P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically Delivered via Email
January 24, 2021

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

RE: CCN: 245495
Cycle Start Date: December 22, 2020

Dear Administrator:

On January 22, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

Electronically delivered
December 30, 2020

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

RE: CCN: 245495
Cycle Start Date: December 22, 2020

Dear Administrator:

On December 22, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" 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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by March 22, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 22, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

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 12/22/2020

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 12/21/20, through 12/22/20, an abbreviated 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 complaint was found to be SUBSTANTIATED: H5495090C 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		1/13/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/08/2021

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

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F 550	Continued From page 1 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident's needs and preferences were honored, and dignity was provided for 1 of 3 residents (R1) reviewed for dignity. Findings included:	F 550	F550: Resident Rights/Exercise of Rights Immediate Corrective Action: Resident 1’s face was washed and he was provided incontinence care and a new brief. Action as it Applies to Others: Call Light and ADL policy remain current. All residents will be reviewed to ensure	

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F 550	Continued From page 2 R1's Diagnosis Report printed on 12/22/20, indicated R1's diagnoses included chronic kidney disease (longstanding disease of the kidneys leading to renal failure, as kidneys fail, waste builds up), type 2 diabetes, ischemic cardiomyopathy (an acquired or hereditary disease of the heart muscle), hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (stroke) affecting left non-dominant side, and muscle weakness. R1's quarterly Minimum Data Set (MDS) dated 11/25/20, indicated R1 was cognitively intact, and required extensive assistance with bed mobility, transfers, dressing, toilet use, personal hygiene, and was frequently incontinent of bowel and bladder. R1's Activity of Daily Living (ADL) Functional / Rehabilitation Care Area Assessment (CAA) dated 9/9/20, indicated R1 required extensive assistance with bed mobility, transfers, personal hygiene, dressing, and toilet use. R1's CAA indicated R1 was to participate in therapies as ordered, and staff were to assist with cares and transitions. R1's care plan dated 8/25/20, indicated R1 had bladder incontinence related to impaired mobility, and needed assistance with toileting. The care plan directed staff to have the call light within reach while in bed, resident to wear incontinence products, staff to empty urinal every shift and as needed, staff to offer toileting every two hours, and to assist with incontinence cares as needed. On 12/21/20, at 12:54 p.m. R1's cares were	F 550	that care plans note their individual toileting programs as well as to offer toileting/incontinence cares per request. All staff educated on call light and ADL policy as well as providing privacy during ADLs and honoring care requests from residents timely. Date of Compliance: 1/13/21 Audits of 5 random residents conducted 3x/week x 4 weeks, 2x/week x 1 week, then monthly x2 months to assure residents' individualized toileting needs are followed. 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. Audits for call lights will be conducted on 5 random call lights 3x/week x 4 weeks, 2x/week x 1 week, then monthly x 2 months to assure call lights are being answered timely. 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	

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F 550

Continued From page 3

observed. Nursing assistant (NA)-A assisted R1 with perineal cares. Following cares, NA-A left R1 uncovered while she went to change gloves and wash her hands. A brown streak was noted down the left side of R1's mouth, going down his neck. R1 stated he had a chocolate protein shake for breakfast, and nobody had cleaned him up.

-at 1:13 p.m. R1 was interviewed, and stated the staff were "rough," and sometimes his head gets "banged on the wall."

On 12/22/20, at 7:19 a.m. R1 was seated in his wheelchair in his room. The brown stain on the left side of his face and neck were still there.

-at 7:43 a.m. R1 put on his call light. Registered nurse (RN)-A and NA-C were in the hallway. Neither responded to R1's call light.
-at 8:00 a.m. NA-A answered R1's call light. R1 stated he felt like he had been incontinent of bowel. NA-A stated she needed to get everyone else up first. R1 was not checked to see if he had been incontinent of bowel.
-at 8:38 a.m. R1 put on his call light.
-at 8:39 a.m. R1's call light was answered by NA-A. R1 again stated he thought he was incontinent of bowel. NA-A left the room, but left the call light on. R1 was not checked to see if he had been incontinent of bowel.
-at 8:41 a.m. NA-A returned to R1's room. R1 stated, "Get me out of the chair." NA-A did not assist R1 back to bed, but left him in his wheelchair, and exited the room.
-at 9:02 a.m. NA-B answered R1's call light. R1 stated he wanted to go back to bed. NA-B stated they would put him back to bed after they got everything "back to the kitchen."
-at 9:35 a.m. NA-B entered R1's room and made

F 550

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THE EMERALDS AT GRAND RAPIDS LLC	**2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744**

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F 550	Continued From page 4 his bed. NA-A entered with a mechanical lift, and R1 was transferred to bed. R1 had a small amount of BM in his incontinent brief, and NA-A and NA-B changed him. -at 10:42 a.m. R1 was interviewed. R1 stated he felt like he had to have a BM, and he would have liked to be able to get up and sit on a toilet. R1 stated he cannot always tell if he has had a BM in his incontinent brief, and he would feel bad if he was incontinent. -at 11:17 a.m. NA-A was interviewed. NA-A stated she did not check to see if R1 had a BM in his incontinent brief when she answered his call light twice. NA-A stated she didn't check because it "was too busy." -at 12:32 p.m. licensed practical nurse (LPN)-A was interviewed. LPN-A stated she would expect staff to assist R1 to the toilet when he stated he thought he had been incontinent, and when he asked to go. -at 1:50 p.m. the director of nursing (DON) was interviewed. The DON stated she would expect staff to assist a resident to the bathroom when they asked, and to check a resident's incontinent brief when the resident stated they thought they had been incontinent. The DON further stated a staff member saying they are too busy was not an acceptable reason for not providing care. The facility policy Monarch Healthcare ADL Assistance Per Care Plan revised 5/20/18, directed staff to check/change/toilet incontinent residents according to the care plan and pericare provided between changes. The facility policy Answering the Call Light	F 550		

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F 550	Continued From page 5 undated, directed staff to do what the resident asks of them. The policy further directed staff to ask the nurse supervisor for help if they cannot fulfill the resident's request.	F 550		
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 ensure a resident was positioned properly and supervised during a meal for 1 of 1 residents (R3) reviewed for supervision during a meal. Findings include: R3's Admission Record printed on 12/22/20, indicated R3 had diagnoses which included pneumonia, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficulty to breathe), and generalized muscle weakness. R3's significant change Minimum Data Set (MDS) dated 12/3/20, indicated R3 had moderately intact cognition. In addition, R3's MDS indicated he required supervision with eating. R3's care plan dated 9/2/20, indicated R3 was to	F 689	F689: Accidents/Supervision Immediate Corrective Action: R3 is now being properly positioned and supervised during meals. Action as it Applies to Others: ADL policy remains current. All residents at high risk for aspiration and/or choking were assessed to ensure they are properly positioned and supervised during meals. Care plans were updated. All staff were educated on the need to correctly position/supervise these high-risk residents during meals per individualized care plan needs. Date of Compliance: 1/13/21 Audits of all residents determined to be high risk for aspiration and/or choking will be conducted 3x/week x 4 weeks, 2x/week x 1 week, then monthly x 2 months to assure that residents are being	1/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689 Continued From page 6
sit at or close to 90 degrees while eating meals.

On 12/22/20, at 7:33 a.m. R3 was observed lying sideways in his bed head off of the pillow with left leg near the edge of the bed, with the head of the bed at approximately at 30 degrees. At 8:11 a.m. R3 was served his meal by registered nurse (RN)-B. The tray table was over his legs, R3's knees were up slightly, and he was slumped down in the bed. R3 had to reach up to reach his food, and was eating eggs with his left hand. The head of the bed was at approximately 30 degrees, not at the directed 90 degrees.
-at 8:15 a.m. RN-B was interviewed, and asked if R3 was in a safe position for eating, and if he needed supervision with eating. RN-B did not respond, but placed a pillow back under R3's head, and asked him if he needed help. The tray table remained up high, and R3 remained lying sideways in bed, reaching up for his food.
-at 8:20 a.m. RN-B was heard asking nursing assistant (NA)-C if R3 needed supervision for meals. RN-B also informed NA-C that R3 was asking for "chicken." No staff returned to boost R1 up in bed, place him at 90 degrees, or supervise his meal.
-at 8:21 a.m. RN-B returned to R3's room, looked in, and then returned to passing breakfast trays.
-at 8:23 a.m. R3 was interviewed. R3 cursed when asked how his meal was. R3 had drank his juice, and had eaten a small amount of eggs. R3 was unable to articulate what was wrong.

-at 11:26 a.m. NA-C was interviewed. NA-C stated R3 received assistance "on and off" with meals. NA-C further stated R3 was recovering from pneumonia, and had not been wanting to get up in a chair for meals. NA-C stated R1 should be sitting up at 90 degrees if eating in bed.

F 689

positioned/supervised per their care plan needs. 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
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F 689	Continued From page 7	F 689		

-at 11:39 a.m. NA-B was interviewed. NA-B stated R3 sometimes needs help to eat, so they got him set up, and would go back and check on him. NA-B stated if R3 was eating in bed, he should be "boosted way up" at almost 90 degrees.

-at 11:54 a.m. RN-A was interviewed. RN-A stated R3 to be supervised when eating, and if he was eating in bed, he should be placed upright at 90 degrees.

- at 1:50 p.m. the director of nursing (DON) was interviewed. The DON stated she would expect staff to get assistance to boost a resident up in bed so they would be as close to 90 degrees as possible, if they were eating a meal in bed. The DON verified eating in bed or at less than 90 degrees would put a resident at risk for aspiration.

The facility policy Dysphagia - Clinical Protocol revised 9/17, directed staff to first try to identify and implement simple interventions to manage the situation. In addition, staff were directed to address factors that make the individual less attentive or drowsy during meals.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 30, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: CCCZ11

Dear Administrator:

The above facility was surveyed on December 21, 2020 through December 22, 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

Minnesota Department of Health

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 12/22/2020

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 *****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 12/21/20, through 12/22/20, 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. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 01/08/21

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5495090C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	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 ensure a resident was positioned properly and supervised during a meal for 1 of 1 residents (R3) reviewed for supervision during a meal. Findings include: R3's Admission Record printed on 12/22/20, indicated R3 had diagnoses which included pneumonia, chronic obstructive pulmonary disease (a group of lung diseases that block	2 830	F689: Accidents/Supervision Immediate Corrective Action: R3 is now being properly positioned and supervised during meals. Action as it Applies to Others: ADL policy remains current. All residents at high risk for aspiration and/or choking were assessed to ensure they are properly positioned and supervised during meals. Care plans were updated. All staff were educated on the need to	1/13/21

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2 830	Continued From page 2 airflow and make it difficulty to breathe), and generalized muscle weakness. R3's significant change Minimum Data Set (MDS) dated 12/3/20, indicated R3 had moderately intact cognition. In addition, R3's MDS indicated he required supervision with eating. R3's care plan dated 9/2/20, indicated R3 was to sit at or close to 90 degrees while eating meals. On 12/22/20, at 7:33 a.m. R3 was observed lying sideways in his bed head off of the pillow with left leg near the edge of the bed, with the head of the bed at approximately at 30 degrees. At 8:11 a.m. R3 was served his meal by registered nurse (RN)-B. The tray table was over his legs, R3's knees were up slightly, and he was slumped down in the bed. R3 had to reach up to reach his food, and was eating eggs with his left hand. The head of the bed was at approximately 30 degrees, not at the directed 90 degrees. -at 8:15 a.m. RN-B was interviewed, and asked if R3 was in a safe position for eating, and if he needed supervision with eating. RN-B did not respond, but placed a pillow back under R3's head, and asked him if he needed help. The tray table remained up high, and R3 remained lying sideways in bed, reaching up for his food. -at 8:20 a.m. RN-B was heard asking nursing assistant (NA)-C if R3 needed supervision for meals. RN-B also informed NA-C that R3 was asking for "chicken." No staff returned to boost R1 up in bed, place him at 90 degrees, or supervise his meal. -at 8:21 a.m. RN-B returned to R3's room, looked in, and then returned to passing breakfast trays. -at 8:23 a.m. R3 was interviewed. R3 cursed when asked how his meal was. R3 had drank his juice, and had eaten a small amount of eggs. R3	2 830	correctly position/supervise these high-risk residents during meals per individualized care plan needs. Date of Compliance: 1/13/21 Audits of all residents determined to be high risk for aspiration and/or choking will be conducted 3x/week x 4 weeks, 2x/week x 1 week, then monthly x 2 months to assure that residents are being positioned/supervised per their care plan needs. 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	

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2 830	Continued From page 3	2 830		

was unable to articulate what was wrong.

-at 11:26 a.m. NA-C was interviewed. NA-C stated R3 received assistance "on and off" with meals. NA-C further stated R3 was recovering from pneumonia, and had not been wanting to get up in a chair for meals. NA-C stated R1 should be sitting up at 90 degrees if eating in bed.

-at 11:39 a.m. NA-B was interviewed. NA-B stated R3 sometimes needs help to eat, so they got him set up, and would go back and check on him. NA-B stated if R3 was eating in bed, he should be "boosted way up" at almost 90 degrees.

-at 11:54 a.m. RN-A was interviewed. RN-A stated R3 to be supervised when eating, and if he was eating in bed, he should be placed upright at 90 degrees.

- at 1:50 p.m. the director of nursing (DON) was interviewed. The DON stated she would expect staff to get assistance to boost a resident up in bed so they would be as close to 90 degrees as possible, if they were eating a meal in bed. The DON verified eating in bed or at less than 90 degrees would put a resident at risk for aspiration.

The facility policy Dysphagia - Clinical Protocol revised 9/17, directed staff to first try to identify and implement simple interventions to manage the situation. In addition, staff were directed to address factors that make the individual less attentive or drowsy during meals.

SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility polices and procedures related to proper positioning and supervision at

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2 830	Continued From page 4 meals. The DON or designee could re-educated staff on these polices and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident's needs and preferences were honored, and dignity was provided for 1 of 3 residents (R1) reviewed for dignity. Findings included: R1's Diagnosis Report printed on 12/22/20, indicated R1's diagnoses included chronic kidney disease (longstanding disease of the kidneys leading to renal failure, as kidneys fail, waste builds up), type 2 diabetes, ischemic cardiomyopathy (an acquired or hereditary disease of the heart muscle), hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (stroke) affecting left	21805	F550: Resident Rights/Exercise of Rights Immediate Corrective Action: Resident 1's face was washed and he was provided incontinence care and a new brief. Action as it Applies to Others: Call Light and ADL policy remain current. All residents will be reviewed to ensure that care plans note their individual toileting programs as well as to offer toileting/incontinence cares per request. All staff educated on call light and ADL policy as well as providing privacy during ADLs and honoring care requests from residents timely. Date of Compliance: 1/13/21 Audits of 5 random residents conducted 3x/week x 4 weeks, 2x/week x 1 week, then monthly x2 months to assure	1/13/21

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21805	Continued From page 5 non-dominant side, and muscle weakness. R1's quarterly Minimum Data Set (MDS) dated 11/25/20, indicated R1 was cognitively intact, and required extensive assistance with bed mobility, transfers, dressing, toilet use, personal hygiene, and was frequently incontinent of bowel and bladder. R1's Activity of Daily Living (ADL) Functional / Rehabilitation Care Area Assessment (CAA) dated 9/9/20, indicated R1 required extensive assistance with bed mobility, transfers, personal hygiene, dressing, and toilet use. R1's CAA indicated R1 was to participate in therapies as ordered, and staff were to assist with cares and transitions. R1's care plan dated 8/25/20, indicated R1 had bladder incontinence related to impaired mobility, and needed assistance with toileting. The care plan directed staff to have the call light within reach while in bed, resident to wear incontinence products, staff to empty urinal every shift and as needed, staff to offer toileting every two hours, and to assist with incontinence cares as needed. On 12/21/20, at 12:54 p.m. R1's cares were observed. Nursing assistant (NA)-A assisted R1 with perineal cares. Following cares, NA-A left R1 uncovered while she went to change gloves and wash her hands. A brown streak was noted down the left side of R1's mouth, going down his neck. R1 stated he had a chocolate protein shake for breakfast, and nobody had cleaned him up. -at 1:13 p.m. R1 was interviewed, and stated the staff were "rough," and sometimes his head gets "banged on the wall."	21805	residents' individualized toileting needs are followed. 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. Audits for call lights will be conducted on 5 random call lights 3x/week x 4 weeks, 2x/week x 1 week, then monthly x 2 months to assure call lights are being answered timely. 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	

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21805	Continued From page 6	21805		

On 12/22/20, at 7:19 a.m. R1 was seated in his wheelchair in his room. The brown stain on the left side of his face and neck were still there.

-at 7:43 a.m. R1 put on his call light. Registered nurse (RN)-A and NA-C were in the hallway. Neither responded to R1's call light.
-at 8:00 a.m. NA-A answered R1's call light. R1 stated he felt like he had been incontinent of bowel. NA-A stated she needed to get everyone else up first. R1 was not checked to see if he had been incontinent of bowel.
-at 8:38 a.m. R1 put on his call light.
-at 8:39 a.m. R1's call light was answered by NA-A. R1 again stated he thought he was incontinent of bowel. NA-A left the room, but left the call light on. R1 was not checked to see if he had been incontinent of bowel.
-at 8:41 a.m. NA-A returned to R1's room. R1 stated, "Get me out of the chair." NA-A did not assist R1 back to bed, but left him in his wheelchair, and exited the room.
-at 9:02 a.m. NA-B answered R1's call light. R1 stated he wanted to go back to bed. NA-B stated they would put him back to bed after they got everything "back to the kitchen."
-at 9:35 a.m. NA-B entered R1's room and made his bed. NA-A entered with a mechanical lift, and R1 was transferred to bed. R1 had a small amount of BM in his incontinent brief, and NA-A and NA-B changed him.
-at 10:42 a.m. R1 was interviewed. R1 stated he felt like he had to have a BM, and he would have liked to be able to get up and sit on a toilet. R1 stated he cannot always tell if he has had a BM in his incontinent brief, and he would feel bad if he was incontinent.

-at 11:17 a.m. NA-A was interviewed. NA-A stated she did not check to see if R1 had a BM in his

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21805	Continued From page 7 incontinent brief when she answered his call light twice. NA-A stated she didn't check because it "was too busy." -at 12:32 p.m. licensed practical nurse (LPN)-A was interviewed. LPN-A stated she would expect staff to assist R1 to the toilet when he stated he thought he had been incontinent, and when he asked to go. -at 1:50 p.m. the director of nursing (DON) was interviewed. The DON stated she would expect staff to assist a resident to the bathroom when they asked, and to check a resident's incontinent brief when the resident stated they thought they had been incontinent. The DON further stated a staff member saying they are too busy was not an acceptable reason for not providing care. The facility policy Monarch Healthcare ADL Assistance Per Care Plan revised 5/20/18, directed staff to check/change/toilet incontinent residents according to the care plan and pericare provided between changes. The facility policy Answering the Call Light undated, directed staff to do what the resident asks of them. The policy further directed staff to ask the nurse supervisor for help if they cannot fulfill the resident's request. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility polices and procedures related to maintaining dignity and answering call lights. The DON or designee could re-educated staff on these polices and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance.	21805		

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21805	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21805		