



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 10, 2023

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

RE: CCN: 245368
Cycle Start Date: April 28, 2023

Dear Administrator:

On April 28, 2023, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On April 19, 2023, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

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 listed below to the CMS Region V Office for imposition:

- 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

Grand Village

May 10, 2023

Page 2

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 \$11,292; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 28, 2023. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Grand Village is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective NO DATA. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Grand Village

May 10, 2023

Page 4

are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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.

Feel free to contact me if you have questions.

Sincerely,



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

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

PRINTED: 05/10/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245368	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/28/2023
NAME OF PROVIDER OR SUPPLIER GRAND VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS On 4/28/23, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed: H53681493C (MN92800) and a deficiency was issued at F689 at PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000	Past noncompliance: no plan of correction required.		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate supervision when staff did not appropriately respond to a sounding exit door alarm for 1 of 3 residents (R1) identified at risk for elopement, who was able to exit the building, despite WanderGuard alarming, resulting in R1 being outside the facility without	F 689	Past noncompliance: no plan of correction required.		

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

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

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

PRINTED: 05/10/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245368	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/28/2023
NAME OF PROVIDER OR SUPPLIER GRAND VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page 1 staff knowledge. This resulted in an immediate jeopardy (IJ). The immediate jeopardy began on 4/16/23, at approximately 3:00 a.m. when R1 was found outside the facility banging on the entrance door near the unit he resided on. The IJ was identified on 4/28/23, and the administrator was notified of the IJ on 4/28/23, at 5:45 p.m. The immediate jeopardy was removed on 4/19/23, and the deficient practice was corrected prior to the start of the survey and was therefore issued at past noncompliance. Findings include: R1's Admission Record indicated admission date of 1/20/20, with diagnosis that included: vascular dementia, epilepsy, muscle weakness and a history of falls. R1's significant change Minimum Data Set (MDS) dated 4/5/23, identified severe cognitive impairment and indicated he did not display wandering behaviors during the assessment period. The MDS indicated R1 required extensive assistance from two staff to transfer and indicated he required extensive assistance for locomotion off the unit. R1's care plan updated 4/19/23, identified a risk for elopement related to impaired safety awareness and diagnosis of severe cognitive impairment related to a traumatic brain injury. Additionally, the care plan indicated areas of vulnerability to include: mobility limitation, poor orientation to time, person and place, memory loss and a history of falls.	F 689			

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

PRINTED: 05/10/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245368	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/28/2023
NAME OF PROVIDER OR SUPPLIER GRAND VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page 2 R1's facility Progress Notes dated April 2023 identified the following: -4/9/23, at 2:19 p.m. R1 was described as pleasant, anxious and exit seeking. -4/9/23, at 9:50 p.m. R1 repeatedly wanted to know when the bus was coming and left his coat on all shift. -4/10/23, 9:51 p.m. R1 exited his room asking staff to grab his coat. R1 stated he had a friend coming to pick him up to take him to work. Staff attempted to re-orient R1 to time and that he did not need to go to work but R1 persisted that he needed his coat and propelled himself around the unit. -4/12/23, 7:07 a.m. R1 had no behaviors on shift but had his coat on and was waiting for the bus to come. -4/13/23, 9:00 p.m. R1 was exit seeking and wandering. -4/14/23, 4:00 a.m. R1 was confused and restless, would put his coat on, self transfer into wheelchair and come to the nurse's station stating he was ready to go. -4/15/23, 10:33 p.m. R1 had been wandering and kept thinking someone was coming to get him to take him to the VFW. R1 slept on the couch in the day area and refused to go to bed. -4/16/23, 4:38 a.m. Writer had been alerted by another nurse that R1 had been brought in from outside after he was found banging on the side door of the "Woods" community. PN indicated,	F 689			

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

PRINTED: 05/10/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245368	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/28/2023
NAME OF PROVIDER OR SUPPLIER GRAND VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page 3 R1 stated a car had pulled up then took off as he attempted to get in. R1 stated he had been heading to work. R1 was asked if had had fallen and he stated he and his wheelchair had tipped forward which was why the knees of his pants were muddy. -4/16/23, 5:02 a.m. Writer was notified R1 was found outside the doors of the unit at 3:00 a.m. with mud on both pant legs. R1 had a history of wandering and a history of falls. 15 minute checks were initiated. An undated, untitled document indicated interviews were conducted with staff who worked on 4/15/23, who indicated there had been nothing out of the ordinary about R1's day, demeanor or behavior. Nursing assistant (NA)-A and NA-B stated R1 came out of his room after supper wearing his jacket and stated he was "waiting for the guys to pick me up for work." NA-A stated it was common for R1 to wear his coat and said R1 had been making comments for several weeks about waiting to be picked up for work. NA-B stated R1 used to say that "sometimes" but had been making that statement every shift for several weeks. Both NAs denied any exit seeking by R1 that shift and said he was asleep on the couch at the end of the shift at 10:30 p.m. NA-C stated he was working when R1 eloped from the facility and said he had assisted R1 to bed around midnight. NA-C stated he had last seen R1 during a routine safety check between 1:45 a.m. and 2:00 a.m. Licensed practical nurse (LPN)-A stated between 2:45 a.m. and 3:00 a.m. on 4/16/23, she was going to assist a NA with cares and heard the main entrance door alarm sounding. LPN-A said she went to the front door and did not see anyone so she turned the alarm	F 689			

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

PRINTED: 05/10/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245368	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/28/2023
NAME OF PROVIDER OR SUPPLIER GRAND VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page 4 off and went back to the unit to assist the NA. LPN-A stated after she exited the resident's room, another resident was standing in the hallway saying she could hear someone. LPN-A said she went into the resident's room but said she could not hear anything and left the room. LPN-A said the resident began yelling and when asked why she was yelling stated, "in case they can hear me." As LPN-A left the room she could hear someone and indicated it sounded like it was coming from down the hall. A NA went to look and at that time LPN-A saw R1 sitting outside the door. When R1 saw LPN-A he began banging on the door and yelling "help me." R1 told LPN-A a car pulled up and then left without him. LPN-A stated she had not seen any vehicles when the alarm sounded or when she found R1 outside. LPN-A said R1 was wearing his winter coat, shoes and a baseball cap. R1 was noted to have mud on his knees but denied falling and stated his wheel chair had tipped forward but he caught himself. The temperature outside was 37 degrees Fahrenheit and R1 had been outside for approximately 10 - 15 minutes. During interview on 4/28/23, at 2:29 p.m. R1 was laying in bed in his room. R1 said he used to work for his cousins on the farm bailing hay and was up at 4:00 in the morning. R1 said he had been at the facility for 10 years or more. When asked about going outside on the night of the 16th, R1 said he had to go outside in his wheel chair. R1 said, "If I get to places, I know how to get around and stuff. If I had to do it again I would probably do it." On 4/28/23, at 2:43 p.m. NA-D stated the reason R1 moved to his current unit two years ago was because of attempts to leave the facility and said	F 689			

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

PRINTED: 05/10/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245368	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/28/2023
NAME OF PROVIDER OR SUPPLIER GRAND VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page 5 back then he had found R1 outside and R1 thought he was meeting a police officer. NA-D stated he was aware R1 had gotten outside again on the 16th and said education and elopement drills had been done after the incident. On 4/28/23, at 3:16 p.m. the administrator stated when LPN-A was interviewed she said she had looked outside and did not see anyone so she silenced the alarm The administrator stated LPN-A had not followed the procedure for a missing resident. The administrator said elopement training had been conducted on 4/6/23, following the closure of the secured unit and said that LPN-A had reviewed the policy and procedure at that time and was re-educated following the incident on 4/16/23. On 4/28/22, at 4:22 p.m. LPN-B stated if an alarm sounded she would go outside and check to see if anyone was there. LPN-B stated she would then call and alert all of the units, check rooms and locations and notify a supervisor. On 4/28/23, at 4:23 p.m. NA-E and dining assistant (DA)-A stated they had received education following the incident on 4/16/23, and said if an alarm sounded indicating a resident had gotten outside they would alert everyone and do a head count. Facility document titled, Missing Resident, Elopement and Wandering Residents dated 4/6/23, indicated if a door alarms and you respond but do not see a resident who would have caused the alarm, initiate a missing resident drill to confirm the whereabouts of each resident. Facility policy Emergency Procedure-Missing	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245368	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/28/2023
NAME OF PROVIDER OR SUPPLIER GRAND VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page 6 Resident dated August 2018, indicated resident elopement resulting in a missing resident was considered a facility emergency. The policy identified the missing resident procedure and directed staff to: Announce missing resident with room number, note the time missing, report to the nursing station to see if signed out and conduct a thorough search for the resident. The past noncompliance immediate jeopardy began on 4/16/23. The immediate jeopardy was removed, and the deficient practice corrected by 4/19/23, after the facility implemented a systemic plan that included the following actions: - R1 was immediately placed on 15 minute checks. - Elopement training on 4/16/23, to include review of the policy and procedure and the implementation of "wander books" (books that contained a picture of all residents assessed at risk for elopement). - Elopement drills performed each shift then daily on 4/17/23 - 4/20/23. - Interdisciplinary team met on 4/19/23, to review and updated care plan interventions to include: increased 1:1 visits, sitting in common area after dinner to increase socialization and improve sleep schedule and removing items from room that act as visual cues for exit seeking behaviors such as work boots and fishing pole. A sign was also placed in R1's room that said congratulations on your retirement. Other interventions included a medication review and referral to neurology.	F 689			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

May 10, 2023

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

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: BGMO11

Dear Administrator:

The above facility survey was completed on April 28, 2023 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56.

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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.

Feel free to contact me with any questions related to this letter.

Sincerely,

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

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/28/2023
NAME OF PROVIDER OR SUPPLIER GRAND VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/28/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during the survey. H53681493C (MN92800)	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/28/2023
NAME OF PROVIDER OR SUPPLIER GRAND VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Continued From page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000			