

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 13, 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 informed you of imposed enforcement remedies.

On September 24, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey/revisit findings:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 24, 2020, will remain in effect.

This Department continues to recommend that CMS impose a 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.

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.

As we notified you in our letter of September 24, 2020, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 24, 2020.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth District Office
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 December 4, 2020 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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/ 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 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,

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

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 10/28/2020 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDII	NG	COV	MPLETED
						С
		245495	B. WING_		09/	/24/2020
	PROVIDER OR SUPPLIER ERALDS AT GRAND R	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	TS .	F 00	00		
	standard survey wa conduct a complain was found not to be	h 9/24/20, an abbreviated as completed at your facility to at investigation. Your facility in compliance with 42 CFR tents for Long Term Care				
	The following comp substantiated: H5495085C H5495086C H5495087C	laints were found to be				
	The following comp unsubstantiated: H5495084C	laint was found to be				
	as your allegation on Department's accept enrolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are four signature is not required of first page of the CMS-2567 of compliance.				
F 580	on-site revisit of you validate that substa regulations has bee your verification. Notify of Changes (acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with Injury/Decline/Room, etc.)	F 58	80		10/30/20
SS=D	(i) A facility must im	14)(i)-(iv)(15) ification of Changes. mediately inform the resident; ident's physician; and notify,				
		ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE
Electron	ically Signed					10/23/2020

(X2) MULTIPLE CONSTRUCTION

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	TIPLE CONSTRUCTION NG) ´COM	(X3) DATE SURVEY COMPLETED	
		245495	B. WING			C / 24/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY 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 E APPROPRIATE	(X5) COMPLETION DATE
F 580	consistent with his representative(s) (A) An accident invresults in injury an physician intervent (B) A significant characterioration in he status in either life clinical complication (C) A need to alter a need to disconting treatment due to a commence a new (D) A decision to the resident from the flags (3, 15(c)(1)(ii). (ii) When making (14)(i) of this sectionall pertinent inform is available and prophysician. (iii) The facility muresident and the rewhen there is-(A) A change in roas specified in §48 (B) A change in restate law or regulate (e)(10) of this section (iv) The facility muresident and the address phone number of the representative(s).	or her authority, the resident when there is- volving the resident which d has the potential for requiring tion; nange in the resident's physical, social status (that is, a alth, mental, or psychosocial-threatening conditions or ons); treatment significantly (that is, nue an existing form of dverse consequences, or to form of treatment); or ransfer or discharge the facility as specified in notification under paragraph (g) on, the facility must ensure that eation specified in §483.15(c)(2) ovided upon request to the esident representative, if any, om or roommate assignment 83.10(e)(6); or sident rights under Federal or ations as specified in paragraph ion. st record and periodically is (mailing and email) and	F 5	80		

	24/2020
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 (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580 Continued From page 2 §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to clarify physician orders for the frequency of use of a protective helmet for 1 of 1 resident (R1) who required the use of a protective helmet. Findings include: Findings include: Findings include: Findings include: R1 was admitted to facility on 9/9/20. R1's hospital discharge summary dated 9/9/20, indicated R1's diagnoses included left middle cerebral artery (MCA) ischemic stroke, cerebral edema and herniation, status post left hemicraniotomy, and sinking skin flap syndrome. R1 was admitted with a helmet, but the 9/9/20, hospital Interagency Transfer Form and Neurology Stroke Discharge Summary lacked orders for use of a helmet and frequency of use. R1's admission Minimum Data Set (MDS) dated 9/15/20, indicated R1 had diagnoses which included cerebrovascular accident (CVA). R1's care plan dated 9/15/20, lacked direction for use of a helmet and frequency of use. R1's undated pocket care plan lacked direction if R1 wore a helmet.	

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F 580	Continued From pa	age 3	F 58	0		
	flap to left side, to vor laying in bed on shift.	esident did not have a bone wear a helmet when out of bed left side, and to check every 06 a.m. registered nurse		All nurses were re-educate educated on timely clarification from the detailed and getting clarification if numbers of timely by the resident's pro-	ntion of orders m Medical ot addressed	
	(RN)-A stated there addressed wearing admitted. RN-A sta R1 should wear the	e was not an order that the helmet when R1 was ted she had determined that helmet that was sent with him		Date of Compliance: 10/30		
	RN-A stated she pr where she cared for knew that the helm RN-A stated the ho were entered into to instructions for weat the hospital dischar regarding R1 wear	side and when out of bed. reviously worked at a hospital or patients like R1, so she let was supposed to be on. ospital discharge orders that he computer did not include aring the helmet. RN-A stated rge orders lacked direction ing the helmet. RN-A stated		Reoccurrence will be prevered of 5 residents orders will be weekly x 4 weeks then more to assure orders are clear as is made if needed. The restaudits will be shared with the committee for input on the increase, decrease, or discaudits.	e conducted hthly x2 months and clarification sults of these he facility QAPI need to	
	On 9/11/20, R1's president was found and was unable to	rogress notes indicated I on the floor next to his bed, answer appropriately if he had as transferred via ambulance		Corrections will be monitored DON/Nurse Managers/Des		
	directed staff to en	ED After Visit Summary (AVS) sure resident was wearing his of the from neurosurgery and				
		n 9/18/20, R1's progress notes would not leave his helmet on.				
	Committee Notes i	lisciplinary Team (IDT) ndicated R1 had a craniotomy oved, refused to wear his				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	CON	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP CO 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		_
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F 580	benefit. On 9/23/20, during 10:54 a.m. through through 2:50 p.m., 4:00 p.m., R1 was helmet. On 9/24/20, during 8:10 a.m. through 1 not wearing a helm On 9/24/20: -at 10:21 a.m., licer stated R1's instruct were listed on the t (TAR) with a start of staff still followed the been current since -at 11:35 a.m., RN-9/12/20, directed staff helmet per protoc rehab. RN-A stated know what the neur wearing the helmet attempt to clarify R instructed staff regard use for R1's helmoursing experience -at 2:45 p.m., R1's R1 was to wear a hoften he should we wore it all the time in the state of the should we wore it all the time in the should we w	continuous observation from 12:45 p.m., from 2:15 p.m. and from 3:06 p.m. through observed not wearing a continuous observation from 10:38 a.m., R1 was observed et. Insed practical nurse (LPN)-A ions for wearing a helmet reatment administration record late of 9/9/20. LPN-A stated lose orders, and they have admission. A stated R1's ER visit on laff to ensure R1 was wearing col from neurosurgery and lupon R1's return, she did not rosurgery protocol was for larding the use and frequency net from her own personal and not from doctors' orders. family member (FM)-A stated elmet, but was uncertain how ar it. FM-A thought he probably because R1 messes with it, le didn't have it on, then R1	F 58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245495	B. WING		C 09/24/2020
	PROVIDER OR SUPPLIER	RAPIDS LLC	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	, , , , , , , , , , , , , , , , , , , ,
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F 689 SS=D	R1 was admitted or The DON stated R clarify when he sho stated R1 was sent instructions directed directed by neurosci-3:52 p.m., the DOI nurses to notify the wearing his helmet expected nurses to A policy on clarifical requested but was	rector of nurses (DON) stated in 9/9/20, from the hospital. It's discharge instructions not uld wear his helmet. The DON to ER and upon return, it is is in the last argery and rehab protocol. It is stated she would expect physician if R1 was not. The DON stated she clarify orders immediately. It is in of physician orders was not provided.	F 580		10/30/20
	as free of accident §483.25(d)(2)Each supervision and as accidents. This REQUIREMED by: Based on observative review, the facility finterventions to mir residents (R3) review. Findings include: R3's admission Mir 6/30/20, indicated F	resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced ion, interview, and document ailed to implement imize the risk of falls for 1 of 3		F689: Free of Accidents Hazards/Supervision/Devices Immediate Corrective Action: R3 fall risk assessment completed now fall mat was discontinued.	and

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	СОМ	E SURVEY PLETED
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F 689	Continued From p	age 6	F 6	89			
	diagnoses include orthopedic afterca amputation, acquir	d malnutrition, encounter for re following surgical red absence of right leg above			Action as it Applies to Others:		
	deficiency which p and central nervou	ess caused by thiamine rimarily affects the peripheral is system) and cerebellar			Managing Falls & Fall Risk Polic reviewed and remains current.	y was	
	balance, gait, extruments of two assistance of two required extensive bed mobility and to	of an inability to coordinate emity and eye movements). icated R3 required total persons for transfer, and assistance of one person for bilet use. The MDS indicated thout injury since admission.		i	All residents were reviewed for fainterventions and have appropria interventions in place. These inte are reflected on NAR pocket can for each resident's individualized	ite erventions e guide	
	7/10/20, indicated stabilize with staff had experienced a	ea Assessment (CAA) dated R3 was not steady/only able to assistance with transitions, and a fall since admission. R3's risk apaired mobility relate to			All nursing staff educated on follocare plans and pocket care plans interventions		
	deconditioning and abuse, malnutrition	d weakness secondary alcohol n, Wernicke's encephalopathy,			Date of Compliance: 10/30/2020		
	above knee ampu interventions to ind while in bed, whee assist with all trans	cognitive impairment, and right tation. The CAA identified fall clude call light within reach elchair for locomotion, staff to sitions, low bed, and concave the edges of the bed.			Reoccurrence will be prevented Observation audit of 5 residents fall interventions in place weekly weeks then monthly x2 months. results of these audits will be shathe facility QAPI committee for in	to ensure x 4 The ared with	
	fall risk related to i deconditioning an	ed 7/21/20, indicated R3 had a mpaired mobility related to weakness secondary to alcoholn, Wernicke's encephalopathy,		1	the need to increase, decrease, discontinue the audits.		
	cerebellar ataxia, above knee ampu care plan directed brakes, call light w mat placed next to	tation and history of falls. The staff R3 required anti-lock rithin reach while in bed, fall bed, wheelchair for sesistance with all transition, low			Corrections will be monitored by: DON/Nurse Managers/Designee		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED C	
		245495	B. WING _		1	/24/2020
	PROVIDER OR SUPPLIER	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP CODI 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 APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	bed and concave in the bed. Review of R3's me 9/10/20, revealed in without injury: -On 6/25/20, R3 was bedside. The IDT in his bedOn 8/11/20, R3 was bedside. The IDT deter attempting to get u a new intervention for all mealsOn 9/4/20, R3 was from his wheelchair out of the wheelchair working order. R3 wheelchairOn 9/10/20, R3 was from his wheelchairOn 9/10/20, R3 was from his wheelchairOn 9/10/20, R3 was from his wheelchair. On 9/23/20, at 2:31 turned on his right door. A concave merimeter was note a low position and the wall. The wheel middle of the room	age 7 nattress to define the edges of dical record from 6/25/20, to ne experienced five falls as found on the floor after a nterdisciplinary team (IDT) neave mattress and low bed is found on the floor at his implemented a fall mat next to as found on the floor next to his imined R3 had been p for supper, and implemented to get R3 up in a wheelchair is found on the floor after a fall ir. The IDT determined R3 slid air and the brakes were not in was provided a new as found on the floor after a fall ir. The IDT determined R3 self is wheelchair slipped away from the was were applied to the I p.m. R3 was observed in bed side facing away from the nattress with a defined and on the bed. The bed was in positioned lengthwise against elchair was positioned in the and not directly next to the as observed on the floor next	F 68	39		

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C		
		245495	B. WING _		09	/24/2020		
	PROVIDER OR SUPPLIEF			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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 689	-At 3:32 p.m. R3 v had been at the famonth. R3 verifier from bed, and statinto the wheelchaithe chair moved. to have an anti-rol mat was observedAt 3:43 p.m. nurs required the use of When asked if R3 stated, "I don't bel R3's fall intervention pocket care plan, obtain one. NA-As were printed/availar R3 required a con lowest position. Nafall mat in use and over here anywayAt 8:44 a.m. NAfalling, and stated the floor next to hid had been saked her to clarify informed LPN-B the on the pocket care transferred from a mat did get put on plan. LPN-B verification. LPN-B verification. In the position of the position o	vas interviewed. R3 stated he cility for approximately one d he had experienced a fall ted he had been trying to get r but the brakes weren't on, and R3's wheelchair was observed lback device attached. No fall I on the floor next to R3's bed. ing assistant (NA)-A stated R3 of a mechanical lift for transfers. was at risk for falls, NA-A stated ons would be located on the and walked to the desk to stated no pocket care plans able at that time. NA-A stated cave mattress, and his bed in A-A verified R3 did not have a I stated, "Not since he's been." B stated R3 was a risk for he was to have a fall mat on s bed when in bed. -B provided a pocket care plan verified the sheet did not	F 68	9				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245495	B. WING			C / 24/2020
	PROVIDER OR SUPPLIER	RAPIDS LLC		STREET ADDRESS, CITY, STATE, 2 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	ZIP CODE	12412020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 689	been doing well, an bed since his transf going to discontinue On 9/24/20, at 3:44 (DON) verified R3 h another unit in the f fall mat was not ide for R3. The DON st planned for R3's us place when in bed. use should have be necessity, prior to do The facility Falls-Cli 3/18, directed base and physician will into try to prevent subthe risks of clinically falling. The policy a had been successfi will continue with cut	d had not had any falls from fer to the new unit, so she was at the fall mat today. p.m. the director of nursing had recently transferred from facility. The DON verified the ntified on the pocket care plan hated if the fall mat was care e, he should have had it in The DON stated R3's fall mat her reassessed to determine hiscontinuing its use. Inical Protocol policy revised d on assessment, the staff dentify pertinent interventions be sequent falls and to address by significant consequences of also indicated if interventions all in fall prevention, the staff the physician whether	F6	89		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 13, 2020

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

Re: State Nursing Home Licensing Orders

Event ID: SODK11

Dear Administrator:

The above facility was surveyed on September 23, 2020 through September 24, 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.

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 District Office
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 IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SU COMPLE					
		00299		B. WING			2 4/2020
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EME	ERALDS AT GRAND R	APIDS LLC		JTH HIGHWA RAPIDS, MN			
(X4) ID		TEMENT OF DEFICIEN	ICIES	ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX TAG		MUST BE PRECEDED SC IDENTIFYING INFO		PREFIX TAG	(EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETE DATE
2 000	Initial Comments			2 000			
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION C	RDER				
	In accordance with 144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall with a schedule of the Minnesota Depart	ction order has be y. If, upon reinsp iency or deficienc ected, a fine for ea be assessed in ac ines promulgated	een issued ection, it is eles cited ach violation ecordance I by rule of				
	Determination of whe corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated du corrected.	compliance with a rule provided at a rule provided at a rule number indicans several items, the items will be compliany item of multi-perent of a fine ever	all the tag ted below. failure to considered nce upon eart rule will en if the item				
	You may request a that may result from orders provided that the Department with notice of assessme	n non-compliance t a written reques nin 15 days of rec	with these it is made to eipt of a				
	INITIAL COMMENT On 9/23/20, through survey was conduct with State Licensure be not in compliance	n 9/24/20, an abb ted to determine o e. Your facility wa	compliance as found to				
	The following comp substantiated:	laints were found	to be				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 10/23/20

STATE FORM 6899 If continuation sheet 1 of 12 SODK11

TITLE

(X6) DATE

Minnesota Department of Health

STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
		00299	B. WING		09/2	; 4/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EME	RALDS AT GRAND F	PAPINS 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 APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	H5495085C H5495086C H5495087C					
	The following compunsubstantiated: H5495084C	laint was found to be				
	signature is not req page of starte form correction is require	ed in ePOC and therefore a uired at the bottom of the first. Although no plan of ed, it is required that the facility of the electronic documents.				
2 830	MN Rule 4658.0520 Proper Nursing Car	C) Subp. 1 Adequate and See; General	2 830			10/30/20
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in 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 bed.				
	by: Based on observati review, the facility for	nimize the risk of falls for 1 of 3		F689: Free of Accidents Hazards/Supervision/Devices Immediate Corrective Action:		

Minnesota Department of Health

STATE FORM SODK11 If continuation sheet 2 of 12

Minnesota Department of Health

MILLIFER	ota Department of He	alli			,	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>	COMPLETED	
					С	
	00299 B. V		B. WING		09/24/2020	
00299					09/2	4/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
		2801 SOL	TH HIGHWA	Y 169		
THE EM	ERALDS AT GRAND F	PAPINS LLC:	APIDS, MN			
			1			
(X4) ID		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIES		DATE
1710		,	1710	DEFICIENCY)		
2 830	Continued From pa	ge 2	2 830			
	Findings include:					
	i ilidiliga ilicidde.					
	P3's admission Min	nimum Data Set (MDS) dated		R3 fall risk assessment completed	land	
		R3 had severe cognitive		now fall mat was discontinued.	anu	
		DS further indicated R3's		now fall that was discontinued.		
	•					
		malnutrition, encounter for		Action as it Applies to Others		
	orthopedic aftercard			Action as it Applies to Others:		
		ed absence of right leg above				
	knee, Wernicke's encephalopathy (a life-threatening illness caused by thiamine			Managing Follo & Foll Dick Policy was		
				Managing Falls & Fall Risk Policy	was	
		imarily affects the peripheral		reviewed and remains current.		
		s system) and cerebellar				
		of an inability to coordinate				
		mity and eye movements).		All residents were reviewed for fall		
		cated R3 required total		interventions and have appropriate		
		ersons for transfer, and		interventions in place. These inter-		
		assistance of one person for		are reflected on NAR pocket care		
		ilet use. The MDS indicated		for each resident's individualized r	eeds.	
	R3 had one fall with	nout injury since admission.				
		a Assessment (CAA) dated		All nursing staff educated on follow		
		R3 was not steady/only able to		care plans and pocket care plans	for fall	
		ssistance with transitions, and		interventions		
		fall since admission. R3's risk				
		paired mobility relate to				
		weakness secondary alcohol		Date of Compliance: 10/30/2020		
	T	, Wernicke's encephalopathy,				
		ognitive impairment, and right				
		ation. The CAA identified fall		Reoccurrence will be prevented by		
	interventions to incl	ude call light within reach		Observation audit of 5 residents to	ensure	
	while in bed, wheel	chair for locomotion, staff to		fall interventions in place weekly x	4	
	assist with all transi	itions, low bed, and concave		weeks then monthly x2 months. The	he	
	mattress to define t	he edges of the bed.		results of these audits will be share	ed with	
		-		the facility QAPI committee for inp	ut on	
	R3's care plan date	ed 7/21/20, indicated R3 had a		the need to increase, decrease, or		
		npaired mobility related to		discontinue the audits.		
		veakness secondary to alcohol				
		, Wernicke's encephalopathy,				
		ognitive impairment, right		Corrections will be monitored by:		
		ation and history of falls. The		DON/Nurse Managers/Designee		

Minnesota Department of Health

STATE FORM SODK11 If continuation sheet 3 of 12

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
,			A. BUILDING:				
00299		B. WING		09/2	: 4/2020		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE EMERALDS AT GRAND RAPIDS LLC			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 CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
2 830	Continued From pa	nge 3	2 830				
	brakes, call light wit mat placed next to locomotion, staff as bed and concave m the bed.	ssistance with all transition, low nattress to define the edges of					
		dical record from 6/25/20, to be experienced five falls					
	•						
	turned on his right s door. A concave m perimeter was note a low position and p the wall. The whee	p.m. R3 was observed in bed side facing away from the nattress with a defined of on the bed. The bed was in positioned lengthwise against elchair was positioned in the and not directly next to the					

Minnesota Department of Health

STATE FORM SODK11 If continuation sheet 4 of 12

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
						С
		00299	B. WING		09/2	24/2020
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE EM	ERALDS AT GRAND F	PAPIDS LLC:	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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 4	2 830			
	bed. No fall mat wat to the bed.	as observed on the floor next				
	had been at the face month. R3 verified from bed, and state into the wheelchair the chair moved. R to have an anti-roll mat was observed -At 3:43 p.m. nursir required the use of When asked if R3 v stated, "I don't belie R3's fall intervention pocket care plan, a obtain one. NA-A st were printed/availal R3 required a conclowest position. NA	as interviewed. R3 stated he dility for approximately one he had experienced a fall and he had been trying to get but the brakes weren't on, and as's wheelchair was observed back device attached. No fall on the floor next to R3's bed. In a assistant (NA)-A stated R3 a mechanical lift for transfers. In was at risk for falls, NA-A eve so, maybe." NA-A stated his would be located on the hid walked to the desk to stated no pocket care plans ble at that time. NA-A stated ave mattress, and his bed in -A verified R3 did not have a stated, "Not since he's been				
		B stated R3 was a risk for ne was to have a fall mat on bed when in bed.				
		B provided a pocket care plan erified the sheet did not d a fall mat.				
	practical nurse care asked her to clarify informed LPN-B the on the pocket care transferred from an	B approached licensed e coordinator (LPN)-B and R3's use of a fall mat. NA-B e fall mat intervention was not plan. LPN-B stated R3 had other unit, and verified the fall the new unit's pocket care				

Minnesota Department of Health

STATE FORM SODK11 If continuation sheet 5 of 12

	ota Department of He						
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	NO FEAN OF CONNECTION		A. BUILDING:		COMPLETED		
						С	
		00299		B. WING		09/2	24/2020
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			2801 SOU	TH HIGHWA	Y 169		
IHE EMI	ERALDS AT GRAND F	RAPIDS LLC	GRAND R	APIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI / MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 5		2 830			
	plan. LPN-B verified the NAs should have been using a fall mat for R3. LPN-B stated R3 had been doing well, and had not had any falls from bed since his transfer to the new unit, so she was going to discontinue the fall mat today.						
	(DON) verified R3 h another unit in the f fall mat was not ide for R3. The DON st planned for R3's us	entified on the pocked tated if the fall mat we se, he should have he The DON stated Ra een reassessed to d	rred from erified the et care plan was care nad it in 3's fall mat etermine				
	and physician will ic to try to prevent sub the risks of clinically falling. The policy a had been successful	d on assessment, the dentify pertinent interpretent falls and to see y significant consequalso indicated if interpretent approaches a with the physician to	he staff erventions o address uences of erventions the staff and will				
	SUGGESTED MET director of nursing of and/or revise policion implementation of i Education could be quality assurance of system to monitor to	or designee could re es and procedures r nterventions followin provided to the state committee could dev	eview related to ng a fall. ff. The relop a				
	TIME PERIOD OF	CORRECTION: Tw	enty-one				

6899

Minnesota Department of Health

	ND DLAN OF CORRECTION INDENTIFICATION NUMBER		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ANDILAN			A. BUILDING:			OOMI LETED	
00299		B. WING		C 09/24/2020			
00299					03/2	4/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE EME	ERALDS AT GRAND F	RAPIDS LLC	TH HIGHWA				
		GRAND R	APIDS, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
21830	Continued From pa	ge 6	21830				
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights		21830			10/30/20	
	Subd. 10. Participation in planning treatment; notification of family members.						
	notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in						
	admitted to the faci family member to p planning, unless the to believe the resid- directive to the con- specified in writing member included in notifying a family m family member to p planning, the facility	the resident has been lity. The facility shall allow the participate in treatment be facility knows or has reason ent has an effective advance trary or knows the resident has that they do not want a family in treatment planning. After tember but prior to allowing a participate in treatment by must make reasonable with reasonable medical					
	practice, to determi executed an advan esident's health car	ne if the resident has ce directive relative to the re decisions. For purposes of asonable efforts" include:					

Minnesota Department of Health

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT GRAND RAPIDS LLC (X4) ID PREFIX TAG COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21830 Continued From page 7 (1) examining the personal effects of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care; and edicetive and whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that		PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE	SURVEY LETED	
NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT GRAND RAPIDS LLC (X4) ID (X5) (X6) ID (X6)			A. BUILDING:				
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 TAG (I) examining the personal effects of the resident in the possession of the facility; (I) inquiring of any emergency contact or family member contacted under this section whether the resident has a physician to whom the resident normally goes for care; and (I) inquiring of the physician to whom the resident normally goes for care; and (I) inquiring of the physician to whom the resident normally goes for care; and the physician to whom the resident normally goes for care; and the physician to whom the resident normally goes for care; and the physician to whom the resident normally goes for care; and the physician to whom the resident normally goes for care; and the physician to whom the resident normally goes for care; and the physician to whom the resident normally goes for care; and the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that	00299		B. WING		_		
THE EMERALDS AT GRAND RAPIDS LLC 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21830 Continued From page 7 (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has a executed an advance directive and whether the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care; and (5) inquiring of the physician to whom the resident normally goes for care; and (6) inquiring of the physician to whom the resident normally goes for care; and (7) inquiring of the physician to whom the resident normally goes for care; and (8) inquiring of the physician to whom the resident normally goes for care; and (9) inquiring of the physician to whom the resident normally goes for care; and (10) inquiring of the physician to whom the resident normally goes for care; and (11) inquiring of the physician to whom the resident normally goes for care; and (12) inquiring of the physician to whom the resident normally goes for care; and (13) inquiring of the physician to whom the resident normally goes for care; and (14) inquiring of the physician to whom the resident normally goes for care; and (15) inquiring of the physician to whom the resident normally goes for care; and (16) inquiring of the physician to whom the resident normally goes for care; and (17) inquiring of the physician to whom the resident normally goes for care; and the physician to whom the resident normally goes for care; and the physician to whom the resident normally goes for care; and the physician to whom the residen					1 03/2	7/2020	
Cantinued From page 7 Cant	NAME OF PROVIDER OR SUPPLIER						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21830 Continued From page 7 (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that	THE EMERALDS AT GRAND RAPIDS	ISTIC:					
(1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that	PREFIX (EACH DEFICIENCY MUST	Γ BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE	
(1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that	21830 Continued From page 7		21830				
the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or	(1) examining the pers resident; (2) examining the med resident in the possession (3) inquiring of any emfamily member contacted whether the resident has directive and whether the physician to whom the recare; and (4) inquiring of the physician to member to participate in accordance with this paraliable to resident for damathe notification of the family member was impropatient's privacy rights. (c) In making reasonathe family member or designated examining the personal examining the personal examining the personal examining the personal examining the facility to notify a family member emergency contact within admission, the facility shall social service agency or lagency that the resident if the facility has been unabmember or designated examinated examining the personal examination, the facility shall social service agency or lagency that the resident if the facility has been unabmember or designated examination.	dical records of the on of the facility; nergency contact or d under this section is executed an advance is resident has a resident normally goes for a secuted an advance if it is a family member or contact or allows a family it is not agraph, the facility is not an individual in a secuted an advance if it is not a secuted an advance it is not advance if it is not a secuted an advance it is not advance it	21830				

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00299		B. WING		C 09/24/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EME	ERALDS AT GRAND R	PAPIDSTIC	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 APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21830	service agency or lot that assists a facility subdivision is not lia damages on the grothe family member participation of the or violated the paties	ncy contact. A county social ocal law enforcement agency in implementing this able to the resident for bunds that the notification of or emergency contact or the family member was improperent's privacy rights.	21830			
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to clarify physician orders for the frequency of use of a protective helmet for 1 of 1 resident (R1) who required the use of a protective helmet.			F580: Notification of Change Immediate Corrective Action:		
	hospital discharge sindicated R1's diagram cerebral artery (MC edema and herniati hemicraniotomy, ar R1 was admitted withospital Interagence	facility on 9/9/20. R1's summary dated 9/9/20, noses included left middle A) ischemic stroke, cerebral on, status post left d sinking skin flap syndrome. th a helmet, but the 9/9/20, y Transfer Form and discharge Summary lacked		Order for helmet use for R1 was of during video visit on 10/9/20. Atter were made to clarify order 9/25, 9/9/29. Nurse Manager R1 was educated timely clarification of orders and good clarification from Medical Director clarification if not addressed timely resident's provider.	npts /28, on etting for	
	R1's admission Min 9/15/20, indicated F impaired. The MDS which included cere	imum Data Set (MDS) dated R1 was severely cognitively indicated R1 had diagnoses ebrovascular accident (CVA).		Action as it Applies to Others: All resident medication and treatm orders were reviewed for clarity. A orders needing clarification were of	ny	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DAT COM			SURVEY .ETED	
			A. BUILDING.		С	
		_	4/2020			
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
THE EM	ERALDS AT GRAND R	PAPINS 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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21830	Continued From pa	ge 9	21830			
	R1's undated pockers.	et care plan lacked direction if		Medication & Treatment orders por reviewed and remained current.	olicy was	
	R1's 9/9/20 treatment administration record (TAR) directed staff that resident did not have a bone flap to left side, to wear a helmet when out of bed or laying in bed on left side, and to check every shift. On 9/24/20, at 11:06 a.m. registered nurse (RN)-A stated there was not an order that addressed wearing the helmet when R1 was admitted. RN-A stated she had determined that R1 should wear the helmet that was sent with him			All nurses were re-educated was on timely clarification of orders an clarification from Medical Director clarification if not addressed timely resident's provider.	d getting for	
				Date of Compliance: 10/30/20.		
R1 should wear the helmet that was sent with him when laying on left side and when out of bed. RN-A stated she previously worked at a hospital where she cared for patients like R1, so she knew that the helmet was supposed to be on. RN-A stated the hospital discharge orders that were entered into the computer did not include instructions for wearing the helmet. RN-A stated the hospital discharge orders lacked direction regarding R1 wearing the helmet. RN-A stated she did not call the doctor to clarify when or how often R1 should wear the helmet. On 9/11/20, R1's progress notes indicated resident was found on the floor next to his bed, and was unable to answer appropriately if he had hit his head. R1 was transferred via ambulance to the Emergency Department (ED).			Reoccurrence will be prevented by of 5 residents orders will be conducted weekly x 4 weeks then monthly x2 to assure orders are clear and clais made if needed. The results of audits will be shared with the facili committee for input on the need to increase, decrease, or discontinuous audits. Corrections will be monitored by:	rification these ity QAPI		
			DON/Nurse Managers/Designee			
	directed staff to ens	D After Visit Summary (AVS) sure resident was wearing his from neurosurgery and				
		9/18/20, R1's progress notes would not leave his helmet on.				

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		SURVEY PLETED	
7110 1 2711	.52		A. BUILDING:				
		00299	B. WING			C 2 4/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE			
THE EMI	ERALDS AT GRAND F	RAPINS LLC:	JTH HIGHWA RAPIDS, 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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
21830	Continued From pa	ige 10	21830				
	R1's 9/18/20 Interdiction Committee Notes in with bone flap removed.	isciplinary Team (IDT) ndicated R1 had a craniotomy oved, refused to wear his rould be doing a risk vs					
	10:54 a.m. through through 2:50 p.m.,	continuous observation from 12:45 p.m., from 2:15 p.m. and from 3:06 p.m. through observed not wearing a					
		continuous observation from l0:38 a.m., R1 was observed et.					
	stated R1's instruct were listed on the to (TAR) with a start d	nsed practical nurse (LPN)-A iions for wearing a helmet reatment administration record late of 9/9/20. LPN-A stated nose orders, and they have admission.					
	9/12/20, directed st a helmet per protoc rehab. RN-A stated know what the neur wearing the helmet attempt to clarify R instructed staff rega of use for R1's helm	A stated R1's ER visit on raff to ensure R1 was wearing col from neurosurgery and upon R1's return, she did not rosurgery protocol was for . RN-A stated she did not 1's orders. RN-A stated she arding the use and frequency net from her own personal and not from doctors' orders.					
	R1 was to wear a h often he should we wore it all the time I	family member (FM)-A stated lelmet, but was uncertain how ar it. FM-A thought he probably because R1 messes with it, le didn't have it on, then R1	,				

Minnesota Department of Health

STATE FORM SODK11 If continuation sheet 11 of 12

Minnesota Department of Health

AND BLAN OF CORRECTION (I) IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP		SURVEY		
		00299	B. WING			C 24/2020
	PROVIDER OR SUPPLIER	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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21830	would mess with his -at 3:38 p.m., the di R1 was admitted or The DON stated R2 clarify when he sho stated R1 was sent instructions directed directed by neuroscious -3:52 p.m., the DON nurses to notify the wearing his helmet expected nurses to A policy on clarificar equested but was SUGGESTED MET The DON or admin revise policy for cla notify physician of reducation to staff readministrator could an auditing system assurance program compliance.	irector of nurses (DON) stated in 9/9/20, from the hospital. It's discharge instructions not ould wear his helmet. The DON it to ER and upon return, it is to wear the helmet as urgery and rehab protocol. N stated she would expect physician if R1 was not. The DON stated she clarify orders immediately.	21830			

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