

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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

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		& MEDICAID SERVICES				0		0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUC			СОМ	E SURVEY IPLETED
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	ERALDS AT GRAND F			GRAND RAP	PIDS, MN 55744			
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F 000	INITIAL COMMENT	ſS	F 00	00				
	was completed at y complaint investiga NOT to be in compl	3/4/21, an abbreviated survey our facility to conduct tions. Your facility was found liance with 42 CFR Part 483, ong Term Care Facilities.						
		laints were found to be H5495099C (MN68385, 7) and H5495100C						
	UNSUBSTANTIATE H5495095C (MN59	laints were found to be ED: H5495094C (MN52729), I318), H5495096C (MN59336), I720), and H5495098C						
	as your allegation o Department's accept enrolled in ePOC, y	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567						
F 686 SS=D	on-site revisit of you validate that substa regulations has bee your verification. Treatment/Svcs to	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with Prevent/Heal Pressure Ulcer 1)(i)(ii)	F 68	6				3/31/21
	resident, the facility (i) A resident receiv	sure ulcers. prehensive assessment of a must ensure that- es care, consistent with						
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE			(X6) DATE
Electron	ically Signed							03/26/2021

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

DEDARTMENT OF LICALTU AND LUMANN SERVICES

PRINTED: 03/29/2021

	-	AND HUMAN SERVICES & MEDICAID SERVICES		C		APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	COMF	E SURVEY PLETED
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/0	
	RALDS AT GRAND F	RAPIDS LLC		2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
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	pressure ulcers and ulcers unless the in demonstrates that if (ii) A resident with p necessary treatmer with professional st promote healing, pr new ulcers from de This REQUIREMEN by: Based on observat review, the facility fa and off-loading of p prevent developme residents (R3) revie Findings include: R3's Transfer/Disch indicated R3's diag obesity, chronic pai weakness. R3's quarterly Minir 1/22/21, indicated F required extensive and transfers. In ad did not walk, and w bowel and bladder. R3's Pressure Ulce (CAA) dated 12/3/2 skin breakdown due frequent bladder indi identified staff were	ards of practice, to prevent d does not develop pressure dividual's clinical condition they were unavoidable; and pressure ulcers receives and services, consistent andards of practice, to revent infection and prevent	F 68		eated on thers: vas / Living ance /ith et vith et y x 2 e is ults of e facility	

Facility ID: 00299

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED	
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F 686	a history of a press was at increased ris to the need for assi incontinence. R3's and reposition R3 e refused reposition R3's Pocket Care F was to be reposition On 3/2/21, at 2:03 p observations, R3 w wheelchair near the wheeled to a table participated in a bir from the table and a the bingo activity, a table and retrieved kitchen, pushed the Staff responded an coffee. R3 wheeled partially closed her approached R3's ro vitals machine from administrator did no Licensed practical n room with a wheele medications. R3 re seatbelt to be readj R3's wheelchair sea LPN-E then admini completed a blood vital signs. LPN-E p exited R3's room at repositioning. No s 4:03 p.m. to 4:40 p	ure ulcer to her coccyx, and sk for skin breakdown related istance with mobility and care plan directed staff to turn every two hours, however, R3	F 68	audits. Corrections will be monitored DON/Nurse Managers/Design			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				FORM	03/29/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DAT COM	E SURVEY PLETED
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NAME OF PROVIDER OR SUPPLIER	•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE EMERALDS AT GRAND RAPIDS LLC			301 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
 F 686 Continued From page 3 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 wheelchai 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 abl 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 	o ir r	586			

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	wheelchair. OT-A s informed him since R3's wheelchair, th weight redistribution On 3/4/21, at 12:20 conducted with the The DON stated sh repositioned very tw know off the top of did not have any sk The facility policy M (Activity of Daily Liv directed, "Based up representative desi plan, ADL assistant residents deemed n Free of Accident Ha CFR(s): 483.25(d)(§483.25(d) Acciden The facility must en §483.25(d)(1) The as free of accident \$483.25(d)(2)Each supervision and ass accidents. This REQUIREMEN by: Based on observat review, the facility f interventions were leave of absence (L interventions were unapproved outings	tated the manufacturer (Robi) modifications were made to e wheelchair could not provide n. p.m., an interview was director of nursing (DON). e believed R3 was to be vo to three hours, but didn't her head. The DON stated R3 in issues. lonarch Healthcare ADL ring) policy revised 5/16, bon resident/resident res, assessment and care ce will be provided to any necessary." azards/Supervision/Devices 1)(2)	F 686		e	3/31/21

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		I AND HUMAN SERVICES E & MEDICAID SERVICES					PROVE 938-039	
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NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/04	2021	
THE EM	ERALDS AT GRAND F	RAPIDS LLC			801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744			
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F 689	Continued From pa	age 5	F 6	89				
	 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 				Educate resident on the risk of going in the community independently notify sta of resident's whereabouts and intended return time. Provide ongoing education to resident a friendly reminders on how to use the resident sign out book when going on a outing. Provide resident with facility contact number and save in phone so that they may provide verbal updates about outir 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 an LOA policies and educate resident on h individual plan and LOA instructions as applicable. Resident #1 Guardian was contacted regarding preferences for resident LOA and care plan updated to reflect change	ff and an ng ne nd nis		
	Respondent's pers nutrition, clothing, s "The Respondent [and conservator du regards to safety an R1's care plan und the community whe plan further identifie the facility with his intoxicated. The ca educated R1 relate facility for extended	onsible decisions concerning onal needs for medical care, shelter or safety." Further, R1] is requesting a guardian ue to his lack of capacity in nd decision making." ated, identified R1 went into en FM-A approved. R1's care ed R1 had a history of leaving roommate, and returning are plan identified staff ed to the risks of leaving the d periods of time in the cold. ded educating R1 on facility			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 indicate whether resident is appropriate dressed for the weather. All residents with Guardians had Guard contacted for their preference on LOAs the resident and care plans updated to reflect this preference, along with necessary steps to follow for individual residents' LOA.	to ely lian		

Facility ID: 00299

	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION		0938-039	
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THE EMI	ERALDS AT GRAND I	RAPIDS LLC		2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744			
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F 689	educating R1 on th community independent whereabouts, and a return time. R1's not R1's physician, and his whereabouts w at the expected time regarding signing the how to contact the emergency; and F1 prior to R1 leaving R1's group sheet u go out of the facility to every outing to ge accompanied by his On 10/23/20, at 5:4 indicated FM-A have concerns regarding anywhere else" in the attempted to leave manual wheelchair On 11/9/20, at 1:34 indicated FM-A wat and not go to the se pandemic. On 12/1/20, at 8:00 indicated the facility approximately 7:45 informed R1 was que	is individual LOA plan, he risks of going into the indently, notifying staff of his notifying staff of his expected ext-of-kin, the charge nurse, d police were to be notified if ere unknown or did not return he, education was provided he resident sign-out book and facility in-case of an W-A approval was required the facility. Indated, directed, "If wanted to y, [FM-A] must be called prior get approval and must be s mother or designee." If p.m. a progress note d called the facility and voiced g R1 going "shopping or his wheelchair. If R1 the facility, FM-A wanted a	F 68	· · · · · ·	ling ensuring te clothing d out for the ed at the by: OAs will be onthly x 2 safety followed. Il be shared ee for input ease or by:		

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		AND HUMAN SERVICES					FORM	03/29/2021 APPROVED 0938-0391
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F 689	Continued From pa outing.	ge 7	F	689				
	indicated FM-A was requesting to go to R1 went to the store	a.m. a progress note contacted regarding R1 a store. FM-A was "okay" if e when it was daylight, d he was back before dark.						
	indicated three 50 r found in R1's room.	p.m. a progress note nilliliter bottles of alcohol were . R1 stated, "I wish those The bottles were removed						
	indicated R1 left the writer advise [sic]." getting dark" and hi be out in "this kind on not dark and he wa eat. R1 returned to slurred speech, thra wanted to die. R1 wo of his wheelchair ar R1's pants were "ha to be unzipped with had a "small abrasi foot. R1's catheter was "severely cold. emergency departm FM-A was notified. indicated FM-A statt to not go out in the	22 p.m. a progress note e facility at 4:40 p.m. "against R1 was instructed it "was is mother did not want him to of weather." R1 replied it was nted to go get something to o the facility at 8:40 p.m. with ashing arms, and stated he was noted to be "half way" out nd was partially undressed. alf off," and his coat was noted his abdomen exposed. R1 on" to the third toe on his right was "frozen" and his body " R1 was sent to the nent (ED) at 9:30 p.m., and The progress notes further red, "She encouraged her son cold or after dark but she says the things he is not suppose						
	Rapids, MN on 12/	ated the temperature in Grand 19/20, was between -5 t (F) and 21 degrees F.						

Facility ID: 00299

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	-	AND HUMAN SERVICES & MEDICAID SERVICES					FORM	APPROVED
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(X4) ID			ID	,				(X5) COMPLETION
TAG			TAG	`	CROSS-REFERENCED TO	THE APPROPF		DATE
			D SERVICES OMB NO.0938-033 NSUPPLERCLIA ATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED 245495 B. WING C 245495 B. WING C 245495 STREET ADDRESS, CITY, STATE, ZIP CODE 200/04/2021 STREET ADDRESS, CITY, STATE, ZIP CODE COMPLETION COULT HIGHWAY 169 GRAND RAPIDS, MN 55744 FICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COULT INDICATE ADDRESS, CITY, STATE, ZIP CODE COMPLETION JUP COULT F 689 COUNT INCOMPLATE INFORMATION) PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCIES DEFICIENCY COMPLETION 20, Indicated R1 P. 689 COULING Intervenous fluids Alwarning COULING Very proteina Id Id Id warning Very Proteina COULING Very proteina Id Id Id warning Very Proteina COULING Very proteina Id					
F 000								
F 689	Continued From pa	ge 8	F 6	89				
245495 B. WING 03/04 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 THE EMERALDS AT GRAND RAPIDS LLC GRAND RAPIDS, MN 55744 3000000000000000000000000000000000000								
	signed out of the la							
		,						
	•	ione and discharged back to						
	,							
		ed to the facility at 4:00 a.m.						
		antibiotic prescription to act infection and "for the areas						
	of frostbite."							
		0 p.m. a progress note						
		s (vs.) benefit information se and unaccompanied LOAs						
		R1. R1 stated he would						
		e facility "if he so chooses."						
	0 10/01/00 110	_						
		5 p.m. a progress note						
		orker, director of nursing ninistrator had a care						
		I-A. A conversation related to						
		re reviewed with FM-A.						

Facility ID: 00299

If continuation sheet Page 9 of 17

PRINTED: 03/29/2021

		AND HUMAN SERVICES					FORM	APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	LE CONSTRUCTION	0		E SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	` ´		;			PLETED
							(C
		245495	B. WING				03/	04/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE,	ZIP CODE		
THE EME	ERALDS AT GRAND R	APIDS LLC			2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	4		
(X4) ID			ID		PROVIDER'S PLAN O (EACH CORRECTIVE AC			(X5) COMPLETION
PREFIX TAG		(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	CROSS-REFERENCED TO	THE APPROPE		DATE
					DEFICIEN	ICY)		
F 689	Continued From pa	ao 0	F 6	00				
1 000	Continued i rom pa	96.9	го	09				
		o.m. a progress note indicated						
		a video in which someone						
		pinning in circles on the y of the smoking patio. R1						
		ould be hurt by doing so.						
	0 0/4/04 / 40 00							
		p.m. indicated R1 had been th his roommate until						
		p.m. The progress notes						
		e appears to be in a very						
	pleasant mood and friendly and giggly."	not quite himself. He is very						
	menary and giggry.							
		ted 2/18/21, at 2:33 p.m.,						
	another resident.	about going to a store with						
	another resident.							
		p.m. R1 was observed to exit						
	his room in an elect	rses' station. R1 was wearing						
		oots. A backpack was						
	00	k of R1's wheelchair. R1 was						
	administered medic returned to his roon	cations at 12:23 p.m., and						
		n ac 12.2 4 p.m.						
		a.m. R1 wheeled towards the						
		R1 was wearing a jacket, hat,						
	proceeded to the sr	ened a door and R1 moking area.						
		-						
		a.m. an interview was						
		-B. NA-B stated residents who act were allowed to leave for						
		d she notified a nurse, or						
	nurse manager, if a	resident wanted to go on an						
		d if she saw a resident leave approval, she would stay with a						
		new if it was approved. NA-B						

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	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IPLE CONSTRUCTION). 0938-039 TE SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED	
						С	
		245495	B. WING		03	/04/2021	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE		
THE EM	ERALDS AT GRAND I	RAPIDS LLC		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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
F 689	Continued From pa	age 10	F 68	39			
	stated residents fill	ed out a sign-out log when					
		ve the facility. NA-B stated R1					
		ore, but was not sure how he ated she believed R1 asked					
		ed to leave. NA-B stated R1					
	was cognitively inta	act, but had a brain injury.					
	On 2/2/24 at 10:20						
		a.m. an interview was ensed practical nurse (LPN)-A.					
		ften went on outings. LPN-A					
		taff when he was leaving and					
		g. LPN-A stated on 12/19/20, going to the store, and returned					
		cated, and his roommate was					
	with him. LPN-A st	tated she was unsure what the					
		when R1 left the facility. LPN-A					
		recall what time R1 had left or lity. LPN-A stated she					
		one for "a couple of hours."					
		R1 had returned, it appeared					
		ut of his wheelchair, and his					
		t him back in." LPN-A stated f his wheelchair and his jacket					
		N-A stated R1's catheter was					
		y was showing. LPN-A stated					
		LPN-A stated NA-C brought					
		I he kept saying that he PN-A stated staff put R1 in his					
		ip with heated blankets, and					
		stated since the incident,					
		know when R1 requested to					
		nd what time he will return. did not recall if she contacted					
	FM-A for approval	for R1 to leave the facility on					
		tated the facility "started"					
		h FM-A after the incident tated she believed R1 had					
		oxicated and had "history" of					
		being admitted to the facility.					

Facility ID: 00299

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		& MEDICAID SERVICES	(X2) MUI T	IPLE CONSTRUCTION). 0938-039 TE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED	
		245495	B. WING _		C 03/04/202		
NAME OF F	PROVIDER OR SUPPLIER		l	STREET ADDRESS, CITY, STATE, ZIP COD	•	/0 4 /2021	
THE EM	ERALDS AT GRAND F	RAPIDS LLC		2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 689	• • • • • • • • • • • • • • • • • • •	age 11 Iid not recall when R1 had	F 68	89			
	been intoxicated be	efore the incident on 12/19/20.					
	conducted with NA	a.m. an interview was -C. NA-C stated R1 liked to go s hanging around another					
	male resident who she was unsure if F	was half his age. NA-C stated R1 normally informed staff utings, but believed he did not					
	sign in and out. NA cognition and "knew	A-C stated R1 had intact w what he was doing." NA-C					
	intoxicated on a co	caught R1's roommate uple of occasions. NA-C vo incidents in which R1 was					
	intoxicated. NA-C when the first incide	stated she was unable to recall ent occurred. NA-C stated R1					
	unsure of the date,	came back from the store, was and she suspected both xicated. NA-C stated LPN-B					
	staff were instructe	rator and DON. NA-C stated d in the future to call 911 if the					
	NA-C stated the se	ck to the facility intoxicated. cond incident happened on ated she arrived to work at					
	dinner. NA-C state	eturned to the facility well after ed staff found R1 in the Unit 4 ne smoking door. NA-C stated					
	R1 was "half way o not verbally make s	ut of his wheelchair" and did sense. NA-C stated R1's belly					
	was frozen. NA-C	rere ice cold, and his catheter stated R1 had no idea where was doing. NA-C stated R1					
	was so disoriented electric wheelchair.	he could not operate his NA-C stated staff brought R1					
	"back side," and his	scrapes were noted on his s belly was "red and purple." ight big toe was bloody, and					
	R1 accused staff of	f trying to kill him. NA-C stated pants and placed heated					

Facility ID: 00299

If continuation sheet Page 12 of 17

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM): 03/29/2021 APPROVED). 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245495	B. WING	i		03	C / 04/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE EM	ERALDS AT GRAND F	APIDS LLC			301 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 689	blankets on him. N hospital. NA-C stati interventions in-place prior to the incident On 3/2/21, at 12:24 conducted with NA- staff when he wishes stated R1 used the supposed to let the to leave. NA-D stati time where R1 tried or was intoxicated. On 3/2/21, at 12:29 conducted with R1. frostbite from the tit 12/19/20. R1 state a red nose." R1 state store, he called for stated the incident of deal. R1 stated FW called her when he R1 stated he would his phone to nursin On 3/2/21, at 12:54 conducted with regi stated R1 liked to g RN-A stated R1 typ restaurant across the also went to the han occasions. RN-A s leave the facility it v stated staff needed made decisions for handed her the pho-	A-C stated R1 was sent to the eed the facility did not have ce when R1 left for a LOA, on 12/19/20. p.m. an interview was D. NA-D stated R1 notified ed to leave the facility. NA-D sign-out book, and staff were nurse know when he wanted ted she was not aware of any I to leave without signing out p.m. an interview was R1 stated he did not have me he left the facility on d it was like when a "child had ated if he wanted to go to the the bus and notified staff. R1 (on 12/19/20) was not a big I-A made sure the facility wished to go on an outing. usually call FM-A and bring	F	589			

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			(V2) MILLI T	TIPLE CONSTRUCTION). 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
						С
		245495	B. WING		03	/04/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
THE EM	ERALDS AT GRAND I	RAPIDS LLC		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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 689	• • • • • • • • • • • • • • • • • • • •	-	F 68	89		
	R1 also use the sig had not seen R1 in there was one occa get intoxicated and RN-A stated R1 ha he was sent to the never disappeared staff needed to call permission. On 3/3/21, at 9:40 conducted with FM R1 was intoxicated 12/19/20. FM-A sta and "sometimes th	o return. RN-A stated staff had in-out book. RN-A stated she toxicated, however, verbalized asion when R1 was known to was sent to the hospital. d suffered from frostbite when hospital. RN-A stated R1 without telling anyone, and the police if he left without a.m. an interview was -A. FM-A stated she was told and suffered from frostbite on ated she was R1's guardian, ey call me about his outings,				
	recall if facility requ the facility on 12/19 put interventions in occurred. FM-A sta the plan as long as the facility was now wished to leave the	n't." FM-A stated she did not rested approval for R1 to leave 0/20. FM-A stated the facility -place after the incident ated she was comfortable with it was enforced. FM-A stated v reliably calling her when R1 e facility. FM-A stated she did uld consume alcohol, but that cision."				
	conducted with soc stated R1 was cog deficit in making go had a history of fre- admission and suff when he was 17 ye lacked consequent FM-A's approval pr SW-A stated on 12	a.m. an interview was sial worker (SW)-A. SW-A nitively intact, however, had a bod choices. SW-A stated R1 quent accidents prior to ered a traumatic brain injury ears old. SW-A stated R1 ial thinking, and required for to leaving the facility. /19/20, R1 and his roommate nd returned to the facility				

Facility ID: 00299

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	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TI	PLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY	
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		G	· · ·	MPLETED	
		245495	B. WING _		C 03/04/2021		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	/// / //////	
THE EMI	ERALDS AT GRAND F	RAPIDS LLC	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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 689	R1's shirt was pulle half-way down. SV hospital, and possil frostbite. SW-A sta facility, a risk vs. be completed with R1 stated the facility w more cognizant wh SW-A stated she w become intoxicated 12/19/20, but thoug occurrence of intox SW-A stated nothin 12/19/20, had happ facility now made s obtained prior to R stated facility staff he left without appr unsure if facility staff he left without appr prior to leaving for intoxicated. RN-C R1 being intoxicated the facility staff he chart appr he command acohol occurred two week roommate left the f RN-C stated R1's r check and went to called her and staff RN-C stated she in	age 14 ed up and his pants were V-A stated R1 was sent to the bly was diagnosed with ated when R1 returned to the enefit document was and his roommate. SW-A ranted both residents to be en they went on an outing. vas unable to recall if R1 had d prior to the incident on ght R1 may have had one other tication prior to 12/19/20. ng like the incident on bened before. SW-A stated the ture FM-A's approval was 1 leaving for an outing. SW-A were to call law enforcement if roval. SW-A stated she was ff obtained FM-A's approval facility on 12/19/20. B a.m. an interview was -C. RN-C stated R1 needed to val, and use the sign-out book an outing. RN-A stated she one occasion in which R1 was stated she was not aware of ed since the incident on , suspected his roommate of . RN-C stated an incident s ago in which R1 and his facility without telling anyone. oommate got his stimulus the store. RN-C stated staff ed they were unable to find R1. astructed staff to call law C stated staff contacted the	F 68	9			

Facility ID: 00299

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	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IPLE CONSTRU	ICTION		NO. 0938-	
	F CORRECTION	IDENTIFICATION NUMBER:				(\\J	COMPLETED	
							С	
		245495	B. WING _			- 03/04/202		21
NAME OF F	PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STATE, ZIP	CODE		
THE EME	RALDS AT GRAND	RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CO CH CORRECTIVE ACTIC SS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	COMPL	K5) LETIO ATE
F 689	Continued From p	age 15	F 68	39				
		permission for him to leave the						
		ed SW-A told her she did not						
		N-C stated she did not know if						
		ons were put into place since						
	R i leit the lacility i	without permission from R1.						
	On 3/3/21, at 10:32	2 a.m. an interview was						
		DON and administrator. The						
		ed staff called R1's cell phone						
		one longer than expected on						
		ninistrator stated R1 stated he were heading back to the						
		stated R1 and his roommate						
		ere intoxicated when they						
		ility. The administrator stated						
	staff put R1 in bed							
		covered him with blankets. The	•					
		ed the ambulance was called of the hospital. The						
		ed R1 was noted to have						
		s and stomach. The						
		ed after the incident occurred a						
		s completed with R1. The						
		ed the facility also added an						
		tacting FM-A prior to R1 The DON stated she was not						
		any interventions in-place prior						
		12/19/20, because R1 was alert	t					
		administrator stated FM-A was	;					
		washy" about R1 leaving the						
		istrator stated staff spoke to R1						
	5	order for consuming alcohol, ed as he did not like the way it						
		administrator stated he did						
		vere any previous incidents in						
	which R1 had bee	n intoxicated at the facility. The	•					
		ed he did not believe there had						
	been any incidents	s since 12/19/20, in which R1						

Facility ID: 00299

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		AND HUMAN SERVICES				FORM	03/29/2021 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMI	E SURVEY PLETED
		245495	B. WING				C 04/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE EM	ERALDS AT GRAND F	APIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	needed FM-A's per facility, and staff we without permission. aware of any occur facility without FM-// administrator stated completed for all re administrator stated staff-education was On 3/4/21, at 11:25 conducted with SW the facility a couple roommate. SW-As staff called FM-A. Shad permission to b was coming back. staff to call FM-A ar leave was approved should enter a note facility knew if FM-// The facility policy S Residents dated 7// individualized, residents interdisciplinary car information obtaine observations to iden	 mission prior to leaving the ere to call the police if he left The DON stated she was not rence in which R1 had left the A's permission. The d a full-house assessment was esidents who took LOAs. The d he was unsure if any s conducted. a.m. a follow-up interview was A-A. SW-A stated R1 had left of weeks ago with his stated she is unsure if facility SW-A stated she asked if R1 eave the facility, and when he SW-A stated she instructed n additional time to ensure the d. SW-A stated she felt staff in R1's medical record so the A was notified. Eafety and Supervision of 17, directed, "Our dent-centered approach to afety and accident hazards for 	F	589			

Facility ID: 00299

If continuation sheet Page 17 of 17



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 <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 <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. 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

Minneso	ta Department of He	alth			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00299	B. WING		C 03/04/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
THE EM	ERALDS AT GRAND F	APIDS I I C	ITH HIGHWA APIDS, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
2 000	Initial Comments		2 000		
	*****ATTE	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh 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	nether a violation has been			
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.			
Ainnesota D	was conducted to d State Licensure. Yo NOT in compliance Please indicate in y correction that you	S: 3/4/21, an abbreviated survey etermine compliance with ur facility was found to be with the MN State Licensure. our electronic plan of have reviewed these orders, e when they will be completed.		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

03/26/21

STATE FORM

Electronically Signed

6899

If continuation sheet 1 of 19

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		00299	B. WING		C 03/04/2021
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
HE EME	ERALDS AT GRAND F	RAPIDSTIC	JTH HIGHWA RAPIDS, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
2 000	Continued From pa	ge 1	2 000		
	SUBSTANTIATED: MN68505, MN6836 (MN70258) with a li and S900. The following comp UNSUBSTANTIATE H5495095C (MN59	Plaints were found to be H5495099C (MN68385, 57) and H5495100C icensing orders issued at S830 Plaints were found to be ED: H5495094C (MN52729), 1318), H5495096C (MN59336), 5720), and H5495098C		The assigned tag number appears in far left column entitled "ID Prefix Tag The state statute/rule number and th corresponding text of the state statut 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 w are in violation of the state statute af statement, "This Rule is not met as evidenced by." Following the survey findings are the Suggested Method of Correction and the Time Period For Correction.	g." e te/rule s" /hich ter the yors
				PLEASE DISREGARD THE HEADIN THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. T WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION	HIS
				VIOLATIONS OF MINNESOTA STA STATUTES/RULES.	TE
2 830	MN Rule 4658.0520 Proper Nursing Car) Subp. 1 Adequate and re; General	2 830		3/31/21
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a			

If continuation sheet 2 of 19

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) (COM	E SURVEY PLETED	
	or connection	BENTH IO/TION NOMBER.	A. BUILDING	·:		
		00299	B. WING		C 03/04/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ГНЕ ЕМІ	ERALDS AT GRAND	RAPIDS LLC	ITH HIGHW APIDS, MN			
(X4) ID	-	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLE ⁻ DATE	
2 830	Continued From pa	age 2	2 830			
		the attending physician that the ain in bed or the resident n bed.				
	by: Based on observat review, the facility t interventions were leave of absence (ent is not met as evidenced ion, interview, and document failed to ensure safety in-place, prior to a resident LOA), and additional developed for subsequent		F689 Free of Accident/Hazard/Supervision/Devices Immediate Corrective Action: Resident #1 now has appropriate		
	unapproved outing residents (R1) revie resulted in actual h for four hours, was department (ED) w	s and/or intoxication for 1 of 3 ewed for accidents. This larm for R1 who left the facility sent to the emergency when he returned, received lids, and was diagnosed with		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		
	Findings include:			resident sign out book when going on an outing.		
	R1's diagnoses inc	cord printed 3/4/21, indicated luded quadriplegia, traumatic ild cognitive impairment.		Provide resident with facility contact number and save in phone so that they may provide verbal updates about outing as necessary		
	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			Resident and facility representative will obtain verbal consent prior to leaving the facility.		
	locomotion. R1 us indwelling urinary c			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		
	5/2/18, indicated fa court appointed gu impaired to the ext	Inservatorship document dated Imily member (FM)-A was R1's ardian/conservator as R1 "was ent of lacking sufficient apacity to make or		applicable. Resident #1 Guardian was contacted regarding preferences for resident LOA and care plan updated to reflect changes.		

STATEME	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP	LETED
		00299	B. WING		C 03/04/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
THE EM	ERALDS AT GRAND F	RAPIDSIIC	UTH HIGHW/ RAPIDS, MN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLET DATE
2 830	Continued From pa	ge 3	2 830			
	communicate respondent's person nutrition, clothing, s "The Respondent [I and conservator du regards to safety ar R1's care plan unda the community whe plan further identified the facility with his r intoxicated. The car educated R1 relate facility for extended Interventions includ LOA policies and hi educating R1 on the community indeper whereabouts, and r return time. R1's ne R1's physician, and his whereabouts we at the expected tim regarding signing th how to contact the facility to every outing to g accompanied by his On 10/23/20, at 5:4 indicated FM-A had concerns regarding	 ansible decisions concerning onal needs for medical care, shelter or safety." Further, R1] is requesting a guardian to his lack of capacity in the decision making." ated, identified R1 went into the mean etc. A approved. R1's care ed R1 had a history of leaving roommate, and returning are plan identified staff d to the risks of leaving the l periods of time in the cold. Ide educating R1 on facility is individual LOA plan, e risks of going into the notifying staff of his expected ext-of-kin, the charge nurse, I police were to be notified if ere unknown or did not return e, education was provided the resident sign-out book and facility in-case of an <i>M</i>-A approval was required the facility. andated, directed, "If wanted to <i>y</i>, [FM-A] must be called prior et approval and must be s mother or designee." 4 p.m. a progress note I called the facility and voiced the facility in the facility and voiced the facility in the facility in the facility and voiced the facility in the facility and voiced the facility in the facility in		Corrective Action as it applie Leave of Absence policy was and remains current. Leave of Absence Sign out E were edited to designate an return time for the resident as indicate whether resident is dressed for the weather. All residents with Guardians contacted for their preference the resident and care plans of reflect this preference, along necessary steps to follow for residents' LOA. All nursing staff were re-edu LOA Policy specifically regar resident is wearing appropria the LOA, resident is signed of LOA, and resident is contact expected return time Date of Compliance: 3/31/21 Recurrence will be prevente Audits of 5 random resident completed weekly x 4 then r months to assure appropriat interventions were in place & The results of these audits v with the facility QAPI commi on the need to increase, dec discontinue the audits. Corrections will be monitored Social Services Director/Des	s reviewed Book forms estimated and column to appropriately had Guardian e on LOAs for updated to y with individual cated on the rding ensuring ate clothing for but for the red at the d by: LOAs will be nonthly x 2 e safety a followed. vill be shared ttee for input crease or	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00299	B. WING			C 03/04/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
THE EME	ERALDS AT GRAND F	RAPIDS I I C	UTH HIGHWAY RAPIDS, MN 5				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
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2 830	Continued From pa	ige 4	2 830				
	indicated FM-A war	p.m. a progress note nted to keep R1 in the facility, tore, due to the COVID-19					
	indicated the facility approximately 7:45 informed R1 was quarting to a store the questioned why R1 facility, due to COV further indicated FM	p.m. a progress note y received a telephone call at p.m. from FM-A. FM-A was uarantined in his room due to previous day. FM-A was allowed to leave the 'ID-19. The progress note M-A had been contacted by the d FM-A agreed to allow the	9				
	indicated FM-A was requesting to go to R1 went to the store	a.m. a progress note s contacted regarding R1 a store. FM-A was "okay" if e when it was daylight, d he was back before dark.					
	indicated three 50 r found in R1's room	p.m. a progress note milliliter bottles of alcohol were . R1 stated, "I wish those ' The bottles were removed					
	indicated R1 left the writer advise [sic]." getting dark" and hi be out in "this kind not dark and he wa eat. R1 returned to slurred speech, thra wanted to die. R1	22 p.m. a progress note e facility at 4:40 p.m. "against R1 was instructed it "was is mother did not want him to of weather." R1 replied it was inted to go get something to o the facility at 8:40 p.m. with ashing arms, and stated he was noted to be "half way" out nd was partially undressed.					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00299	B. WING			C 03/04/2021	
AME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
HE EMI	ERALDS AT GRAND F	RAPIDSIIC	UTH HIGHWAY RAPIDS, 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
	foot. R1's catheter was "severely cold. emergency departm FM-A was notified. indicated FM-A stat to not go out in the that her son will do to do." Accuweather indica Rapids, MN on 12/ ⁷ degrees Fahrenheit	on" to the third toe on his right was "frozen" and his body " R1 was sent to the nent (ED) at 9:30 p.m., and The progress notes further ed, "She encouraged her son cold or after dark but she says the things he is not suppose the things he is not suppose the the temperature in Grand 19/20, was between -5 t (F) and 21 degrees F.					
	signed out of the fa ED Provider Notes was evaluated with and altered mental however, had cold l and was belligerent suspected trauma, out of his wheelcha required a sedation were given in additi measures. R1 was frostbite on both of alcohol level was 0. intoxication. A Urin collected and was e tract infection]" due	dated 12/19/20, indicated R1 a concern for hypothermia status. R1 felt warm-to-touch, knees, was slurring words, c. R1 had no witnessed or but was assumed he had slid ir. R1 was agitated, and protocol. Intravenous fluids on to external warming noted to have "superficial his knees." R1's blood 2 and consistent with alysis (urine sample) was expected to be "dirty [urinary to freezing. R1 was iotic and discharged back to					
	indicated R1 return R1 returned with ar	3 a.m. a progress note ed to the facility at 4:00 a.m. a antibiotic prescription to act infection and "for the areas					

If continuation sheet 6 of 19

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00299	B. WING			C 04/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 6	2 830			
	indicated risk versu related to alcohol u were presented to f continue to leave th On 12/21/20, at 1:3 indicated a social w (DON), and the adr conference with FM risk vs. benefits we On 1/1/21, at 9:00 p R1 showed a nurse had taken of him sp "icy/snowy" walkwa	0 p.m. a progress note is (vs.) benefit information se and unaccompanied LOAs R1. R1 stated he would he facility "if he so chooses." 5 p.m. a progress note vorker, director of nursing ninistrator had a care 1-A. A conversation related to re reviewed with FM-A. b.m. a progress note indicated a video in which someone binning in circles on the y of the smoking patio. R1 build be hurt by doing so.				
	out of the facility wi approximately 6:00 further indicated "H	p.m. indicated R1 had been th his roommate until p.m. The progress notes e appears to be in a very not quite himself. He is very				
		ted 2/18/21, at 2:33 p.m., about going to a store with				
	his room in an elect approached the nur a jacket, hat, and b hanging on the bac	rses' station. R1 was wearing oots. A backpack was k of R1's wheelchair. R1 was cations at 12:23 p.m., and				
		a.m. R1 wheeled towards the R1 was wearing a jacket, hat,				

If continuation sheet 7 of 19

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	Сом	E SURVEY PLETED
		00299	B. WING		C 03/04/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
THE EME	ERALDS AT GRAND F	RAPIDSIIC	UTH HIGHWA) RAPIDS, MN 🕴			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 7	2 830			
	and boots. Staff op proceeded to the si	pened a door and R1 moking area.				
	conducted with NA- were cognitively intro- outings. NA-B state nurse manager, if a outing. NA-B state the facility without a resident until she ku stated residents fille they wanted to leav liked to go to the sta- got there. NA-B sta staff when he wante was cognitively inta	a.m. an interview was B. NA-B stated residents who act were allowed to leave for a resident wanted to go on an d if she saw a resident leave approval, she would stay with a new if it was approved. NA-B ed out a sign-out log when the facility. NA-B stated R1 ore, but was not sure how he ated she believed R1 asked ed to leave. NA-B stated R1 ict, but had a brain injury.				
	conducted with lice LPN-A stated R1 of stated R1 did tell st where he was going R1 stated he was g to the facility intoxic with him. LPN-A st temperature was w stated she did not r returned to the facil believed R1 was go LPN-A stated when like he had fallen ou roommate had "put R1 was "half out" of was unzipped. LPN frozen, and his belly R1 was "so cold."	a.m. an interview was nsed practical nurse (LPN)-A. iten went on outings. LPN-A aff when he was leaving and g. LPN-A stated on 12/19/20, ioing to the store, and returned cated, and his roommate was ated she was unsure what the hen R1 left the facility. LPN-A ecall what time R1 had left or lity. LPN-A stated she one for "a couple of hours." R1 had returned, it appeared ut of his wheelchair, and his him back in." LPN-A stated f his wheelchair and his jacket V-A stated R1's catheter was y was showing. LPN-A stated LPN-A stated NA-C brought				
	R1 to his room and "wanted to die." LP	he kept saying that he PN-A stated staff put R1 in his p with heated blankets, and				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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		00299	B. WING		03/	04/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
	ERALDS AT GRAND F		UTH HIGHWA	Y 169		
	LINALDO AI GINAND I	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 8	2 830			
	called 911. LPN-A FM-A expected to A leave the facility, ar LPN-A stated she of FM-A for approval a 12/19/20. LPN-A s communicating with occurred. LPN-A s previously been into intoxication since b LPN-A stated she of been intoxicated she of on 3/2/21, at 10:59 conducted with NA on outings, and wa male resident who she was unsure if F when he went on o sign in and out. NA cognition and "knew stated facility staff of intoxicated on a co stated there was tw intoxicated. NA-C when the first incide and his roommate unsure of the date, residents were into called the administ staff were instructer residents came bac NA-C stated the se 12/19/20. NA-C stated dinner. NA-C stated dining room near th	stated since the incident, know when R1 requested to ad what time he will return. did not recall if she contacted for R1 to leave the facility on tated the facility "started" h FM-A after the incident tated she believed R1 had oxicated and had "history" of eing admitted to the facility. did not recall when R1 had efore the incident on 12/19/20. a.m. an interview was -C. NA-C stated R1 liked to go s hanging around another was half his age. NA-C stated R1 normally informed staff utings, but believed he did not A-C stated R1 had intact w what he was doing." NA-C caught R1's roommate uple of occasions. NA-C /o incidents in which R1 was stated she was unable to recal ent occurred. NA-C stated R1 came back from the store, was and she suspected both xicated. NA-C stated LPN-B rator and DON. NA-C stated d in the future to call 911 if the ck to the facility intoxicated. cond incident happened on ated she arrived to work at eturned to the facility well after ad staff found R1 in the Unit 4 he smoking door. NA-C stated ut of his wheelchair" and did	1			
		sense. NA-C stated R1's belly ere ice cold, and his catheter				

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
THE EMI	ERALDS AT GRAND F	RAPIDS I I C	UTH HIGHWAY RAPIDS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETI DATE
2 830	Continued From pa	ge 9	2 830			
	he was or what he was so disoriented electric wheelchair. to his room, minor s "back side," and his NA-C stated R1's ri R1 accused staff of staff removed R1's blankets on him. N hospital. NA-C stati interventions in-pla- prior to the incident On 3/2/21, at 12:24 conducted with NA- staff when he wishe stated R1 used the supposed to let the to leave. NA-D stati	stated R1 had no idea where was doing. NA-C stated R1 he could not operate his NA-C stated staff brought R1 scrapes were noted on his s belly was "red and purple." ght big toe was bloody, and f trying to kill him. NA-C stated pants and placed heated IA-C stated R1 was sent to the ted the facility did not have ce when R1 left for a LOA, on 12/19/20. p.m. an interview was -D. NA-D stated R1 notified ed to leave the facility. NA-D sign-out book, and staff were nurse know when he wanted ted she was not aware of any t to leave without signing out	t			
	conducted with R1. frostbite from the til 12/19/20. R1 state a red nose." R1 sta store, he called for stated the incident deal. R1 stated FM called her when he R1 stated he would his phone to nursin On 3/2/21, at 12:54	p.m. an interview was R1 stated he did not have me he left the facility on d it was like when a "child had ated if he wanted to go to the the bus and notified staff. R1 (on 12/19/20) was not a big 1-A made sure the facility wished to go on an outing. usually call FM-A and bring g staff. p.m. an interview was istered nurse (RN)-A. RN-A				
	stated R1 liked to g RN-A stated R1 typ	o on outings quite often. ically went to a store or he highway. RN-A stated R1				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		СОМ	E SURVEY PLETED C
		00299	B. WING		03/04/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
THE EME	ERALDS AT GRAND F	RAPIDS LLC	UTH HIGHWAY RAPIDS, MN 🚦			
(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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 10	2 830			
	occasions. RN-A s leave the facility it v stated staff needed made decisions for handed her the pho- line when he wisher informed staff of wh he was expected to R1 also use the sig had not seen R1 int there was one occa get intoxicated and RN-A stated R1 had he was sent to the l never disappeared staff needed to call permission. On 3/3/21, at 9:40 a conducted with FM- R1 was intoxicated 12/19/20. FM-A sta and "sometimes they do recall if facility requ the facility on 12/19 put interventions in- occurred. FM-A sta	rdware store on a couple of tated when R1 wanted to vas a "special case." RN-A to contact FM-A, and FM-A him. RN-A stated R1 usually one with FM-A already on the d to leave. RN-A stated R1 nen he was leaving and when o return. RN-A stated staff had in-out book. RN-A stated she toxicated, however, verbalized asion when R1 was known to was sent to the hospital. d suffered from frostbite when hospital. RN-A stated R1 without telling anyone, and the police if he left without a.m. an interview was -A. FM-A stated she was told and suffered from frostbite on ated she was R1's guardian, ey call me about his outings, n't." FM-A stated she did not ested approval for R1 to leave 0/20. FM-A stated the facility -place after the incident ated she was comfortable with it was enforced. FM-A stated				
	wished to leave the not believe R1 show was a "doctor's dec On 3/3/21, at 9:56 a conducted with soc	reliably calling her when R1 facility. FM-A stated she did uld consume alcohol, but that cision." a.m. an interview was ial worker (SW)-A. SW-A nitively intact, however, had a				
	deficit in making go	ood choices. SW-A stated R1 quent accidents prior to				

	(EACH DEFICIENCY		B. WING			C 04/2021
(X4) ID PREFIX	RALDS AT GRAND R SUMMARY STA (EACH DEFICIENCY					J4/ZUZ I
(X4) ID PREFIX	SUMMARY STA (EACH DEFICIENCY	RAPIDS I I C		ATE, ZIP CODE		
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PRÉFIX		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLET DATE
2 830	Continued From pa	ge 11	2 830			
	admission and suffe	ered a traumatic brain injury				
		ars old. SW-A stated R1				
		al thinking, and required				
		ior to leaving the facility.				
	SW-A stated on 12/	19/20, R1 and his roommate				
		nd returned to the facility				
		to 7:30 p.m. SW-A stated				
		d up and his pants were				
		/-A stated R1 was sent to the bly was diagnosed with				
		ted when R1 returned to the				
		nefit document was				
		and his roommate. SW-A				
		anted both residents to be				
		en they went on an outing.				
	SW-A stated she wa	as unable to recall if R1 had				
		prior to the incident on				
		ht R1 may have had one other				
		ication prior to 12/19/20.				
		g like the incident on				
		ened before. SW-A stated the				
		ure FM-A's approval was				
		l leaving for an outing. SW-A vere to call law enforcement if				
		oval. SW-A stated she was				
		ff obtained FM-A's approval				
	prior to leaving the					
	On 3/3/21, at 10:23	a.m. an interview was				
		-C. RN-C stated R1 needed to				
		val, and use the sign-out book				
		an outing. RN-A stated she				
	5	one occasion in which R1 was				
		stated she was not aware of				
		d since the incident on				
		suspected his roommate of				
		RN-C stated an incident				
		s ago in which R1 and his acility without telling anyone.				
		commate got his stimulus				

PRINTED: 03/29/2021 FORM APPROVED

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00299	B. WING		C 03/04/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
HE EME	ERALDS AT GRAND F	RAPIDSIIC	UTH HIGHWAY RAPIDS, MN 5			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 12	2 830			
	called her and state RN-C stated she in enforcement. RN-C DON, however, R1 RN-C stated she sy FM-A gave SW-A p facility. RN-C state speak to FM-A. RN any new interventio R1 left the facility w On 3/3/21, at 10:32 conducted with the administrator state because he was go 12/19/20. The adm and his roommate facility. The DON s got "drunk" and we returned to the faci staff put R1 in bed, assessment, and c administrator state frostbite to his toes administrator state frostbite to his toes administrator state intervention of cont leaving the facility. sure if there were a to the incident on 1	overed him with blankets. The difference of the difference was called				
	facility. The admini- about obtaining an however, R1 refuse	vashy" about R1 leaving the strator stated staff spoke to R1 order for consuming alcohol, ed as he did not like the way it e administrator stated he did				

TATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	СОМІ СОМІ	E SURVEY PLETED
		00299	B. WING		03/04/2021	
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
HE EM	ERALDS AT GRAND F		UTH HIGHWAY RAPIDS, MN 🗧			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ige 13	2 830			
	which R1 had been administrator stated been any incidents had been intoxicate needed FM-A's per facility, and staff we without permission. aware of any occur facility without FM-// administrator stated completed for all re administrator stated staff-education was		t			
	conducted with SW the facility a couple roommate. SW-As staff called FM-A. had permission to I was coming back. staff to call FM-A an leave was approved	a.m. a follow-up interview was 7-A. SW-A stated R1 had left of weeks ago with his stated she is unsure if facility SW-A stated she asked if R1 eave the facility, and when he SW-A stated she instructed n additional time to ensure the d. SW-A stated she felt staff in R1's medical record so the A was notified.	5			
	Residents dated 7/ individualized, resid safety addresses si individual residents interdisciplinary car information obtaine observations to ide	lent-centered approach to afety and accident hazards for				
	director of nursing,	THOD OF CORRECTION: The or designee, could review and procedures related to				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLETED	
		00299	B. WING		C 03/04/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EM	ERALDS AT GRAND I	RAPIDSTIC	JTH HIGHWA RAPIDS, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
2 830	Continued From pa	age 14	2 830			
	nursing, or designe resident leave of al The director of nurs compliance regard leaves of absences	absences. The director of ee, could train staff related to osence policies/procedures. sing, or designee, could audit ing resident supervision and S. R CORRECTION: Twenty-one				
2 900	(21) days	5 Subp. 3 Rehab - Pressure	2 900		3/31/21	
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the nursing care plan which				
	without pressure s pressure sores un condition demonstr	to enters the nursing home ores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and				
	receives necessar	who has pressure sores y treatment and services to revent infection, and prevent veloping.				
	by: Based on observat review, the facility f and off-loading of p prevent developme	ent is not met as evidenced ion, interview, and document failed to ensure repositioning pressure was completed to ent of pressure ulcers for 1 of 3 ewed for pressure ulcers.		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		

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STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00299			C 03/04/2021	
NAME OF	PROVIDER OR SUPPLIER		•	STATE, ZIP CODE	03/04/2021	
	ERALDS AT GRAND F	RAPIDS I I C				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	GRAND I ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	55744 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉ	
2 900	Continued From pa	age 15	2 900			
	Findings include: R3's Transfer/Dischindicated R3's diag obesity, chronic pai weakness. R3's quarterly Minin 1/22/21, indicated F required extensive and transfers. In ac did not walk, and w bowel and bladder. R3's Pressure Ulce (CAA) dated 12/3/2 skin breakdown du frequent bladder in- identified staff were toileting, and repos R3's care plan date a history of a press was at increased ri- to the need for assi- incontinence. R3's and reposition R3 e refused repositionin R3's Pocket Care F was to be reposition On 3/2/21, at 2:03 p observations, R3 w wheelchair near the wheeled to a table participated in a bir from the table and the bingo activity, a	harge Report dated 3/4/21, noses included morbid in, heart failure, and muscle mum Data Set (MDS) dated R3 was cognitively intact and assistance with bed mobility dition, the MDS indicated R3 as occasionally incontinent of er/Injury Care Area Assessment 0, identified R3 was at risk for e to impaired mobility and continence. The CAA further e to check, change, offer ition R3 every two hours. ed 10/18/20, indicated R3 had ure ulcer to her coccyx, and sk for skin breakdown related istance with mobility and care plan directed staff to turn every two hours, however, R3		individualized needs on care plan. Corrective Action as it applies to of The Activity of Daily Living Policy w reviewed and remains current. All nurses, TMAs, and NARs were re-educated on the Activity of Daily Policy specifically providing assista with repositioning per resident individualized care pan. All residents needing assistance w repositioning will be provided this assistance per care plan/care shee details. Date of Compliance: 3/31/2021 Recurrence will be prevented by: Audits of 5 random residents will b completed weekly x 4 then monthly months to assure timely assistance provided for repositioning. The res these audits will be shared with the QAPI committee for input on the m increase, decrease or discontinue audits. Corrections will be monitored by: DON/Nurse Managers/Designee	vas v Living ance ith et e y x 2 e is ults of e facility eed to	

If continuation sheet 16 of 19

	NT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED
		00299	B. WING			04/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
THE EM	ERALDS AT GRAND F	RAPIDSIIC	JTH HIGHWAY RAPIDS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ge 16	2 900			
	coffee. R3 wheeled partially closed her approached R3's ro vitals machine from administrator did no Licensed practical r room with a wheele medications. R3 re seatbelt to be readj R3's wheelchair sea LPN-E then adminis completed a blood vital signs. LPN-E p exited R3's room at repositioning. No s 4:03 p.m. to 4:40 p.	d R3 requested a cup of to her room at 3:23 p.m. and door. The administrator bom and removed a wheeled a R3's room entry. The ot offer to reposition R3. hurse (LPN)-E entered R3's ed vitals machine and oral equested her wheelchair usted. LPN-E unfastened atbelt and readjusted it. stered R3's oral medications, glucose check, and took R3's berformed hand hygiene and t 4:02 p.m. R3 was not offered taff entered R3's room from .m. 2 hours and 37 minutes he continuous observation				
	conducted with LPN be repositioned events the tilt function on h independently offloat she believed it was	o.m. an interview was N-E. LPN-E stated R3 was to ery two hours, however, used her wheelchair to aded pressure. LPN-E stated acceptable to offload he wheelchair tilt function.				
	conducted with R3. reposition her, but s she used the tilt fur	a.m. an interview was R3 stated staff offered to she often refused. R3 stated action on her electric sition when she was up.				
	conducted with train (TMA)-A. TMA-A st and repositioned. T	a.m., an interview was ned medication assistant ated R3 needed to be turned MA-A stated R3 was able to side and scoot back in her				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00299	B. WING		C 03/04/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
HE EME	ERALDS AT GRAND F	RAPIDS LLC	UTH HIGHWAY RAPIDS, MN 5			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ge 17	2 900			
	make sure R3 was TMA-A states some back or "wiggled" in pressure should be On 3/4/21, at 10:12 conducted with occ OT-A stated R3 wa wheelchair, and this to offload pressure to "slightly" reposition cushion was recent for better positionin were requested for stated he would con		r			
	follow-up interview OT-A stated modified wheelchair. OT-A stated informed him since	eximately 10:30 a.m., a was conducted with OT-A. cations were made to R3's tated the manufacturer (Robi) modifications were made to e wheelchair could not provide n.				
	conducted with the The DON stated sh repositioned very tw	p.m., an interview was director of nursing (DON). he believed R3 was to be vo to three hours, but didn't her head. The DON stated R3 in issues.	3			
	(Activity of Daily Liv directed, "Based up representative desi	Ionarch Healthcare ADL ving) policy revised 5/16, pon resident/resident res, assessment and care ce will be provided to any necessary."				

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PRINTED: 03/29/2021 FORM APPROVED

Minnesc	ta Department of He	ealth			TORMATINOVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00299	B. WING		C 03/04/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
THE EMI	ERALDS AT GRAND F	ZAPIDSTIC	JTH HIGHW RAPIDS, 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 COMPLETE
2 900	all residents at risk they recieved the n prevent pressure ul director of nursing, random audits of ca	sing, or designee, could review for pressure ulcers to assure ecessary treatment/services to lcers from developing. The or designee, could conduct	2 900		
Minnesota D STATE FOR	epartment of Health		6899		If continuation shart 10 -f 10
SIALEFUR	VI		0000	Y11V11	If continuation sheet 19 of 19