CFR(s): NFPA 101 SS=F 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:

(X2) MULTIPLE CONSTRUCTION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	2) MULTIPLE CONSTRUCTION BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVE COMPLETED		
		245495	B. WING			09/0	02/2020	
	PROVIDER OR SUPPLIER ERALDS AT GRAND I	RAPIDS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 712	Based on review of interview, it was de to conduct several the NFPA 101 "The edition (LSC) section	of reports, records and staff etermined that the facility failed fire drills in accordance with a Life Safety Code" 2012 on 19.7.1.6, during the last his deficient practice could	K 7	712	K712 1. The facility is now sending a fire signal during fire drills to the monitor company. 2. 9/30/2020 3. Maintenance Director	drills to the monitoring		
	all available fire dri with the Maintenan that the facility did during the fire drills 6 of 12 fire drills.	10:15 a.m., during the review of II documentation and interview ce Supervisor it was revealed not send a fire alarm signal to the monitoring company for lition was confirmed by a						
K 911 SS=E	Maintenance Supe Electrical Systems CFR(s): NFPA 101 Electrical Systems List in the REMARI Chapter 6 Electrica are not addressed are deficient. This is applicable Life Saficitation, should be Chapter 6 (NFPA 9	rvisor Other - Other KS section any NFPA 99 al Systems requirements that by the provided K-Tags, but information, along with the ety Code or NFPA standard included on Form CMS-2567.	K	911			10/7/20	
	Based on observa the facility had mul affecting the facility	tion and interview with the staff tiple deficient conditions y's electrical system that were with the NFPA 101 "The Life			K911 1. The electrical panel labeled L3 electrical breakers are.now labeled. cover was replaced on the electrical			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245495 B. WING 09/02/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 THE EMERALDS AT GRAND RAPIDS LLC **GRAND RAPIDS, MN 55744** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 911 Continued From page 9 K 911 Safety Code" 2012 edition, NFPA 70 "National junction box located in the wing 2 Electrical Code" 1999 edition, and the NFPA 99 medication room. "Health Care Facilities Code" 2012 edition. This 9/24/2020 deficient practice could affect 28 of 93 residents. Maintenance Director Findings include: 1. On 09/02/2020 at 1208 a.m., during the facility tour observations revealed that the electrical panel labeled L3 did not have the electrical breakers labeled. following 2. On 09/02/2020 at 12:20 a.m., during the facility tour observations revealed that the electrical junction box located in the wing 2 medication room was missing exposing wires. The cover was replaced at the time of the inspection. This deficient condition was verified by the Maintenance Supervisor. K 920 | Electrical Equipment - Power Cords and Extens K 920 10/7/20 CFR(s): NFPA 101 SS=B Electrical Equipment - Power Cords and **Extension Cords** Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for

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