DEPARTMENT OF HEALTH

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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	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 9/23/20, through 9/24/20, an abbreviated standard survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5495085C H5495086C H5495087C The following complaint was found to be unsubstantiated: H5495084C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify,	F 580		10/30/20

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

Electronically Signed | 10/23/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	**2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 §483.5) 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: 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 was severely cognitively impaired. The MDS 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. R1's 9/9/20 treatment administration record (TAR)	F 580	F580: Notification of Change Immediate Corrective Action: Order for helmet use for R1 was clarified during video visit on 10/9/20. Attempts were made to clarify order 9/25, 9/28, 9/29. Nurse Manager R1 was educated on timely clarification of orders and getting clarification from Medical Director for clarification if not addressed timely by the resident's provider. Action as it Applies to Others: All resident medication and treatment orders were reviewed for clarity. Any orders needing clarification were clarified. Medication & Treatment orders policy was reviewed and remained current.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3 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 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). On 9/12/20, R1's ED After Visit Summary (AVS) directed staff to ensure resident was wearing his helmet per protocol from neurosurgery and rehab. On 9/10/20 through 9/18/20, R1's progress notes indicated resident would not leave his helmet on. R1's 9/18/20 Interdisciplinary Team (IDT) Committee Notes indicated R1 had a craniotomy with bone flap removed, refused to wear his	F 580	All nurses were re-educated was educated on timely clarification of orders and getting clarification from Medical Director for clarification if not addressed timely by the resident's provider. Date of Compliance: 10/30/20. Reoccurrence will be prevented by: Audit of 5 residents orders will be conducted weekly x 4 weeks then monthly x2 months to assure orders are clear and clarification is made if needed. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/Nurse Managers/Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4	F 580		

helmet and RN-A would be doing a risk vs benefit.

On 9/23/20, during continuous observation from 10:54 a.m. through 12:45 p.m., from 2:15 p.m. through 2:50 p.m., and from 3:06 p.m. through 4:00 p.m., R1 was observed not wearing a helmet.

On 9/24/20, during continuous observation from 8:10 a.m. through 10:38 a.m., R1 was observed not wearing a helmet.

On 9/24/20:
-at 10:21 a.m., licensed practical nurse (LPN)-A stated R1's instructions for wearing a helmet were listed on the treatment administration record (TAR) with a start date of 9/9/20. LPN-A stated staff still followed those orders, and they have been current since admission.

-at 11:35 a.m., RN-A stated R1's ER visit on 9/12/20, directed staff to ensure R1 was wearing a helmet per protocol from neurosurgery and rehab. RN-A stated upon R1's return, she did not know what the neurosurgery protocol was for wearing the helmet. RN-A stated she did not attempt to clarify R1's orders. RN-A stated she instructed staff regarding the use and frequency of use for R1's helmet from her own personal nursing experience and not from doctors' orders.

-at 2:45 p.m., R1's family member (FM)-A stated R1 was to wear a helmet, but was uncertain how often he should wear it. FM-A thought he probably wore it all the time because R1 messes with it, and would think if he didn't have it on, then R1 would mess with his head.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5 -at 3:38 p.m., the director of nurses (DON) stated R1 was admitted on 9/9/20, from the hospital. The DON stated R1's discharge instructions not clarify when he should wear his helmet. The DON stated R1 was sent to ER and upon return, instructions directed R1 to wear the helmet as directed by neurosurgery and rehab protocol. -3:52 p.m., the DON stated she would expect nurses to notify the physician if R1 was not wearing his helmet. The DON stated she expected nurses to clarify orders immediately. A policy on clarification of physician orders was requested but was not provided.	F 580		
F 689 SS=D	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 observation, interview, and document review, the facility failed to implement interventions to minimize the risk of falls for 1 of 3 residents (R3) reviewed for falls. Findings include: R3's admission Minimum Data Set (MDS) dated 6/30/20, indicated R3 had severe cognitive impairment. The MDS further indicated R3's	F 689	F689: Free of Accidents Hazards/Supervision/Devices Immediate Corrective Action: R3 fall risk assessment completed and now fall mat was discontinued.	10/30/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	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 diagnoses included malnutrition, encounter for orthopedic aftercare following surgical amputation, acquired absence of right leg above knee, Wernicke's encephalopathy (a life-threatening illness caused by thiamine deficiency which primarily affects the peripheral and central nervous system) and cerebellar ataxia (symptoms of an inability to coordinate balance, gait, extremity and eye movements). The MDS also indicated R3 required total assistance of two persons for transfer, and required extensive assistance of one person for bed mobility and toilet use. The MDS indicated R3 had one fall without injury since admission. R3's Falls Care Area Assessment (CAA) dated 7/10/20, indicated R3 was not steady/only able to stabilize with staff assistance with transitions, and had experienced a fall since admission. R3's risk factors included impaired mobility relate to deconditioning and weakness secondary alcohol abuse, malnutrition, Wernicke's encephalopathy, cerebellar ataxia, cognitive impairment, and right above knee amputation. The CAA identified fall interventions to include call light within reach while in bed, wheelchair for locomotion, staff to assist with all transitions, low bed, and concave mattress to define the edges of the bed. R3's care plan dated 7/21/20, indicated R3 had a fall risk related to impaired mobility related to deconditioning an weakness secondary to alcohol abuse, malnutrition, Wernicke's encephalopathy, cerebellar ataxia, cognitive impairment, right above knee amputation and history of falls. The care plan directed staff R3 required anti-lock brakes, call light within reach while in bed, fall mat placed next to bed, wheelchair for locomotion, staff assistance with all transition, low	F 689	Action as it Applies to Others: Managing Falls & Fall Risk Policy was reviewed and remains current. All residents were reviewed for fall interventions and have appropriate interventions in place. These interventions are reflected on NAR pocket care guide for each resident's individualized needs. All nursing staff educated on following care plans and pocket care plans for fall interventions Date of Compliance: 10/30/2020 Reoccurrence will be prevented by: Observation audit of 5 residents to ensure fall interventions in place weekly x 4 weeks then monthly x2 months. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/Nurse Managers/Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	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 7	F 689		

bed and concave mattress to define the edges of the bed.

Review of R3's medical record from 6/25/20, to 9/10/20, revealed he experienced five falls without injury:

-On 6/25/20, R3 was found on the floor after a fall from bed. The interdisciplinary team (IDT) implemented a concave mattress and low bed
-On 7/5/20, R3 was found on the floor at his bedside. The IDT implemented a fall mat next to his bed.
-On 8/11/20, R3 was found on the floor next to his bed. The IDT determined R3 had been attempting to get up for supper, and implemented a new intervention to get R3 up in a wheelchair for all meals.
-On 9/4/20, R3 was found on the floor after a fall from his wheelchair. The IDT determined R3 slid out of the wheelchair and the brakes were not in working order. R3 was provided a new wheelchair.
-On 9/10/20, R3 was found on the floor after a fall from his wheelchair. The IDT determined R3 self transferred and the wheelchair slipped away from him. Anti-lock brakes were applied to the wheelchair.

On 9/23/20, at 2:31 p.m. R3 was observed in bed turned on his right side facing away from the door. A concave mattress with a defined perimeter was noted on the bed. The bed was in a low position and positioned lengthwise against the wall. The wheelchair was positioned in the middle of the room and not directly next to the bed. No fall mat was observed on the floor next to the bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	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 8	F 689		

-At 3:32 p.m. R3 was interviewed. R3 stated he had been at the facility for approximately one month. R3 verified he had experienced a fall from bed, and stated he had been trying to get into the wheelchair but the brakes weren't on, and the chair moved. R3's wheelchair was observed to have an anti-rollback device attached. No fall mat was observed on the floor next to R3's bed.

-At 3:43 p.m. nursing assistant (NA)-A stated R3 required the use of a mechanical lift for transfers. When asked if R3 was at risk for falls, NA-A stated, "I don't believe so, maybe." NA-A stated R3's fall interventions would be located on the pocket care plan, and walked to the desk to obtain one. NA-A stated no pocket care plans were printed/available at that time. NA-A stated R3 required a concave mattress, and his bed in lowest position. NA-A verified R3 did not have a fall mat in use and stated, "Not since he's been over here anyway."

-At 8:44 a.m. NA-B stated R3 was a risk for falling, and stated he was to have a fall mat on the floor next to his bed when in bed.

-At 10:29 a.m. NA-B provided a pocket care plan for R3's unit, and verified the sheet did not indicate R3 required a fall mat.

-At 10:31 a.m. NA-B approached licensed practical nurse care coordinator (LPN)-B and asked her to clarify R3's use of a fall mat. NA-B informed LPN-B the fall mat intervention was not on the pocket care plan. LPN-B stated R3 had transferred from another unit, and verified the fall mat did get put on the new unit's pocket care plan. LPN-B verified the NAs should have been using a fall mat for R3. LPN-B stated R3 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	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 9	F 689		

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.

On 9/24/20, at 3:44 p.m. the director of nursing (DON) verified R3 had recently transferred from another unit in the facility. The DON verified the fall mat was not identified on the pocket care plan for R3. The DON stated if the fall mat was care planned for R3's use, he should have had it in place when in bed. The DON stated R3's fall mat use should have been reassessed to determine necessity, prior to discontinuing its use.

The facility Falls-Clinical Protocol policy revised 3/18, directed based on assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. The policy also indicated if interventions had been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed.

DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	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	2 000		

*****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 9/23/20, through 9/24/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be not in compliance with the MN State licensure.

The following complaints were found to be substantiated:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	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 H5495085C H5495086C H5495087C The following complaint was found to be unsubstantiated: H5495084C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of starte form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement interventions to minimize the risk of falls for 1 of 3 residents (R3) reviewed for falls.	2 830	F689: Free of Accidents Hazards/Supervision/Devices Immediate Corrective Action:	10/30/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	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
2 830	Continued From page 2 Findings include: R3's admission Minimum Data Set (MDS) dated 6/30/20, indicated R3 had severe cognitive impairment. The MDS further indicated R3's diagnoses included malnutrition, encounter for orthopedic aftercare following surgical amputation, acquired absence of right leg above knee, Wernicke's encephalopathy (a life-threatening illness caused by thiamine deficiency which primarily affects the peripheral and central nervous system) and cerebellar ataxia (symptoms of an inability to coordinate balance, gait, extremity and eye movements). The MDS also indicated R3 required total assistance of two persons for transfer, and required extensive assistance of one person for bed mobility and toilet use. The MDS indicated R3 had one fall without injury since admission. R3's Falls Care Area Assessment (CAA) dated 7/10/20, indicated R3 was not steady/only able to stabilize with staff assistance with transitions, and had experienced a fall since admission. R3's risk factors included impaired mobility relate to deconditioning and weakness secondary alcohol abuse, malnutrition, Wernicke's encephalopathy, cerebellar ataxia, cognitive impairment, and right above knee amputation. The CAA identified fall interventions to include call light within reach while in bed, wheelchair for locomotion, staff to assist with all transitions, low bed, and concave mattress to define the edges of the bed. R3's care plan dated 7/21/20, indicated R3 had a fall risk related to impaired mobility related to deconditioning an weakness secondary to alcohol abuse, malnutrition, Wernicke's encephalopathy, cerebellar ataxia, cognitive impairment, right above knee amputation and history of falls. The	2 830	R3 fall risk assessment completed and now fall mat was discontinued. Action as it Applies to Others: Managing Falls & Fall Risk Policy was reviewed and remains current. All residents were reviewed for fall interventions and have appropriate interventions in place. These interventions are reflected on NAR pocket care guide for each resident's individualized needs. All nursing staff educated on following care plans and pocket care plans for fall interventions Date of Compliance: 10/30/2020 Reoccurrence will be prevented by: Observation audit of 5 residents to ensure fall interventions in place weekly x 4 weeks then monthly x2 months. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/Nurse Managers/Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	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
2 830	Continued From page 3	2 830		

care plan directed staff R3 required anti-lock brakes, call light within reach while in bed, fall mat placed next to bed, wheelchair for locomotion, staff assistance with all transition, low bed and concave mattress to define the edges of the bed.

Review of R3's medical record from 6/25/20, to 9/10/20, revealed he experienced five falls without injury:

-On 6/25/20, R3 was found on the floor after a fall from bed. The interdisciplinary team (IDT) implemented a concave mattress and low bed
-On 7/5/20, R3 was found on the floor at his bedside. The IDT implemented a fall mat next to his bed.
-On 8/11/20, R3 was found on the floor next to his bed. The IDT determined R3 had been attempting to get up for supper, and implemented a new intervention to get R3 up in a wheelchair for all meals.
-On 9/4/20, R3 was found on the floor after a fall from his wheelchair. The IDT determined R3 slid out of the wheelchair and the brakes were not in working order. R3 was provided a new wheelchair.
-On 9/10/20, R3 was found on the floor after a fall from his wheelchair. The IDT determined R3 self transferred and the wheelchair slipped away from him. Anti-lock brakes were applied to the wheelchair.

On 9/23/20, at 2:31 p.m. R3 was observed in bed turned on his right side facing away from the door. A concave mattress with a defined perimeter was noted on the bed. The bed was in a low position and positioned lengthwise against the wall. The wheelchair was positioned in the middle of the room and not directly next to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	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
2 830	Continued From page 4 bed. No fall mat was observed on the floor next to the bed. -At 3:32 p.m. R3 was interviewed. R3 stated he had been at the facility for approximately one month. R3 verified he had experienced a fall from bed, and stated he had been trying to get into the wheelchair but the brakes weren't on, and the chair moved. R3's wheelchair was observed to have an anti-rollback device attached. No fall mat was observed on the floor next to R3's bed. -At 3:43 p.m. nursing assistant (NA)-A stated R3 required the use of a mechanical lift for transfers. When asked if R3 was at risk for falls, NA-A stated, "I don't believe so, maybe." NA-A stated R3's fall interventions would be located on the pocket care plan, and walked to the desk to obtain one. NA-A stated no pocket care plans were printed/available at that time. NA-A stated R3 required a concave mattress, and his bed in lowest position. NA-A verified R3 did not have a fall mat in use and stated, "Not since he's been over here anyway." -At 8:44 a.m. NA-B stated R3 was a risk for falling, and stated he was to have a fall mat on the floor next to his bed when in bed. -At 10:29 a.m. NA-B provided a pocket care plan for R3's unit, and verified the sheet did not indicate R3 required a fall mat. -At 10:31 a.m. NA-B approached licensed practical nurse care coordinator (LPN)-B and asked her to clarify R3's use of a fall mat. NA-B informed LPN-B the fall mat intervention was not on the pocket care plan. LPN-B stated R3 had transferred from another unit, and verified the fall mat did get put on the new unit's pocket care	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	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
2 830	Continued From page 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.

On 9/24/20, at 3:44 p.m. the director of nursing (DON) verified R3 had recently transferred from another unit in the facility. The DON verified the fall mat was not identified on the pocket care plan for R3. The DON stated if the fall mat was care planned for R3's use, he should have had it in place when in bed. The DON stated R3's fall mat use should have been reassessed to determine necessity, prior to discontinuing its use.

The facility Falls-Clinical Protocol policy revised 3/18, directed based on assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. The policy also indicated if interventions had been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed.

SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and/or revise policies and procedures related to implementation of interventions following a fall. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan.

TIME PERIOD OF CORRECTION: Twenty-one (21) Days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	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
21830	Continued From page 6	21830		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; 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 an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:	21830		10/30/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	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
21830	Continued From page 7	21830		

(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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	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
21830	Continued From page 8 designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that 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. 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. 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 was severely cognitively impaired. The MDS 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.	21830	F580: Notification of Change Immediate Corrective Action: Order for helmet use for R1 was clarified during video visit on 10/9/20. Attempts were made to clarify order 9/25, 9/28, 9/29. Nurse Manager R1 was educated on timely clarification of orders and getting clarification from Medical Director for clarification if not addressed timely by the resident's provider. Action as it Applies to Others: All resident medication and treatment orders were reviewed for clarity. Any orders needing clarification were clarified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	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
21830	Continued From page 9 R1's undated pocket care plan lacked direction if R1 wore a helmet. 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 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). On 9/12/20, R1's ED After Visit Summary (AVS) directed staff to ensure resident was wearing his helmet per protocol from neurosurgery and rehab. On 9/10/20 through 9/18/20, R1's progress notes indicated resident would not leave his helmet on.	21830	Medication & Treatment orders policy was reviewed and remained current. All nurses were re-educated was educated on timely clarification of orders and getting clarification from Medical Director for clarification if not addressed timely by the resident's provider. Date of Compliance: 10/30/20. Reoccurrence will be prevented by: Audit of 5 residents orders will be conducted weekly x 4 weeks then monthly x2 months to assure orders are clear and clarification is made if needed. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/Nurse Managers/Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	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
21830	Continued From page 10	21830		

R1's 9/18/20 Interdisciplinary Team (IDT) Committee Notes indicated R1 had a craniotomy with bone flap removed, refused to wear his helmet and RN-A would be doing a risk vs benefit.

On 9/23/20, during continuous observation from 10:54 a.m. through 12:45 p.m., from 2:15 p.m. through 2:50 p.m., and from 3:06 p.m. through 4:00 p.m., R1 was observed not wearing a helmet.

On 9/24/20, during continuous observation from 8:10 a.m. through 10:38 a.m., R1 was observed not wearing a helmet.

On 9/24/20:
-at 10:21 a.m., licensed practical nurse (LPN)-A stated R1's instructions for wearing a helmet were listed on the treatment administration record (TAR) with a start date of 9/9/20. LPN-A stated staff still followed those orders, and they have been current since admission.

-at 11:35 a.m., RN-A stated R1's ER visit on 9/12/20, directed staff to ensure R1 was wearing a helmet per protocol from neurosurgery and rehab. RN-A stated upon R1's return, she did not know what the neurosurgery protocol was for wearing the helmet. RN-A stated she did not attempt to clarify R1's orders. RN-A stated she instructed staff regarding the use and frequency of use for R1's helmet from her own personal nursing experience and not from doctors' orders.

-at 2:45 p.m., R1's family member (FM)-A stated R1 was to wear a helmet, but was uncertain how often he should wear it. FM-A thought he probably wore it all the time because R1 messes with it, and would think if he didn't have it on, then R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	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
21830	Continued From page 11 would mess with his head. -at 3:38 p.m., the director of nurses (DON) stated R1 was admitted on 9/9/20, from the hospital. The DON stated R1's discharge instructions not clarify when he should wear his helmet. The DON stated R1 was sent to ER and upon return, instructions directed R1 to wear the helmet as directed by neurosurgery and rehab protocol. -3:52 p.m., the DON stated she would expect nurses to notify the physician if R1 was not wearing his helmet. The DON stated she expected nurses to clarify orders immediately. A policy on clarification of physician orders was requested but was not provided. SUGGESTED METHOD FOR CORRECTION: The DON or administrator could develop and/or revise policy for clarifying physician orders and notify physician of resident refusals. Provide education to staff regarding the policy. DON or administrator could then develop and implement an auditing system as part of the facility's quality assurance program to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21830		