Electronically delivered
March 19, 2021

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

RE: CCN: 245495
Cycle Start Date: March 4, 2021

Dear Administrator:

On March 4, 2021, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 3, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 3, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 3, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 3, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Emeralds At Grand Rapids Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 3, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being

corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Terri 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
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 4, 2021 if your facility does not

achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (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 03/04/2021

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

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F 000	INITIAL COMMENTS On 3/1/21, through 3/4/21, an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5495099C (MN68385, MN68505, MN68367) and H5495100C (MN70258). The following complaints were found to be UNSUBSTANTIATED: H5495094C (MN52729), H5495095C (MN59318), H5495096C (MN59336), H5495097C (MN66720), and H5495098C (MN68369). 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. 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 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		3/31/21

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

Electronically Signed | 03/26/2021

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F 686	Continued From page 1 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure repositioning and off-loading of pressure was completed to prevent development of pressure ulcers for 1 of 3 residents (R3) reviewed for pressure ulcers. Findings include: R3's Transfer/Discharge Report dated 3/4/21, indicated R3's diagnoses included morbid obesity, chronic pain, heart failure, and muscle weakness. R3's quarterly Minimum Data Set (MDS) dated 1/22/21, indicated R3 was cognitively intact and required extensive assistance with bed mobility and transfers. In addition, the MDS indicated R3 did not walk, and was occasionally incontinent of bowel and bladder. R3's Pressure Ulcer/Injury Care Area Assessment (CAA) dated 12/3/20, identified R3 was at risk for skin breakdown due to impaired mobility and frequent bladder incontinence. The CAA further identified staff were to check, change, offer toileting, and reposition R3 every two hours. R3's care plan dated 10/18/20, indicated R3 had	F 686	F686 Treatment to Prevent/Treat Pressure Ulcers Immediate Corrective Action: Resident #5 was repositioned. NAR assigned to this resident was educated on need to reposition resident per individualized needs on care plan. Corrective Action as it applies to others: The Activity of Daily Living Policy was reviewed and remains current. All nurses, TMAs, and NARs were re-educated on the Activity of Daily Living Policy specifically providing assistance with repositioning per resident individualized care pan. All residents needing assistance with repositioning will be provided this assistance per care plan/care sheet details. Date of Compliance: 3/31/2021 Recurrence will be prevented by: Audits of 5 random residents will be completed weekly x 4 then monthly x 2 months to assure timely assistance is provided for repositioning. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the	

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F 686	Continued From page 2 a history of a pressure ulcer to her coccyx, and was at increased risk for skin breakdown related to the need for assistance with mobility and incontinence. R3's care plan directed staff to turn and reposition R3 every two hours, however, R3 refused repositioning at times. R3's Pocket Care Plan dated 3/1/21, indicated R3 was to be repositioned every two hours. On 3/2/21, at 2:03 p.m. during constant observations, R3 was seated in a motorized wheelchair near the entrance of her room. R3 wheeled to a table in the facility dining room and participated in a bingo activity. R3 wheeled away from the table and spoke to an individual about the bingo activity, and again wheeled towards a table and retrieved a mug. R3 wheeled to the kitchen, pushed the door open, and stated "hello." Staff responded and R3 requested a cup of coffee. R3 wheeled to her room at 3:23 p.m. and partially closed her door. The administrator approached R3's room and removed a wheeled vitals machine from R3's room entry. The administrator did not offer to reposition R3. Licensed practical nurse (LPN)-E entered R3's room with a wheeled vitals machine and oral medications. R3 requested her wheelchair seatbelt to be readjusted. LPN-E unfastened R3's wheelchair seatbelt and readjusted it. LPN-E then administered R3's oral medications, completed a blood glucose check, and took R3's vital signs. LPN-E performed hand hygiene and exited R3's room at 4:02 p.m. R3 was not offered repositioning. No staff entered R3's room from 4:03 p.m. to 4:40 p.m. 2 hours and 37 minutes had passed since the continuous observation began.	F 686	audits. Corrections will be monitored by: DON/Nurse Managers/Designee	

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F 686	Continued From page 3	F 686		

On 3/2/21, at 4:40 p.m. an interview was conducted with LPN-E. LPN-E stated R3 was to be repositioned every two hours, however, used the tilt function on her wheelchair to independently offloaded pressure. LPN-E stated she believed it was acceptable to offload pressure by using the wheelchair tilt function.

On 3/4/21, at 9:34 a.m. an interview was conducted with R3. R3 stated staff offered to reposition her, but she often refused. R3 stated she used the tilt function on her electric wheelchair to reposition when she was up.

On 3/4/21, at 9:51 a.m., an interview was conducted with trained medication assistant (TMA)-A. TMA-A stated R3 needed to be turned and repositioned. TMA-A stated R3 was able to roll herself side-to-side and scoot back in her wheelchair. TMA-A stated staff were supposed to make sure R3 was repositioned every two hours. TMA-A states sometimes R3 tilted her wheelchair back or "wiggled" independently. TMA-A stated pressure should be offloaded for one minute.

On 3/4/21, at 10:12 a.m. an interview was conducted with occupational therapist (OT)-A. OT-A stated R3 was able to independently tilt her wheelchair, and this was an acceptable method to offload pressure. OT-A stated R3 was also able to "slightly" reposition herself. OT-A stated a cushion was recently added to R3's wheelchair for better positioning. Manufacturer guidelines were requested for R3's wheelchair and OT-A stated he would contact the vendor.

On 3/4/21, at approximately 10:30 a.m., a follow-up interview was conducted with OT-A. OT-A stated modifications were made to R3's

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F 686	Continued From page 4 wheelchair. OT-A stated the manufacturer (Robi) informed him since modifications were made to R3's wheelchair, the wheelchair could not provide weight redistribution. On 3/4/21, at 12:20 p.m., an interview was conducted with the director of nursing (DON). The DON stated she believed R3 was to be repositioned very two to three hours, but didn't know off the top of her head. The DON stated R3 did not have any skin issues. The facility policy Monarch Healthcare ADL (Activity of Daily Living) policy revised 5/16, directed, "Based upon resident/resident representative desires, assessment and care plan, ADL assistance will be provided to any residents deemed necessary."	F 686		
F 689 SS=G	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 safety interventions were in-place, prior to a resident leave of absence (LOA), and additional interventions were developed for subsequent unapproved outings and/or intoxication for 1 of 3 residents (R1) reviewed for accidents. This	F 689	F689 Free of Accident/Hazard/Supervision/Devices Immediate Corrective Action: Resident #1 now has appropriate interventions in place for LOAs. Personalized Interventions include:	3/31/21

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F 689	Continued From page 5 resulted in actual harm for R1 who left the facility for four hours, was sent to the emergency department (ED) when he returned, received intravenous (IV) fluids, and was diagnosed with superficial frostbite. Findings include: R1's Admission Record printed 3/4/21, indicated R1's diagnoses included quadriplegia, traumatic brain injury, and mild cognitive impairment. R1's quarterly Minimum Data Set (MDS) dated 2/25/21, identified R1 had intact cognition. R1 was totally dependent upon staff for transfers, did not walk, and required supervision with locomotion. R1 used a wheelchair and had an indwelling urinary catheter. A Guardianship/Conservatorship document dated 5/2/18, indicated family member (FM)-A was R1's court appointed guardian/conservator as R1 "was impaired to the extent of lacking sufficient understanding or capacity to make or communicate responsible decisions concerning Respondent's personal needs for medical care, nutrition, clothing, shelter or safety." Further, "The Respondent [R1] is requesting a guardian and conservator due to his lack of capacity in regards to safety and decision making." R1's care plan undated, identified R1 went into the community when FM-A approved. R1's care plan further identified R1 had a history of leaving the facility with his roommate, and returning intoxicated. The care plan identified staff educated R1 related to the risks of leaving the facility for extended periods of time in the cold. Interventions included educating R1 on facility	F 689	Educate resident on the risk of going into the community independently notify staff of resident's whereabouts and intended return time. Provide ongoing education to resident and friendly reminders on how to use the resident sign out book when going on an outing. Provide resident with facility contact number and save in phone so that they may provide verbal updates about outing as necessary Resident and facility representative will obtain verbal consent prior to leaving the facility. Elopement risk evaluation per policy. Educate resident on facility bed hold and LOA policies and educate resident on his individual plan and LOA instructions as applicable. Resident #1 Guardian was contacted regarding preferences for resident LOA and care plan updated to reflect changes. Corrective Action as it applies to others: Leave of Absence policy was reviewed and remains current. Leave of Absence Sign out Book forms were edited to designate an estimated return time for the resident and column to indicate whether resident is appropriately dressed for the weather. All residents with Guardians had Guardian contacted for their preference on LOAs for the resident and care plans updated to reflect this preference, along with necessary steps to follow for individual residents' LOA.	

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F 689	Continued From page 6 LOA policies and his individual LOA plan, educating R1 on the risks of going into the community independently, notifying staff of his whereabouts, and notifying staff of his expected return time. R1's next-of-kin, the charge nurse, R1's physician, and police were to be notified if his whereabouts were unknown or did not return at the expected time, education was provided regarding signing the resident sign-out book and how to contact the facility in-case of an emergency; and FM-A approval was required prior to R1 leaving the facility. R1's group sheet undated, directed, "If wanted to go out of the facility, [FM-A] must be called prior to every outing to get approval and must be accompanied by his mother or designee." On 10/23/20, at 5:44 p.m. a progress note indicated FM-A had called the facility and voiced concerns regarding R1 going "shopping or anywhere else" in his wheelchair. If R1 attempted to leave the facility, FM-A wanted a manual wheelchair given to him. On 11/9/20, at 1:34 p.m. a progress note indicated FM-A wanted to keep R1 in the facility, and not go to the store, due to the COVID-19 pandemic. On 12/1/20, at 8:00 p.m. a progress note indicated the facility received a telephone call at approximately 7:45 p.m. from FM-A. FM-A was informed R1 was quarantined in his room due to a trip to a store the previous day. FM-A questioned why R1 was allowed to leave the facility, due to COVID-19. The progress note further indicated FM-A had been contacted by the day shift nurse, and FM-A agreed to allow the	F 689	All nursing staff were re-educated on the LOA Policy specifically regarding ensuring resident is wearing appropriate clothing for the LOA, resident is signed out for the LOA, and resident is contacted at the expected return time Date of Compliance: 3/31/21 Recurrence will be prevented by: Audits of 5 random resident LOAs will be completed weekly x 4 then monthly x 2 months to assure appropriate safety interventions were in place & 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. Corrections will be monitored by: Social Services Director/Designee	

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F 689	Continued From page 7	F 689		

outing.

On 12/4/20, at 9:24 a.m. a progress note indicated FM-A was contacted regarding R1 requesting to go to a store. FM-A was "okay" if R1 went to the store when it was daylight, however, requested he was back before dark.

On 12/8/20, at 4:11 p.m. a progress note indicated three 50 milliliter bottles of alcohol were found in R1's room. R1 stated, "I wish those bottles were mine." The bottles were removed from R1's room.

On 12/19/20, at 11:22 p.m. a progress note indicated R1 left the facility at 4:40 p.m. "against writer advise [sic]." R1 was instructed it "was getting dark" and his mother did not want him to be out in "this kind of weather." R1 replied it was not dark and he wanted to go get something to eat. R1 returned to the facility at 8:40 p.m. with slurred speech, thrashing arms, and stated he wanted to die. R1 was noted to be "half way" out of his wheelchair and was partially undressed. R1's pants were "half off," and his coat was noted to be unzipped with his abdomen exposed. R1 had a "small abrasion" to the third toe on his right foot. R1's catheter was "frozen" and his body was "severely cold." R1 was sent to the emergency department (ED) at 9:30 p.m., and FM-A was notified. The progress notes further indicated FM-A stated, "She encouraged her son to not go out in the cold or after dark but she says that her son will do the things he is not suppose to do."

Accuweather indicated the temperature in Grand Rapids, MN on 12/19/20, was between -5 degrees Fahrenheit (F) and 21 degrees F.

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	245495	A. BUILDING _____ B. WING _____	C 03/04/2021

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

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A document titled Resident Sign Out indicated R1 signed out of the facility at 4:40 p.m. on 12/19/20.

ED Provider Notes dated 12/19/20, indicated R1 was evaluated with a concern for hypothermia and altered mental status. R1 felt warm-to-touch, however, had cold knees, was slurring words, and was belligerent. R1 had no witnessed or suspected trauma, but was assumed he had slid out of his wheelchair. R1 was agitated, and required a sedation protocol. Intravenous fluids were given in addition to external warming measures. R1 was noted to have "superficial frostbite on both of his knees." R1's blood alcohol level was 0.2 and consistent with intoxication. A Urinalysis (urine sample) was collected and was expected to be "dirty [urinary tract infection]" due to freezing. R1 was prescribed an antibiotic and discharged back to the facility.

On 12/20/20, at 4:13 a.m. a progress note indicated R1 returned to the facility at 4:00 a.m. R1 returned with an antibiotic prescription to prevent a urinary tract infection and "for the areas of frostbite."

On 12/21/20, at 1:00 p.m. a progress note indicated risk versus (vs.) benefit information related to alcohol use and unaccompanied LOAs were presented to R1. R1 stated he would continue to leave the facility "if he so chooses."

On 12/21/20, at 1:35 p.m. a progress note indicated a social worker, director of nursing (DON), and the administrator had a care conference with FM-A. A conversation related to risk vs. benefits were reviewed with FM-A.

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On 1/1/21, at 9:00 p.m. a progress note indicated R1 showed a nurse a video in which someone had taken of him spinning in circles on the "icy/snowy" walkway of the smoking patio. R1 was educated he could be hurt by doing so.

On 2/1/21, at 10:28 p.m. indicated R1 had been out of the facility with his roommate until approximately 6:00 p.m. The progress notes further indicated "He appears to be in a very pleasant mood and not quite himself. He is very friendly and giggly."

A progress note dated 2/18/21, at 2:33 p.m., indicated R1 talked about going to a store with another resident.

On 3/1/21, at 12:18 p.m. R1 was observed to exit his room in an electric wheelchair and approached the nurses' station. R1 was wearing a jacket, hat, and boots. A backpack was hanging on the back of R1's wheelchair. R1 was administered medications at 12:23 p.m., and returned to his room at 12:24 p.m.

On 3/2/21, at 10:24 a.m. R1 wheeled towards the smoking entrance. R1 was wearing a jacket, hat, and boots. Staff opened a door and R1 proceeded to the smoking area.

On 3/2/21, at 10:26 a.m. an interview was conducted with NA-B. NA-B stated residents who were cognitively intact were allowed to leave for outings. NA-B stated she notified a nurse, or nurse manager, if a resident wanted to go on an outing. NA-B stated if she saw a resident leave the facility without approval, she would stay with a resident until she knew if it was approved. NA-B

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stated residents filled out a sign-out log when they wanted to leave the facility. NA-B stated R1 liked to go to the store, but was not sure how he got there. NA-B stated she believed R1 asked staff when he wanted to leave. NA-B stated R1 was cognitively intact, but had a brain injury.

On 3/2/21, at 10:39 a.m. an interview was conducted with licensed practical nurse (LPN)-A. LPN-A stated R1 often went on outings. LPN-A stated R1 did tell staff when he was leaving and where he was going. LPN-A stated on 12/19/20, R1 stated he was going to the store, and returned to the facility intoxicated, and his roommate was with him. LPN-A stated she was unsure what the temperature was when R1 left the facility. LPN-A stated she did not recall what time R1 had left or returned to the facility. LPN-A stated she believed R1 was gone for "a couple of hours." LPN-A stated when R1 had returned, it appeared like he had fallen out of his wheelchair, and his roommate had "put him back in." LPN-A stated R1 was "half out" of his wheelchair and his jacket was unzipped. LPN-A stated R1's catheter was frozen, and his belly was showing. LPN-A stated R1 was "so cold." LPN-A stated NA-C brought R1 to his room and he kept saying that he "wanted to die." LPN-A stated staff put R1 in his bed, warmed him up with heated blankets, and called 911. LPN-A stated since the incident, FM-A expected to know when R1 requested to leave the facility, and what time he will return. LPN-A stated she did not recall if she contacted FM-A for approval for R1 to leave the facility on 12/19/20. LPN-A stated the facility "started" communicating with FM-A after the incident occurred. LPN-A stated she believed R1 had previously been intoxicated and had "history" of intoxication since being admitted to the facility.

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LPN-A stated she did not recall when R1 had been intoxicated before the incident on 12/19/20.

On 3/2/21, at 10:59 a.m. an interview was conducted with NA-C. NA-C stated R1 liked to go on outings, and was hanging around another male resident who was half his age. NA-C stated she was unsure if R1 normally informed staff when he went on outings, but believed he did not sign in and out. NA-C stated R1 had intact cognition and "knew what he was doing." NA-C stated facility staff caught R1's roommate intoxicated on a couple of occasions. NA-C stated there was two incidents in which R1 was intoxicated. NA-C stated she was unable to recall when the first incident occurred. NA-C stated R1 and his roommate came back from the store, was unsure of the date, and she suspected both residents were intoxicated. NA-C stated LPN-B called the administrator and DON. NA-C stated staff were instructed in the future to call 911 if the residents came back to the facility intoxicated. NA-C stated the second incident happened on 12/19/20. NA-C stated she arrived to work at 6:00 p.m. and R1 returned to the facility well after dinner. NA-C stated staff found R1 in the Unit 4 dining room near the smoking door. NA-C stated R1 was "half way out of his wheelchair" and did not verbally make sense. NA-C stated R1's belly was red, his legs were ice cold, and his catheter was frozen. NA-C stated R1 had no idea where he was or what he was doing. NA-C stated R1 was so disoriented he could not operate his electric wheelchair. NA-C stated staff brought R1 to his room, minor scrapes were noted on his "back side," and his belly was "red and purple." NA-C stated R1's right big toe was bloody, and R1 accused staff of trying to kill him. NA-C stated staff removed R1's pants and placed heated

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blankets on him. NA-C stated R1 was sent to the hospital. NA-C stated the facility did not have interventions in-place when R1 left for a LOA, prior to the incident on 12/19/20.

On 3/2/21, at 12:24 p.m. an interview was conducted with NA-D. NA-D stated R1 notified staff when he wished to leave the facility. NA-D stated R1 used the sign-out book, and staff were supposed to let the nurse know when he wanted to leave. NA-D stated she was not aware of any time where R1 tried to leave without signing out or was intoxicated.

On 3/2/21, at 12:29 p.m. an interview was conducted with R1. R1 stated he did not have frostbite from the time he left the facility on 12/19/20. R1 stated it was like when a "child had a red nose." R1 stated if he wanted to go to the store, he called for the bus and notified staff. R1 stated the incident (on 12/19/20) was not a big deal. R1 stated FM-A made sure the facility called her when he wished to go on an outing. R1 stated he would usually call FM-A and bring his phone to nursing staff.

On 3/2/21, at 12:54 p.m. an interview was conducted with registered nurse (RN)-A. RN-A stated R1 liked to go on outings quite often. RN-A stated R1 typically went to a store or restaurant across the highway. RN-A stated R1 also went to the hardware store on a couple of occasions. RN-A stated when R1 wanted to leave the facility it was a "special case." RN-A stated staff needed to contact FM-A, and FM-A made decisions for him. RN-A stated R1 usually handed her the phone with FM-A already on the line when he wished to leave. RN-A stated R1 informed staff of when he was leaving and when

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he was expected to return. RN-A stated staff had R1 also use the sign-out book. RN-A stated she had not seen R1 intoxicated, however, verbalized there was one occasion when R1 was known to get intoxicated and was sent to the hospital. RN-A stated R1 had suffered from frostbite when he was sent to the hospital. RN-A stated R1 never disappeared without telling anyone, and staff needed to call the police if he left without permission.

On 3/3/21, at 9:40 a.m. an interview was conducted with FM-A. FM-A stated she was told R1 was intoxicated and suffered from frostbite on 12/19/20. FM-A stated she was R1's guardian, and "sometimes they call me about his outings, sometimes they don't." FM-A stated she did not recall if facility requested approval for R1 to leave the facility on 12/19/20. FM-A stated the facility put interventions in-place after the incident occurred. FM-A stated she was comfortable with the plan as long as it was enforced. FM-A stated the facility was now reliably calling her when R1 wished to leave the facility. FM-A stated she did not believe R1 should consume alcohol, but that was a "doctor's decision."

On 3/3/21, at 9:56 a.m. an interview was conducted with social worker (SW)-A. SW-A stated R1 was cognitively intact, however, had a deficit in making good choices. SW-A stated R1 had a history of frequent accidents prior to admission and suffered a traumatic brain injury when he was 17 years old. SW-A stated R1 lacked consequential thinking, and required FM-A's approval prior to leaving the facility. SW-A stated on 12/19/20, R1 and his roommate went to the store and returned to the facility between 7:00 p.m. to 7:30 p.m. SW-A stated

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R1's shirt was pulled up and his pants were half-way down. SW-A stated R1 was sent to the hospital, and possibly was diagnosed with frostbite. SW-A stated when R1 returned to the facility, a risk vs. benefit document was completed with R1 and his roommate. SW-A stated the facility wanted both residents to be more cognizant when they went on an outing. SW-A stated she was unable to recall if R1 had become intoxicated prior to the incident on 12/19/20, but thought R1 may have had one other occurrence of intoxication prior to 12/19/20. SW-A stated nothing like the incident on 12/19/20, had happened before. SW-A stated the facility now made sure FM-A's approval was obtained prior to R1 leaving for an outing. SW-A stated facility staff were to call law enforcement if he left without approval. SW-A stated she was unsure if facility staff obtained FM-A's approval prior to leaving the facility on 12/19/20.

On 3/3/21, at 10:23 a.m. an interview was conducted with RN-C. RN-C stated R1 needed to call FM-A for approval, and use the sign-out book prior to leaving for an outing. RN-A stated she was only aware of one occasion in which R1 was intoxicated. RN-C stated she was not aware of R1 being intoxicated since the incident on 12/19/20, however, suspected his roommate of consuming alcohol. RN-C stated an incident occurred two weeks ago in which R1 and his roommate left the facility without telling anyone. RN-C stated R1's roommate got his stimulus check and went to the store. RN-C stated staff called her and stated they were unable to find R1. RN-C stated she instructed staff to call law enforcement. RN-C stated staff contacted the DON, however, R1 had since been tracked down. RN-C stated she spoke to R1 and he told her

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FM-A gave SW-A permission for him to leave the facility. RN-C stated SW-A told her she did not speak to FM-A. RN-C stated she did not know if any new interventions were put into place since R1 left the facility without permission from R1.

On 3/3/21, at 10:32 a.m. an interview was conducted with the DON and administrator. The administrator stated staff called R1's cell phone because he was gone longer than expected on 12/19/20. The administrator stated R1 stated he and his roommate were heading back to the facility. The DON stated R1 and his roommate got "drunk" and were intoxicated when they returned to the facility. The administrator stated staff put R1 in bed, performed a skin assessment, and covered him with blankets. The administrator stated the ambulance was called and R1 was sent to the hospital. The administrator stated R1 was noted to have frostbite to his toes and stomach. The administrator stated after the incident occurred a risk vs. benefit was completed with R1. The administrator stated the facility also added an intervention of contacting FM-A prior to R1 leaving the facility. The DON stated she was not sure if there were any interventions in-place prior to the incident on 12/19/20, because R1 was alert and oriented. The administrator stated FM-A was historically "wishy washy" about R1 leaving the facility. The administrator stated staff spoke to R1 about obtaining an order for consuming alcohol, however, R1 refused as he did not like the way it made him feel. The administrator stated he did not believe there were any previous incidents in which R1 had been intoxicated at the facility. The administrator stated he did not believe there had been any incidents since 12/19/20, in which R1 had been intoxicated. The DON stated R1

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needed FM-A's permission prior to leaving the facility, and staff were to call the police if he left without permission. The DON stated she was not aware of any occurrence in which R1 had left the facility without FM-A's permission. The administrator stated a full-house assessment was completed for all residents who took LOAs. The administrator stated he was unsure if any staff-education was conducted.

On 3/4/21, at 11:25 a.m. a follow-up interview was conducted with SW-A. SW-A stated R1 had left the facility a couple of weeks ago with his roommate. SW-A stated she is unsure if facility staff called FM-A. SW-A stated she asked if R1 had permission to leave the facility, and when he was coming back. SW-A stated she instructed staff to call FM-A an additional time to ensure the leave was approved. SW-A stated she felt staff should enter a note in R1's medical record so the facility knew if FM-A was notified.

The facility policy Safety and Supervision of Residents dated 7/17, directed, "Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents." Further, "The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents."

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 19, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: Y11V11

Dear Administrator:

The above facility was surveyed on March 1, 2021 through March 4, 2021 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:

Terri 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
Office: (218) 302-6151 Mobile: (218) 766-2720

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

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

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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 3/1/21, through 3/4/21, 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 is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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

Electronically Signed | 03/26/21

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 03/04/2021

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5495099C (MN68385, MN68505, MN68367) and H5495100C (MN70258) with a licensing orders issued at S830 and S900. The following complaints were found to be UNSUBSTANTIATED: H5495094C (MN52729), H5495095C (MN59318), H5495096C (MN59336), H5495097C (MN66720), and H5495098C (MN68369).	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
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	2 830		3/31/21

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2 830	Continued From page 2 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 safety interventions were in-place, prior to a resident leave of absence (LOA), and additional interventions were developed for subsequent unapproved outings and/or intoxication for 1 of 3 residents (R1) reviewed for accidents. This resulted in actual harm for R1 who left the facility for four hours, was sent to the emergency department (ED) when he returned, received intravenous (IV) fluids, and was diagnosed with superficial frostbite. Findings include: R1's Admission Record printed 3/4/21, indicated R1's diagnoses included quadriplegia, traumatic brain injury, and mild cognitive impairment. R1's quarterly Minimum Data Set (MDS) dated 2/25/21, identified R1 had intact cognition. R1 was totally dependent upon staff for transfers, did not walk, and required supervision with locomotion. R1 used a wheelchair and had an indwelling urinary catheter. A Guardianship/Conservatorship document dated 5/2/18, indicated family member (FM)-A was R1's court appointed guardian/conservator as R1 "was impaired to the extent of lacking sufficient understanding or capacity to make or	2 830	F689 Free of Accident/Hazard/Supervision/Devices Immediate Corrective Action: Resident #1 now has appropriate interventions in place for LOAs. Personalized Interventions include: Educate resident on the risk of going into the community independently notify staff of resident's whereabouts and intended return time. Provide ongoing education to resident and friendly reminders on how to use the resident sign out book when going on an outing. Provide resident with facility contact number and save in phone so that they may provide verbal updates about outing as necessary Resident and facility representative will obtain verbal consent prior to leaving the facility. Elopement risk evaluation per policy. Educate resident on facility bed hold and LOA policies and educate resident on his individual plan and LOA instructions as applicable. Resident #1 Guardian was contacted regarding preferences for resident LOA and care plan updated to reflect changes.	

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2 830	Continued From page 3 communicate responsible decisions concerning Respondent's personal needs for medical care, nutrition, clothing, shelter or safety." Further, "The Respondent [R1] is requesting a guardian and conservator due to his lack of capacity in regards to safety and decision making." R1's care plan undated, identified R1 went into the community when FM-A approved. R1's care plan further identified R1 had a history of leaving the facility with his roommate, and returning intoxicated. The care plan identified staff educated R1 related to the risks of leaving the facility for extended periods of time in the cold. Interventions included educating R1 on facility LOA policies and his individual LOA plan, educating R1 on the risks of going into the community independently, notifying staff of his whereabouts, and notifying staff of his expected return time. R1's next-of-kin, the charge nurse, R1's physician, and police were to be notified if his whereabouts were unknown or did not return at the expected time, education was provided regarding signing the resident sign-out book and how to contact the facility in-case of an emergency; and FM-A approval was required prior to R1 leaving the facility. R1's group sheet undated, directed, "If wanted to go out of the facility, [FM-A] must be called prior to every outing to get approval and must be accompanied by his mother or designee." On 10/23/20, at 5:44 p.m. a progress note indicated FM-A had called the facility and voiced concerns regarding R1 going "shopping or anywhere else" in his wheelchair. If R1 attempted to leave the facility, FM-A wanted a manual wheelchair given to him.	2 830	Corrective Action as it applies to others: Leave of Absence policy was reviewed and remains current. Leave of Absence Sign out Book forms were edited to designate an estimated return time for the resident and column to indicate whether resident is appropriately dressed for the weather. All residents with Guardians had Guardian contacted for their preference on LOAs for the resident and care plans updated to reflect this preference, along with necessary steps to follow for individual residents' LOA. All nursing staff were re-educated on the LOA Policy specifically regarding ensuring resident is wearing appropriate clothing for the LOA, resident is signed out for the LOA, and resident is contacted at the expected return time Date of Compliance: 3/31/21 Recurrence will be prevented by: Audits of 5 random resident LOAs will be completed weekly x 4 then monthly x 2 months to assure appropriate safety interventions were in place & 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. Corrections will be monitored by: Social Services Director/Designee	

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2 830	Continued From page 4 On 11/9/20, at 1:34 p.m. a progress note indicated FM-A wanted to keep R1 in the facility, and not go to the store, due to the COVID-19 pandemic. On 12/1/20, at 8:00 p.m. a progress note indicated the facility received a telephone call at approximately 7:45 p.m. from FM-A. FM-A was informed R1 was quarantined in his room due to a trip to a store the previous day. FM-A questioned why R1 was allowed to leave the facility, due to COVID-19. The progress note further indicated FM-A had been contacted by the day shift nurse, and FM-A agreed to allow the outing. On 12/4/20, at 9:24 a.m. a progress note indicated FM-A was contacted regarding R1 requesting to go to a store. FM-A was "okay" if R1 went to the store when it was daylight, however, requested he was back before dark. On 12/8/20, at 4:11 p.m. a progress note indicated three 50 milliliter bottles of alcohol were found in R1's room. R1 stated, "I wish those bottles were mine." The bottles were removed from R1's room. On 12/19/20, at 11:22 p.m. a progress note indicated R1 left the facility at 4:40 p.m. "against writer advise [sic]." R1 was instructed it "was getting dark" and his mother did not want him to be out in "this kind of weather." R1 replied it was not dark and he wanted to go get something to eat. R1 returned to the facility at 8:40 p.m. with slurred speech, thrashing arms, and stated he wanted to die. R1 was noted to be "half way" out of his wheelchair and was partially undressed. R1's pants were "half off," and his coat was noted to be unzipped with his abdomen exposed. R1	2 830		

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2 830	Continued From page 5	2 830		

had a "small abrasion" to the third toe on his right foot. R1's catheter was "frozen" and his body was "severely cold." R1 was sent to the emergency department (ED) at 9:30 p.m., and FM-A was notified. The progress notes further indicated FM-A stated, "She encouraged her son to not go out in the cold or after dark but she says that her son will do the things he is not suppose to do."

Accuweather indicated the temperature in Grand Rapids, MN on 12/19/20, was between -5 degrees Fahrenheit (F) and 21 degrees F.

A document titled Resident Sign Out indicated R1 signed out of the facility at 4:40 p.m. on 12/19/20.

ED Provider Notes dated 12/19/20, indicated R1 was evaluated with a concern for hypothermia and altered mental status. R1 felt warm-to-touch, however, had cold knees, was slurring words, and was belligerent. R1 had no witnessed or suspected trauma, but was assumed he had slid out of his wheelchair. R1 was agitated, and required a sedation protocol. Intravenous fluids were given in addition to external warming measures. R1 was noted to have "superficial frostbite on both of his knees." R1's blood alcohol level was 0.2 and consistent with intoxication. A Urinalysis (urine sample) was collected and was expected to be "dirty [urinary tract infection]" due to freezing. R1 was prescribed an antibiotic and discharged back to the facility.

On 12/20/20, at 4:13 a.m. a progress note indicated R1 returned to the facility at 4:00 a.m. R1 returned with an antibiotic prescription to prevent a urinary tract infection and "for the areas of frostbite."

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2 830	Continued From page 6 On 12/21/20, at 1:00 p.m. a progress note indicated risk versus (vs.) benefit information related to alcohol use and unaccompanied LOAs were presented to R1. R1 stated he would continue to leave the facility "if he so chooses." On 12/21/20, at 1:35 p.m. a progress note indicated a social worker, director of nursing (DON), and the administrator had a care conference with FM-A. A conversation related to risk vs. benefits were reviewed with FM-A. On 1/1/21, at 9:00 p.m. a progress note indicated R1 showed a nurse a video in which someone had taken of him spinning in circles on the "icy/snowy" walkway of the smoking patio. R1 was educated he could be hurt by doing so. On 2/1/21, at 10:28 p.m. indicated R1 had been out of the facility with his roommate until approximately 6:00 p.m. The progress notes further indicated "He appears to be in a very pleasant mood and not quite himself. He is very friendly and giggly." A progress note dated 2/18/21, at 2:33 p.m., indicated R1 talked about going to a store with another resident. On 3/1/21, at 12:18 p.m. R1 was observed to exit his room in an electric wheelchair and approached the nurses' station. R1 was wearing a jacket, hat, and boots. A backpack was hanging on the back of R1's wheelchair. R1 was administered medications at 12:23 p.m., and returned to his room at 12:24 p.m. On 3/2/21, at 10:24 a.m. R1 wheeled towards the smoking entrance. R1 was wearing a jacket, hat,	2 830		

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2 830	Continued From page 7 and boots. Staff opened a door and R1 proceeded to the smoking area. On 3/2/21, at 10:26 a.m. an interview was conducted with NA-B. NA-B stated residents who were cognitively intact were allowed to leave for outings. NA-B stated she notified a nurse, or nurse manager, if a resident wanted to go on an outing. NA-B stated if she saw a resident leave the facility without approval, she would stay with a resident until she knew if it was approved. NA-B stated residents filled out a sign-out log when they wanted to leave the facility. NA-B stated R1 liked to go to the store, but was not sure how he got there. NA-B stated she believed R1 asked staff when he wanted to leave. NA-B stated R1 was cognitively intact, but had a brain injury. On 3/2/21, at 10:39 a.m. an interview was conducted with licensed practical nurse (LPN)-A. LPN-A stated R1 often went on outings. LPN-A stated R1 did tell staff when he was leaving and where he was going. LPN-A stated on 12/19/20, R1 stated he was going to the store, and returned to the facility intoxicated, and his roommate was with him. LPN-A stated she was unsure what the temperature was when R1 left the facility. LPN-A stated she did not recall what time R1 had left or returned to the facility. LPN-A stated she believed R1 was gone for "a couple of hours." LPN-A stated when R1 had returned, it appeared like he had fallen out of his wheelchair, and his roommate had "put him back in." LPN-A stated R1 was "half out" of his wheelchair and his jacket was unzipped. LPN-A stated R1's catheter was frozen, and his belly was showing. LPN-A stated R1 was "so cold." LPN-A stated NA-C brought R1 to his room and he kept saying that he "wanted to die." LPN-A stated staff put R1 in his bed, warmed him up with heated blankets, and	2 830		

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called 911. LPN-A stated since the incident, FM-A expected to know when R1 requested to leave the facility, and what time he will return. LPN-A stated she did not recall if she contacted FM-A for approval for R1 to leave the facility on 12/19/20. LPN-A stated the facility "started" communicating with FM-A after the incident occurred. LPN-A stated she believed R1 had previously been intoxicated and had "history" of intoxication since being admitted to the facility. LPN-A stated she did not recall when R1 had been intoxicated before the incident on 12/19/20.

On 3/2/21, at 10:59 a.m. an interview was conducted with NA-C. NA-C stated R1 liked to go on outings, and was hanging around another male resident who was half his age. NA-C stated she was unsure if R1 normally informed staff when he went on outings, but believed he did not sign in and out. NA-C stated R1 had intact cognition and "knew what he was doing." NA-C stated facility staff caught R1's roommate intoxicated on a couple of occasions. NA-C stated there was two incidents in which R1 was intoxicated. NA-C stated she was unable to recall when the first incident occurred. NA-C stated R1 and his roommate came back from the store, was unsure of the date, and she suspected both residents were intoxicated. NA-C stated LPN-B called the administrator and DON. NA-C stated staff were instructed in the future to call 911 if the residents came back to the facility intoxicated. NA-C stated the second incident happened on 12/19/20. NA-C stated she arrived to work at 6:00 p.m. and R1 returned to the facility well after dinner. NA-C stated staff found R1 in the Unit 4 dining room near the smoking door. NA-C stated R1 was "half way out of his wheelchair" and did not verbally make sense. NA-C stated R1's belly was red, his legs were ice cold, and his catheter

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was frozen. NA-C stated R1 had no idea where he was or what he was doing. NA-C stated R1 was so disoriented he could not operate his electric wheelchair. NA-C stated staff brought R1 to his room, minor scrapes were noted on his "back side," and his belly was "red and purple." NA-C stated R1's right big toe was bloody, and R1 accused staff of trying to kill him. NA-C stated staff removed R1's pants and placed heated blankets on him. NA-C stated R1 was sent to the hospital. NA-C stated the facility did not have interventions in-place when R1 left for a LOA, prior to the incident on 12/19/20.

On 3/2/21, at 12:24 p.m. an interview was conducted with NA-D. NA-D stated R1 notified staff when he wished to leave the facility. NA-D stated R1 used the sign-out book, and staff were supposed to let the nurse know when he wanted to leave. NA-D stated she was not aware of any time where R1 tried to leave without signing out or was intoxicated.

On 3/2/21, at 12:29 p.m. an interview was conducted with R1. R1 stated he did not have frostbite from the time he left the facility on 12/19/20. R1 stated it was like when a "child had a red nose." R1 stated if he wanted to go to the store, he called for the bus and notified staff. R1 stated the incident (on 12/19/20) was not a big deal. R1 stated FM-A made sure the facility called her when he wished to go on an outing. R1 stated he would usually call FM-A and bring his phone to nursing staff.

On 3/2/21, at 12:54 p.m. an interview was conducted with registered nurse (RN)-A. RN-A stated R1 liked to go on outings quite often. RN-A stated R1 typically went to a store or restaurant across the highway. RN-A stated R1

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also went to the hardware store on a couple of occasions. RN-A stated when R1 wanted to leave the facility it was a "special case." RN-A stated staff needed to contact FM-A, and FM-A made decisions for him. RN-A stated R1 usually handed her the phone with FM-A already on the line when he wished to leave. RN-A stated R1 informed staff of when he was leaving and when he was expected to return. RN-A stated staff had R1 also use the sign-out book. RN-A stated she had not seen R1 intoxicated, however, verbalized there was one occasion when R1 was known to get intoxicated and was sent to the hospital. RN-A stated R1 had suffered from frostbite when he was sent to the hospital. RN-A stated R1 never disappeared without telling anyone, and staff needed to call the police if he left without permission.

On 3/3/21, at 9:40 a.m. an interview was conducted with FM-A. FM-A stated she was told R1 was intoxicated and suffered from frostbite on 12/19/20. FM-A stated she was R1's guardian, and "sometimes they call me about his outings, sometimes they don't." FM-A stated she did not recall if facility requested approval for R1 to leave the facility on 12/19/20. FM-A stated the facility put interventions in-place after the incident occurred. FM-A stated she was comfortable with the plan as long as it was enforced. FM-A stated the facility was now reliably calling her when R1 wished to leave the facility. FM-A stated she did not believe R1 should consume alcohol, but that was a "doctor's decision."

On 3/3/21, at 9:56 a.m. an interview was conducted with social worker (SW)-A. SW-A stated R1 was cognitively intact, however, had a deficit in making good choices. SW-A stated R1 had a history of frequent accidents prior to

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admission and suffered a traumatic brain injury when he was 17 years old. SW-A stated R1 lacked consequential thinking, and required FM-A's approval prior to leaving the facility. SW-A stated on 12/19/20, R1 and his roommate went to the store and returned to the facility between 7:00 p.m. to 7:30 p.m. SW-A stated R1's shirt was pulled up and his pants were half-way down. SW-A stated R1 was sent to the hospital, and possibly was diagnosed with frostbite. SW-A stated when R1 returned to the facility, a risk vs. benefit document was completed with R1 and his roommate. SW-A stated the facility wanted both residents to be more cognizant when they went on an outing. SW-A stated she was unable to recall if R1 had become intoxicated prior to the incident on 12/19/20, but thought R1 may have had one other occurrence of intoxication prior to 12/19/20. SW-A stated nothing like the incident on 12/19/20, had happened before. SW-A stated the facility now made sure FM-A's approval was obtained prior to R1 leaving for an outing. SW-A stated facility staff were to call law enforcement if he left without approval. SW-A stated she was unsure if facility staff obtained FM-A's approval prior to leaving the facility on 12/19/20.

On 3/3/21, at 10:23 a.m. an interview was conducted with RN-C. RN-C stated R1 needed to call FM-A for approval, and use the sign-out book prior to leaving for an outing. RN-A stated she was only aware of one occasion in which R1 was intoxicated. RN-C stated she was not aware of R1 being intoxicated since the incident on 12/19/20, however, suspected his roommate of consuming alcohol. RN-C stated an incident occurred two weeks ago in which R1 and his roommate left the facility without telling anyone. RN-C stated R1's roommate got his stimulus

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check and went to the store. RN-C stated staff called her and stated they were unable to find R1. RN-C stated she instructed staff to call law enforcement. RN-C stated staff contacted the DON, however, R1 had since been tracked down. RN-C stated she spoke to R1 and he told her FM-A gave SW-A permission for him to leave the facility. RN-C stated SW-A told her she did not speak to FM-A. RN-C stated she did not know if any new interventions were put into place since R1 left the facility without permission from R1.

On 3/3/21, at 10:32 a.m. an interview was conducted with the DON and administrator. The administrator stated staff called R1's cell phone because he was gone longer than expected on 12/19/20. The administrator stated R1 stated he and his roommate were heading back to the facility. The DON stated R1 and his roommate got "drunk" and were intoxicated when they returned to the facility. The administrator stated staff put R1 in bed, performed a skin assessment, and covered him with blankets. The administrator stated the ambulance was called and R1 was sent to the hospital. The administrator stated R1 was noted to have frostbite to his toes and stomach. The administrator stated after the incident occurred a risk vs. benefit was completed with R1. The administrator stated the facility also added an intervention of contacting FM-A prior to R1 leaving the facility. The DON stated she was not sure if there were any interventions in-place prior to the incident on 12/19/20, because R1 was alert and oriented. The administrator stated FM-A was historically "wishy washy" about R1 leaving the facility. The administrator stated staff spoke to R1 about obtaining an order for consuming alcohol, however, R1 refused as he did not like the way it made him feel. The administrator stated he did

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not believe there were any previous incidents in which R1 had been intoxicated at the facility. The administrator stated he did not believe there had been any incidents since 12/19/20, in which R1 had been intoxicated. The DON stated R1 needed FM-A's permission prior to leaving the facility, and staff were to call the police if he left without permission. The DON stated she was not aware of any occurrence in which R1 had left the facility without FM-A's permission. The administrator stated a full-house assessment was completed for all residents who took LOAs. The administrator stated he was unsure if any staff-education was conducted.

On 3/4/21, at 11:25 a.m. a follow-up interview was conducted with SW-A. SW-A stated R1 had left the facility a couple of weeks ago with his roommate. SW-A stated she is unsure if facility staff called FM-A. SW-A stated she asked if R1 had permission to leave the facility, and when he was coming back. SW-A stated she instructed staff to call FM-A an additional time to ensure the leave was approved. SW-A stated she felt staff should enter a note in R1's medical record so the facility knew if FM-A was notified.

The facility policy Safety and Supervision of Residents dated 7/17, directed, "Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents." Further, "The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents."

SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review applicable policies and procedures related to

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2 830	Continued From page 14 resident leaves of absences. The director of nursing, or designee, could train staff related to resident leave of absence policies/procedures. The director of nursing, or designee, could audit compliance regarding resident supervision and leaves of absences. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure repositioning and off-loading of pressure was completed to prevent development of pressure ulcers for 1 of 3 residents (R3) reviewed for pressure ulcers.	2 900	F686 Treatment to Prevent/Treat Pressure Ulcers Immediate Corrective Action: Resident #5 was repositioned. NAR assigned to this resident was educated on need to reposition resident per	3/31/21

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2 900	Continued From page 15 Findings include: R3's Transfer/Discharge Report dated 3/4/21, indicated R3's diagnoses included morbid obesity, chronic pain, heart failure, and muscle weakness. R3's quarterly Minimum Data Set (MDS) dated 1/22/21, indicated R3 was cognitively intact and required extensive assistance with bed mobility and transfers. In addition, the MDS indicated R3 did not walk, and was occasionally incontinent of bowel and bladder. R3's Pressure Ulcer/Injury Care Area Assessment (CAA) dated 12/3/20, identified R3 was at risk for skin breakdown due to impaired mobility and frequent bladder incontinence. The CAA further identified staff were to check, change, offer toileting, and reposition R3 every two hours. R3's care plan dated 10/18/20, indicated R3 had a history of a pressure ulcer to her coccyx, and was at increased risk for skin breakdown related to the need for assistance with mobility and incontinence. R3's care plan directed staff to turn and reposition R3 every two hours, however, R3 refused repositioning at times. R3's Pocket Care Plan dated 3/1/21, indicated R3 was to be repositioned every two hours. On 3/2/21, at 2:03 p.m. during constant observations, R3 was seated in a motorized wheelchair near the entrance of her room. R3 wheeled to a table in the facility dining room and participated in a bingo activity. R3 wheeled away from the table and spoke to an individual about the bingo activity, and again wheeled towards a table and retrieved a mug. R3 wheeled to the	2 900	individualized needs on care plan. Corrective Action as it applies to others: The Activity of Daily Living Policy was reviewed and remains current. All nurses, TMAs, and NARs were re-educated on the Activity of Daily Living Policy specifically providing assistance with repositioning per resident individualized care pan. All residents needing assistance with repositioning will be provided this assistance per care plan/care sheet details. Date of Compliance: 3/31/2021 Recurrence will be prevented by: Audits of 5 random residents will be completed weekly x 4 then monthly x 2 months to assure timely assistance is provided for repositioning. 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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kitchen, pushed the door open, and stated "hello." Staff responded and R3 requested a cup of coffee. R3 wheeled to her room at 3:23 p.m. and partially closed her door. The administrator approached R3's room and removed a wheeled vitals machine from R3's room entry. The administrator did not offer to reposition R3. Licensed practical nurse (LPN)-E entered R3's room with a wheeled vitals machine and oral medications. R3 requested her wheelchair seatbelt to be readjusted. LPN-E unfastened R3's wheelchair seatbelt and readjusted it. LPN-E then administered R3's oral medications, completed a blood glucose check, and took R3's vital signs. LPN-E performed hand hygiene and exited R3's room at 4:02 p.m. R3 was not offered repositioning. No staff entered R3's room from 4:03 p.m. to 4:40 p.m. 2 hours and 37 minutes had passed since the continuous observation began.

On 3/2/21, at 4:40 p.m. an interview was conducted with LPN-E. LPN-E stated R3 was to be repositioned every two hours, however, used the tilt function on her wheelchair to independently offloaded pressure. LPN-E stated she believed it was acceptable to offload pressure by using the wheelchair tilt function.

On 3/4/21, at 9:34 a.m. an interview was conducted with R3. R3 stated staff offered to reposition her, but she often refused. R3 stated she used the tilt function on her electric wheelchair to reposition when she was up.

On 3/4/21, at 9:51 a.m., an interview was conducted with trained medication assistant (TMA)-A. TMA-A stated R3 needed to be turned and repositioned. TMA-A stated R3 was able to roll herself side-to-side and scoot back in her

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wheelchair. TMA-A stated staff were supposed to make sure R3 was repositioned every two hours. TMA-A states sometimes R3 tilted her wheelchair back or "wiggled" independently. TMA-A stated pressure should be offloaded for one minute.

On 3/4/21, at 10:12 a.m. an interview was conducted with occupational therapist (OT)-A. OT-A stated R3 was able to independently tilt her wheelchair, and this was an acceptable method to offload pressure. OT-A stated R3 was also able to "slightly" reposition herself. OT-A stated a cushion was recently added to R3's wheelchair for better positioning. Manufacturer guidelines were requested for R3's wheelchair and OT-A stated he would contact the vendor.

On 3/4/21, at approximately 10:30 a.m., a follow-up interview was conducted with OT-A. OT-A stated modifications were made to R3's wheelchair. OT-A stated the manufacturer (Robi) informed him since modifications were made to R3's wheelchair, the wheelchair could not provide weight redistribution.

On 3/4/21, at 12:20 p.m., an interview was conducted with the director of nursing (DON). The DON stated she believed R3 was to be repositioned very two to three hours, but didn't know off the top of her head. The DON stated R3 did not have any skin issues.

The facility policy Monarch Healthcare ADL (Activity of Daily Living) policy revised 5/16, directed, "Based upon resident/resident representative desires, assessment and care plan, ADL assistance will be provided to any residents deemed necessary."

SUGGESTED METHOD OF CORRECTION:

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2 900	Continued From page 18 The director of nursing, or designee, could review all residents at risk for pressure ulcers to assure they recieved the necessary treatment/services to prevent pressure ulcers from developing. The director of nursing, or designee, could conduct random audits of care delivery. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		