

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 1, 2021

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

RE: CCN: 245495 Survey Cycle Start Date: August 18, 2021

Dear Administrator:

On August 18, 2021 a survey was completed at your facility by the Minnesota Department of Health to investigate a complaint 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. At the time of survey, the complaint was substantiated but no deficiencies were issued, because corrective action was taken prior to the survey. A plan of correction is not required.

Also at the time of this survey, the investigator also assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, found no violations of these rules promulgated under Minnesota Statute § 144.653 and/or Minnesota Statute § 144A.10.

The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to federal deficiencies only.

Electronically attached is your copy of the Federal CMS-2567 Form and State Form.

Feel free to contact me if you have questions.

Sincerely,

Kim Tyson

Kim Tyson, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-3831 Email: kim.tyson@state.mn.us

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0		0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
245495		B. WING			C 08/18/2021		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE EME	ERALDS AT GRAND F	RAPIDS LLC			801 SOUTH HIGHWAY 169 SRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	FO	000			
	conducted at your f to be IN compliance CFR 483, Subpart I Term Care Facilities The following comp SUBSTANTIATED: H5495111C (MN75 were cited due to a facility prior to surve Because you are en signature is not req page of the CMS-25	plaint was found to be 795), however, no deficiencies ctions implemented by the ey. nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as					
LABORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

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.

PRINTED: 09/01/2021

STATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIERCILA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION 00299 B. WING C C 00299 B. WING B. WING C 08/18/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 C C C (X4) ID PREEX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREEX REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION OR DEFICIENCY COMPLETE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DEFICIENCY) 2 000 Initial Comments 2 000 2 000 C COMPLETE DEFICIENCY) DEFICIENCY 2 000 Intical Comments 2 000 2 000 C C C 1 n 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 requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several litems, failure to comply with any of the items will be considered ID ID ID	Minnesota Department of Health						
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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.		144A.10, this corre- pursuant to a surver found that the defice herein are not corre- not corrected shall with a schedule of f the Minnesota Depa Determination of wit corrected requires of requirements of the number and MN Ru When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess that was violated du	ction order has been issued ey. If, upon reinspection, it is siency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health. hether a violation has been compliance with all e rule provided at the tag ule number indicated below. ns several items, failure to the items will be considered . Lack of compliance upon any item of multi-part rule will sment of a fine even if the item				
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.		that may result from orders provided that the Department wit	n non-compliance with these at a written request is made to hin 15 days of receipt of a				
INITIAL COMMENTS: On 8/18/21 a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.		On 8/18/21 a comp your facility by surv Department of Hea found IN compliance	laint survey was conducted at eyors from the Minnesota lth (MDH). Your facility was				
The following complaint was found to be Vinnesota Department of Health	Vinnesota De		plaint was found to be				

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

TITLE

(X6) DATE

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Minnesota Department of H	lealth			TORMATTIC	JVLD		
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Minnesota Department of Health		1	1				