

Protecting, Maintaining and Improving the Health of All Minnesotans

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



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: 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:

PRINTED: 02/10/2021 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COMPLETED	
		245495	B. WING		C 12/22/2020	
NAME OF F	PROVIDER OR SUPPLIER	2-0-100		STREET ADDRESS, CITY, STATE, ZIP CODE	12/22/2020	
TW WILL OF T	NOVIDEN ON GOLF EIEN			2801 SOUTH HIGHWAY 169		
THE EME	ERALDS AT GRAND R	RAPIDS LLC		GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE COMPLÉTION	
F 000	INITIAL COMMENT	TS .	F 00	00		
	survey was comple complaint investiga NOT to be in compl Requirements for L The following comp SUBSTANTIATED: The facility's plan of	ugh 12/22/20, an abbreviated ted at your facility to conduct a tion. Your facility was found liance with 42 CFR Part 483, ong Term Care Facilities. Islaint was found to be H5495090C If correction (POC) will serve for compliance upon the				
F 550 SS=D	Department's accept Because you are ensignature is not requipage of the CMS-28 submission of the Enverification of computer of the Enverification of computer revisit of you validate that substate regulations has been your verification. Resident Rights/ExcCFR(s): 483.10(a) (\$483.10(a) Resident has a self-determination,	prolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as diance. acceptable electronic POC, ander facility may be conducted to notial compliance with the en attained in accordance with ercise of Rights 1)(2)(b)(1)(2)	F 58	50	1/13/21	
ABORATOP)	outside the facility, this section. §483.10(a)(1) A fac with respect and digresident in a manner.	including those specified in illity must treat each resident gnity and care for each er and in an environment that	IATI IPE	TITLE	(X6) DATE	
	ically Signed	E. VOOLLEICH NEI NEOENTATIVE O OIGI	., (I OI\L	11122	01/08/2021	

(X2) MULTIPLE CONSTRUCTION

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			l ` ′	TIPLE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
		245495	B. WING			C 22/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE CORRECTION OF CO	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 550	promotes mainten her quality of life, rindividuality. The fipromote the rights §483.10(a)(2) The access to quality of severity of condition must establish and practices regarding provision of service residents regardle §483.10(b) Exercise The resident has trights as a resident or resident of the life §483.10(b)(1) The resident can exercite from the facility. §483.10(b)(2) The free of interference correprisal from the facility. §483.10(b)(2) The free of interference reprisal from the facility. Subpart. This REQUIREMED by: Based on observative and preference and pref	ance or enhancement of his or recognizing each resident's acility must protect and of the resident. facility must provide equal care regardless of diagnosis, on, or payment source. A facility dimaintain identical policies and gransfer, discharge, and the es under the State plan for all ses of payment source. See of Rights. The right to exercise his or her acility and as a citizen United States. facility must ensure that the cise his or her rights without cion, discrimination, or reprisal acility in exercising his or her apported by the facility in the ner rights as required under this exercise were honored, and dignity of 3 residents (R1) reviewed	F 5	F550: Resident Rights/E) Immediate Corrective Acti Resident 1's face was was was provided incontinence new brief. Action as it Applies to Oth Call Light and ADL policy All residents will be review	on: shed and he e care and a ers: remain current.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION 3	` ´сом	(X3) DATE SURVEY COMPLETED C	
		245495	B. WING			22/2020	
	PROVIDER OR SUPPLIER ERALDS AT GRAND F	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIF 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 550	indicated R1's diag disease (longstand leading to renal fail builds up), type 2 d cardiomyopathy (ardisease of the hear hemiparesis (must paralysis on one side the arms, legs, and cerebral infarction (non-dominant side, R1's quarterly Minit 11/25/20, indicated required extensive transfers, dressing, and was frequently bladder. R1's Activity of Dail Rehabilitation Care dated 9/9/20, indicated required extensive transfers, dressing, and was frequently bladder. R1's Activity of Dail Rehabilitation Care dated 9/9/20, indicated R1 was to ordered, and staff was transitions. R1's care plan date bladder incontinent and needed assistate plan directed staff to eneeded, staff to eneeded, staff to off and to assist with in	port printed on 12/22/20, noses included chronic kidney ing disease of the kidneys ure, as kidneys fail, waste	F 550	that care plans note their toileting programs as well toileting/incontinence care All staff educated on call I policy as well as providing ADLs and honoring care residents timely. Date of Compliance: 1/13, Audits of 5 random reside 3x/week x 4 weeks, 2x/we then monthly x2 months to residents' individualized to are followed. The results of will be shared with the fact committee for input on the increase, decrease, or disaudits. Audits for call lights will be random call lights 3x/weel 2x/week x 1 week, then months to assure call light answered timely. The rest audits will be shared with committee for input on the increase, decrease, or disaudits. Corrections will be monito DON/Nurse Managers/Decrease.	as to offer es per request. ight and ADL privacy during equests from /21 ents conducted eek x 1 week, assure oileting needs of these audits eility QAPI eneed to continue the econducted on 5 k x 4 weeks, nonthly x 2 ts are being alts of these the facility QAPI eneed to continue the eneed to continue the eneed to continue the eneed to continue the eneed by:		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245495	B. WING				C 22/2020
	PROVIDER OR SUPPLIER	RAPIDS LLC		2801 S	TADDRESS, CITY, STATE, ZIP CODE SOUTH HIGHWAY 169 ND RAPIDS, MN 55744	121	22/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 550	with perineal cares uncovered while sh wash her hands. A the left side of R1's R1 stated he had a breakfast, and nobe-at 1:13 p.m. R1 wastaff were "rough," "banged on the wald On 12/22/20, at 7:1 wheelchair in his rolleft side of his face-at 7:43 a.m. R1 punurse (RN)-A and Neither responded-at 8:00 a.m. NA-A stated he felt like hebowel. NA-A stated else up first. R1 wabeen incontinent of-at 8:38 a.m. R1 punat 8:38 a.m. R1 punat 8:39 a.m. R1's on NA-A. R1 again statincontinent of bowethe call light on. R1 had been incontinent at 8:41 a.m. NA-A stated, "Get me out assist R1 back to be wheelchair, and exilated he wanted to they would put him everything "back to	assistant (NA)-A assisted R1. Following cares, NA-A left R1 be went to change gloves and brown streak was noted down mouth, going down his neck. chocolate protein shake for ody had cleaned him up. as interviewed, and stated the and sometimes his head gets I." 9 a.m. R1 was seated in his form. The brown stain on the and neck were still there. at on his call light. Registered NA-C were in the hallway. To R1's call light. answered R1's call light. answered R1's call light. answered R1's call light. answered to get everyone is not checked to see if he had bowel. To his call light. The had been incontinent of she needed to get everyone is not checked to see if he had bowel. The had showel had bowel. The had been incontinent of the chair of bowel. The had been incontinent of she needed to get everyone is not checked to see if he had bowel. The had been incontinent of the thought he was bell. NA-A left the room, but left was not checked to see if he not of bowel. The had bowel and had answered R1's room. R1 to the chair." NA-A did not ed, but left him in his ited the room. answered R1's call light. R1 ogo back to bed. NA-B stated back to bed after they got	F 5	50			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	. ,	(X3) DATE SURVEY COMPLETED	
		245495	B. WING _		12	C / 22/2020	
	PROVIDER OR SUPPLIER	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZIP 0 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 550	his bed. NA-A enter R1 was transferred amount of BM in his and NA-B changed at 10:42 a.m. R1 will felt like he had to his liked to be able to get stated he cannot a his incontinent brie was incontinent. -at 11:17 a.m. NA-A she did not check to incontinent brief whice. NA-A stated "was too busy." -at 12:32 p.m. licer was interviewed. Listaff to assist R1 to thought he had been asked to go. -at 1:50 p.m. the did interviewed. The D staff to assist a rest they asked, and to brief when the residents deep incontine staff member saying acceptable reason. The facility policy Nassistance Per Cad directed staff to che residents according provided between of the staff to che residents according provided between the staff to che residents according to the staff to che residents acc	red with a mechanical lift, and I to bed. R1 had a small s incontinent brief, and NA-A I him. vas interviewed. R1 stated he ave a BM, and he would have get up and sit on a toilet. R1 lways tell if he has had a BM in f, and he would feel bad if he A was interviewed. NA-A stated to see if R1 had a BM in his nen she answered his call light she didn't check because it ased practical nurse (LPN)-A PN-A stated she would expect to the toilet when he stated he en incontinent, and when he rector of nursing (DON) was ON stated she would expect ident to the bathroom when check a resident's incontinent dent stated they thought they ent. The DON further stated a light are too busy was not an for not providing care. Monarch Healthcare ADL re Plan revised 5/20/18, eck/change/toilet incontinent get to the care plan and pericare	F 55				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245495	B. WING		12/2	2 2/2020
	PROVIDER OR SUPPLIER	APIDS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	undated, directed s asks of them. The p ask the nurse supe fulfill the resident's	taff to do what the resident policy further directed staff to rvisor for help if they cannot	F 550			1/13/21
	CFR(s): 483.25(d)(§483.25(d) Accident The facility must en §483.25(d)(1) The rease free of accident §483.25(d)(2)Each supervision and assaccidents. This REQUIREMEN by: Based on observative review, the facility frositioned properly for 1 of 1 residents during a meal. Findings include: R3's Admission Resindicated R3 had dipneumonia, chronic disease (a group of airflow and make it generalized muscle R3's significant characteristics and the dated 12/3/20, indicated required supervisions.	ts. sure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced ion, interview, and document ailed to ensure a resident was and supervised during a meal (R3) reviewed for supervision cord printed on 12/22/20, agnoses which included c obstructive pulmonary lung diseases that block difficulty to breathe), and weakness. nge Minimum Data Set (MDS) cated R3 had moderately intact n, R3's MDS indicated he		F689: Accidents/Supervision Immediate Corrective Action: R3 is now being properly positioned 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 eathey are properly positioned and supervised during meals. Care plan updated. All staff were educated on the need correctly position/supervise these high-risk residents during meals perindividualized care plan needs. Date of Compliance: 1/13/21 Audits of all residents determined the high risk for aspiration and/or chok be conducted 3x/week x 4 weeks, 2x/week x 1 week, then monthly x 2 months to assure that residents are	d and ion ensure ns were d to er o be ing will	7.10/21

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		245495	B. WING _			C / 22/2020	
	PROVIDER OR SUPPLIER	RAPIDS LLC		STREET ADDRESS, CITY, STATE, ZI 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	•		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE			
F 689	on 12/22/20, at 7:3 sideways in his bed leg near the edge obed at approximate R3 was served his (RN)-B. The tray taknees were up sligdown in the bed. R food, and was eatinhead of the bed wadegrees, not at the -at 8:15 a.m. RN-B R3 was in a safe poneeded supervision respond, but place head, and asked hit table remained up sideways in bed, re-at 8:20 a.m. RN-B assistant (NA)-C if meals. RN-B also asking for "chicken R1 up in bed, place supervise his meal -at 8:21 a.m. RN-B in, and then returned at 8:23 a.m. R3 was when asked how higuice, and had eate was unable to artic -at 11:26 a.m. NA-C stated R3 received meals. NA-C further from pneumonia, a up in a chair for means.	degrees while eating meals. 3 a.m. R3 was observed lying thead off of the pillow with left of the bed, with the head of the ely at 30 degrees. At 8:11 a.m. meal by registered nurse ble was over his legs, R3's htly, and he was slumped the analysis and to reach up to reach his ag eggs with his left hand. The is at approximately 30 directed 90 degrees. was interviewed, and asked if osition for eating, and if he is with eating. RN-B did not do a pillow back under R3's im if he needed help. The tray high, and R3 remained lying eaching up for his food. was heard asking nursing R3 needed supervision for informed NA-C that R3 was at the mat 90 degrees, or	F 68	positioned/supervised peneeds. The results of the shared with the facility Qualifor input on the need to indecrease, or discontinue Corrections will be monite DON/Nurse Managers/Descriptions of the provided in the provided	se audits will be API committee ncrease, the audits. ored by:		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245495	B. WING				C 22/2020
	PROVIDER OR SUPPLIER	RAPIDS LLC		280	EET ADDRESS, CITY, STATE, ZIP CODE 1 SOUTH HIGHWAY 169 AND RAPIDS, MN 55744	<u> 121</u>	2212020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	R3 sometimes need set up, and would g NA-B stated if R3 w "boosted way up" a -at 11:54 a.m. RN-AR3 to be supervised eating in bed, he shadegrees. - at 1:50 p.m. the di interviewed. The DG staff to get assistant bed so they would be possible, if they well DON verified eating degrees would put aspiration. The facility policy D revised 9/17, direct and implement simple the situation. In additional results of the set up.	B was interviewed. NA-B stated ds help to eat, so they got him to back and check on him. It was eating in bed, he should be trained almost 90 degrees. A was interviewed. RN-A stated d when eating, and if he was hould be placed upright at 90 degrees as a resident up in the east close to 90 degrees as a reeating a meal in bed. The gin bed or at less than 90 a resident at risk for a resident to first try to identify ple interventions to manage lition, staff were directed to to make the individual less	F 6	89			



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. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

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

Phone: (218) 302-6151

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health Licensing and Certification Program

Program Assurance Unit Health Regulation Division

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

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

PRINTED: 02/10/2021 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		o. I `	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00299	E	B. WING		12/2	; 2/2020
NAME OF	PROVIDER OR SUPPLIER	STF	REET ADDR	RESS. CITY. S	TATE, ZIP CODE		
		280		H HIGHWAY	,		
I HE EIVII	ERALDS AT GRAND R	GR GR	AND RA	PIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	*****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section order has been issury. If, upon reinspection, iency or deficiencies cited ected, a fine for each violable assessed in accordantines promulgated by rule artment of Health.	ied it is d ation ace				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all erule provided at the tagule number indicated belons several items, failure the items will be consider Lack of compliance uponly item of multi-part rule ment of a fine even if the uring the initial inspection	ow. co red on will e item				
	that may result from orders provided tha the Department witl	hearing on any assessment non-compliance with the transition and the transition are the transition of a sent for non-compliance.	ese de to				
	survey was conductivith State Licensure NOT in compliance Please indicate in y correction that you	rs: gh 12/22/20, an abbrevia ted to determine complia e. Your facility was found with the MN State Licens our electronic plan of have reviewed these orde when they will be comp	to be sure.				

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

01/08/21 **Electronically Signed**

STATE FORM 6899 CCCZ11 If continuation sheet 1 of 9

TITLE

(X6) DATE

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	` 'c	OATE SURVEY	
			A. BUILDING:			
		00299	B. WING		C 12/22/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
THE EM	ERALDS AT GRAND F	PAPINS LLC:	TH HIGHWA APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 000	Continued From page 1		2 000			
	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.					
2 830	MN Rule 4658.0520 Subp. 1 Adequate and		2 830		1/13/21	
	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.					
	by: Based on observative review, the facility for positioned properly for 1 of 1 residents during a meal. Findings include: R3's Admission Residuated R3 had dipneumonia, chronic	ent is not met as evidenced ion, interview, and document ailed to ensure a resident was and supervised during a meal (R3) reviewed for supervision cord printed on 12/22/20, agnoses which included a obstructive pulmonary flung diseases that block		F689: Accidents/Supervision Immediate Corrective Action: R3 is now being properly positioned an 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 ensurthey are properly positioned and supervised during meals. Care plans wupdated. All staff were educated on the need to	e	

Minnesota Department of Health

STATE FORM 6899 CCCZ11 If continuation sheet 2 of 9

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDING:	<u> </u>		
		00299	B. WING		C 12/22/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EMI	ERALDS AT GRAND F	RAPIDSTIC	TH HIGHWA			
	0.18.44.5% 0.74		APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From page 2		2 830			
2 830	airflow and make it generalized muscle R3's significant chadated 12/3/20, indic cognition. In addition required supervision R3's care plan date sit at or close to 90 On 12/22/20, at 7:3 sideways in his bedieg near the edge obed at approximate R3 was served his (RN)-B. The tray tak nees were up slight down in the bed. R3 food, and was eating head of the bed wadegrees, not at the -at 8:15 a.m. RN-B R3 was in a safe poneeded supervision respond, but placed head, and asked hit table remained up I sideways in bed, re-at 8:20 a.m. RN-B assistant (NA)-C if meals. RN-B also in asking for "chicken R1 up in bed, place supervise his mealat 8:21 a.m. RN-B	difficulty to breathe), and a weakness. ange Minimum Data Set (MDS) cated R3 had moderately intact on, R3's MDS indicated he in with eating. and 9/2/20, indicated R3 was to degrees while eating meals. and and an	2 830	correctly position/supervise these residents during meals per individ care plan needs. Date of Compliance: 1/13/21 Audits of all residents determined high risk for aspiration and/or chobe conducted 3x/week x 4 weeks, 2x/week x 1 week, then monthly x months to assure that residents a positioned/supervised per their caneeds. The results of these audits shared with the facility QAPI comminput on the need to increase, decor discontinue the audits. Corrections will be monitored by: DON/Nurse Managers/Designee	to be king will 2 re being re plan s will be mittee for	
	-at 8:23 a.m. R3 wa when asked how hi	as interviewed. R3 cursed is meal was. R3 had drank his n a small amount of eggs. R3				

Minnesota Department of Health

STATE FORM 6899 CCCZ11 If continuation sheet 3 of 9

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPP IDENTIFICATION		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00299		B. WING			C 22/2020
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EMI	ERALDS AT GRAND F	RAPIDS LLC		TH HIGHWA APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCY MUST BE PRECEDED SC IDENTIFYING INFOR	CIES BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	was unable to articular to a transfer to get assistant bed so they would be possible, if they were DON verified eating degrees would put a situation. In addaddress factors tha attentive or drowsy	culate what was wroten assistance "on and restated R3 was rend had not been wals. NA-C stated Fores if eating in be as was interviewed. It is back and check was eating in bed, but almost 90 degree as close to 90 degree a	NA-C d off" with covering anting to get the should be d. NA-B stated hey got him on him. he should be es. RN-A stated I if he was right at 90 DON) was ald expect dent up in egrees as bed. The han 90 or Protocol o identify o manage rected to all less CTION: The	2 830			
	director of nursing of and/or revise facility related to proper po	polices and proce	edures				

Minnesota Department of Health

STATE FORM 6899 CCCZ11 If continuation sheet 4 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
00299		B. WING		C 12/22/2020			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						1,2020	
THE EMERALDS AT GRAND RAPIDS LLC 2801 SOUTH HIGHWAY 169							
	GRAND RAPIDS, MN 55744						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 4	2 830				
	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.						
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights		21805			1/13/21	
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a					
	by: Based on observati review, the facility fa needs and preferen was provided for 1 of for dignity. Findings included: R1's Diagnosis Rep indicated R1's diagnosis disease (longstandi leading to renal failt builds up), type 2 di cardiomyopathy (and disease of the hear hemiparesis (muso paralysis on one sic the arms, legs, and	ent is not met as evidenced on, interview, and document ailed to ensure a resident's ces were honored, and dignity of 3 residents (R1) reviewed ort printed on 12/22/20, noses included chronic kidneying disease of the kidneys ure, as kidneys fail, waste abetes, ischemic acquired or hereditary through the muscle), hemiplegia and the weakness or partial the of the body that can affect facial muscles) following stroke) affecting left		F550: Resident Rights/Exercise of Immediate Corrective Action: Resident 1's face was washed and provided incontinence care and a rebrief. Action as it Applies to Others: Call Light and ADL policy remain of All residents will be reviewed to enthat care plans note their individual toileting programs as well as to off toileting/incontinence cares per recall staff educated on call light and policy as well as providing privacy ADLs and honoring care requests residents timely. Date of Compliance: 1/13/21 Audits of 5 random residents cond 3x/week x 4 weeks, 2x/week x 1 weeks and monthly x2 months to assure	d he was new urrent. sure I er quest. ADL during from		

Minnesota Department of Health

STATE FORM 6899 CCCZ11 If continuation sheet 5 of 9

NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT GRAND RAPIDS LLC STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATI		SURVEY LETED	
NAME OF PROVIDER OR SUPPLIER THE FMERAL DS AT GRAND RAPIDS LLC STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169							
THE EMERAL DS AT GRAND RAPIDS LLC 2801 SOUTH HIGHWAY 169			00299	B. WING 12/22/20			2/2020
THE EMERAL DS AT GRAND RAPIDS LLC	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
טווחוט ווחו טטודי	THE EM	ERALDS AT GRAND R	RAPIDSTIC				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIANCE)	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	(X5) COMPLETE DATE
21805 Continued From page 5 21805	21805	Continued From pa	ge 5	21805			
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 perinael 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	21805	non-dominant side, R1's quarterly Minir 11/25/20, indicated required extensive transfers, dressing, and was frequently bladder. R1's Activity of Daily Rehabilitation Care dated 9/9/20, indicated 9/9/20, indicated R1 was to ordered, are plan date hygiene, dressing, a indicated R1 was to ordered, and staff v transitions. R1's care plan date bladder incontinent and needed assista plan directed staff to reach while in bed, products, staff to er needed, staff to offe and to assist with ir On 12/21/20, at 12: observed. Nursing a with perineal cares, uncovered while sh wash her hands. A the left side of R1's R1 stated he had a breakfast, and nobe -at 1:13 p.m. R1 was	and muscle weakness. num Data Set (MDS) dated R1 was cognitively intact, and assistance with bed mobility, toilet use, personal hygiene, incontinent of bowel and y Living (ADL) Functional / Area Assessment (CAA) ated R1 required extensive I mobility, transfers, personal and toilet use. R1's CAA aparticipate in therapies as were to assist with cares and are related to impaired mobility, ance with toileting. The care to have the call light within resident to wear incontinence appty urinal every shift and as the toileting every two hours, accontinence cares as needed. 54 p.m. R1's cares were assistant (NA)-A assisted R1. Following cares, NA-A left R1 e went to change gloves and brown streak was noted down mouth, going down his neck, chocolate protein shake for ody had cleaned him up.	21805	are followed. The results of these will be shared with the facility QAF committee for input on the need to increase, decrease, or discontinue audits. Audits for call lights will be conduct random call lights 3x/week x 4 wee 2x/week x 1 week, then monthly x months to assure call lights are be answered timely. The results of the audits will be shared with the facili committee for input on the need to increase, decrease, or discontinue audits. Corrections will be monitored by:	audits Pl the the sted on 5 eks, 2 eing ese ty QAPI	

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
00299		B. WING	B. WING		C			
	00299 B. WING 12/22/2020							
NAME OF F	PROVIDER OR SUPPLIER	STR	EET ADDRESS, CITY	, STATE, ZIP CODE				
THE EM	ERALDS AT GRAND R	RAPIDSTIC	1 SOUTH HIGHV AND RAPIDS, MI					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
21805	Continued From pa	ge 6	21805					
	On 12/22/20, at 7:1 wheelchair in his ro left side of his face	9 a.m. R1 was seated in lom. The brown stain on tand neck were still there.	he					
	-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 lightat 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 bowelat 8:38 a.m. R1 put on his call lightat 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		R1					
			,					
		returned to R1's room. R						
	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.		ot					
	-at 9:02 a.m. NA-B stated he wanted to they would put him	answered R1's call light. I go back to bed. NA-B staback to bed after they go	ated					
	his bed. NA-A enter	the kitchen." entered R1's room and med with a mechanical lift, to bed. R1 had a small						
	amount of BM in his and NA-B changed	s incontinent brief, and NA						
	felt like he had to ha liked to be able to g stated he cannot al	ave a BM, and he would he up and sit on a toilet. Feways tell if he has had a Effand he would feel bad if	nave R1 BM in					
		was interviewed NΔ-Δ s	tated					

she did not check to see if R1 had a BM in his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
00299		B. WING		C 12/22/2020		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 12/2	2/2020
THE EMI	ERALDS AT GRAND F	RAPIDS LLC	TH HIGHWA			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	APIDS, MN	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLÉTE DATE
21805	Continued From pa	ge 7	21805			
	incontinent brief when she answered his call light twice. NA-A stated she didn't check because it "was too busy."					
	was interviewed. LF staff to assist R1 to	sed practical nurse (LPN)-A PN-A stated she would expect the toilet when he stated he in incontinent, and when he				
	interviewed. The Do staff to assist a resi they asked, and to brief when the resid had been incontine staff member sayin	rector of nursing (DON) was ON stated she would expect ident to the bathroom when check a resident's incontinent dent stated they thought they nt. The DON further stated a g they are too busy was not an 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.					
	undated, directed s asks of them. The	nswering the Call Light taff to do what the resident policy further directed staff to rvisor for help if they cannot request.				
	director of nursing of and/or revise facility related to maintaini lights. The DON or staff on these police	THOD OF CORRECTION: The or designee, could review y polices and procedures ng dignity and answering call designee could re-educated es and procedures. The DON develop monitoring systems to mpliance.				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING:		PLETED		
		l =		С		
00299			B. WING		12/2	22/2020
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 ORAND RAPIDS LLC					
INE EIVI	ERALDS AT GRAND R	GRAND I	55744			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 8	21805			
21805	·	ge 8 R CORRECTION: Twenty one	21805			

Minnesota Department of Health