*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
July 1, 2024

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

RE: CCN: 245495
Cycle Start Date: June 20, 2024

Dear Administrator:

On June 20, 2024, a survey was completed at your facility by the Minnesota Department 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

## DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by September 20, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 20, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc:  Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>On 6/18/24 and 6/20/24, a standard abbreviated survey was conducted at your facility. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaint was reviewed. H54954412C (MN00103977) with a deficiency issued at F684 and F689.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced | F 684 | | 7/12/24 |

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

Electronically Signed | 07/10/2024

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 1<br>by:<br>Based on interview and document review, the facility failed to ensure physician orders to obtain a Basic Metabolic Panel (BMP), and Urine Analysis (UA)/Urine Culture (UC) with susceptibility and sensitivity, timely for 1 of 3 residents (R1) reviewed, who was diagnosed with a urinary tract infection (UTI)<br><br>Findings include:<br><br>R1's significant change Minimal Data Set (MDS) dated 6/17/24, indicated R1 had diagnoses which included vascular dementia, anxiety and R1 had severely impaired cognition.<br><br>R1's progress note dated 6/3/24, revealed R1 was evaluated by the physician related to nursing requested resident to be seen regarding her agitation, behaviors, and multiple falls. Resident had fallen 7 times since her admission. Resident is disoriented to place and time. Physician discussed with family who stated resident smelt like urine and her room smelled of strong urine. Further, family reported resident frequently would get a urinary tract infection (UTI) and exhibited behaviors and more confusion when she had a UTI. New orders were as follows, Basic Metabolic Panel (BMP), and Urine Analysis (UA)/Urine Culture (UC) with susceptibility and sensitivity.<br><br>R1's Active Order from Aeris Medical Group dated 6/3/24, revealed R1's physician ordered a BMP, UA)/UC with susceptibility and sensitivity. The order was signed by the physician on 6/7/24.<br><br>R1's After Visit Summary dated 6/8/24, revealed R1 was evaluated due to altered mental status and was diagnosed with acute cystitis (infection in | F 684 | Immediate Corrective Action:<br><br>R1 discharged from facility 6/27/24.<br><br>Corrective Action as it applies to others:<br><br>All residents will have lab orders reviewed for the last 2 weeks to identify orders were completed.<br><br>Nurses will be educated on facility policy “Medication and Treatment Orders”, and completing ordered labs in a timely manner.<br><br>Recurrence will be prevented by:<br><br>Audits will be conducted weekly x3 weeks on physician lab orders, and order completion/ follow-up. Audits and findings will be reported to QAPI committee for further recommendations.¿<br><br>Corrections will be monitored by: Director of Nursing or Designee | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 2<br>the bladder) with hematuria.<br><br>On 6/18/24 at 12:51 p.m., family member (FM)-B stated R1 had a history of UTIs and would often show signs of confusion, hallucinations, unsteady on feet, and strong-smelling odor. Further, FM-B stated R1 was sent to the emergency room and diagnosed with a UTI recently.<br><br>On 6/20/24 at 11:35 a.m., registered nurse (RN)-C stated R1's nurse practitioner (NP) spoke to RN-C regarding ordering a UA/UC and BMP labs following the NP's evaluation on 6/3/24. RN-C stated NP communicated the orders verbally, and RN-C confirmed she did not follow-up on them and no evidence of the order in R1's record. Further, RN-C stated NP wrote another order on 6/11/24, wanting the results of the UA/UC and the BMP. RN-C stated staff were expected to contact the NP if the staff do not receive the order. Further, RN-C stated R1 was diagnosed and treated for a UTI following her emergency room visit on 6/8/24, she was noted to have had increased behaviors and the UTI could have contributed to R1's incident of leaving the facility without staff's knowledge as well as the falls R1 was having.<br><br>On 6/20/24 at 2:00 p.m., director of nursing stated R1 was "very incontinent" and would often urinate on the floor in her room. DON stated she spoke with R1's NP regarding the need to rule out a UTI due to behaviors and I know NP was going to order a UA/UC. Further, DON confirmed she was not aware the UA/UC was not obtained, and a BMP lab was not completed either. DON stated the NP ordered the UA/UC and BMP on 6/3/24, however the facility did not receive the written order until 6/8/24 and R1 had already been to the | F 684 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 3<br>emergency room and was diagnosed with a UTI there after completing a UA/UC. In addition, DON stated if staff were aware the NP ordered a UA/UA, they would be expected to follow up on getting the order timelier.<br><br>Review of facility policy titled Medication and Treatment Orders dated 2/24, indicated verbal orders must be recorded in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order. | F 684 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide adequate supervision for 1 of 3 residents (R1) reviewed, who was cognitively impaired and able to leave the building without staff's knowledge into the courtyard which resulted in a fall and being able to exit the secured area. In addition, the facility failed to implement fall interventions for 1 of 3 residents (R1), who was at high risk for falls.<br><br>Findings include:<br><br>R1's significant change Minimal Data Set (MDS) | F 689 | Immediate Corrective Action:<br><br>R1 discharged from facility 6/27/24.<br><br>Corrective Action as it applies to others:<br><br>Wanderguard door alarm was replaced on dining room courtyard door on 6/26/24.<br><br>Fall interventions for falls occurring in the last 2 weeks will be audited for fall intervention completion. | 7/12/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 4<br>dated 6/17/24, indicated R1 had diagnoses which included vascular dementia, anxiety and R1 had severely impaired cognition. Further, MDS indicated R1 had two or more falls with no injury and one fall with injury.<br><br>R1's care plan as of 6/18/24, indicated R1 had an alteration in cognition related to dementia and R1's daughter assists with decision making. R1 had a history of consistent wandering, pacing, agitation, restlessness/anxiousness, hallucinations, and history of eloping the facility. Due to these behaviors, R1 was at high risk for falls. Further, R1's care plan identified R1 was at risk for elopement and directed staff to offer resident chocolate and diet coke when agitated or anxious, monitor and document exit seeking behaviors, WanderGuard was in place and would be monitored for proper functioning, door alarms answered promptly, and R1 would be invited to activities of their choosing.<br><br>Review of R1's Incident Review and Analysis dated 6/1/24 at 10:44 a.m., indicated R1 was found on the ground next to the gazebo in the locked and gates courtyard. R1 was noted to be confuses and unable to tell staff what she was doing. After review of the fall, the interdisciplinary team implemented staff were to offer and assist resident with walks in the courtyard.<br><br>Review of R1's Incident Review and Analysis dated 6/8/24 at 4:30 p.m., revealed R1 was observed by nursing assistant (NA) walking outside wing 3 windows. Staff members responded immediately to direct resident back inside. Upon investigation, R1 went into the secured courtyard, and pushed on the gate to the fence and was able to exit through the fence. | F 689 | Elopement Policy reviewed, and remains current. Maintenance Department will be educated on accurately completing wanderguard door audits, and elopement policy.<br><br>Fall Prevention and Management policy reviewed and remains current. IDT team responsible for completing fall incident review and analysis will be educated on fall prevention and management policy.<br><br>Recurrence will be prevented by:<br><br>Maintenance will monitor wanderguard door functionality weekly x 3 weeks. Fall intervention implementation will be audited weekly x 3 weeks, and then monthly x2 months. Audits and findings will be reported to QAPI committee for further recommendations.¿<br><br>Corrections will be monitored by:<br>Administrator or Designee | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 5<br>Following the incident, the following interventions were implemented by the IDT: R1 was sent to the emergency department for clinical evaluation, psychiatric provider to evaluate R1 on 6/12/24, remain on 15- minute checks, new elopement assessment completed, and skin check was completed with no injuries noted.<br><br>Review of facility's Logbook Documentation, which was to check operation of door monitors and patient wandering system, indicated on 5/14/24 door E9 (the door in the dining room to exit into the courtyard) passed the inspection, on 5/21/24 E9 door failed the inspection, on 5/30/24 and 6/3/24 E9 door was marked as NA (not applicable), on 6/11/24 the inspection was not completed, and on 6/17/24 E9 door was marked as passed the inspection.<br><br>On 6/18/24 at 12:15 p.m., R1 was observed laying in her bed accompanied by family member (FM)-A. R1 was noted to have one gripper sock on and the other bare foot. Further, there was a WanderGuard observed on her right ankle.<br><br>On 6/18/24 at 12:15 p.m., FM-A stated R1 had left the facility without staff's knowledge "a couple times", but did not get far. FM-A was unsure about the details of the incidents. Further, FM-A stated R1 has had a few falls with no major injuries however, FM-A felt R1 had improved within the last two weeks due to new medication changes.<br><br>On 6/18/24 at 12:51 p.m., FM-B stated R1's cognitive impairment and behaviors were new as of most recent surgery when she had anesthesia. FM-B stated since admission to the facility R1 had required a WanderGuard due to wandering | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 6<br>and exiting the facility.<br><br>On 6/20/24 at 8:42 a.m., R1 was observed in the commons area by the nursing station, sitting in a stationary chair and appeared to be sleeping. R1 had a 4-wheeled walker next to her.<br><br>On 6/20/24 at 8:44 a.m., NA-A stated R1 was confused and would often exhibit wandering behaviors and staff were to visually check on R1 every 15 minutes to ensure safety. NA-A stated she was aware R1 exited the facility without staff knowledge but was unsure of details of the incident.<br><br>On 6/20/24 at 8:58 a.m., NA-B stated R1 required a lot of staff prompting to completed activities of daily living (ADLs) and exhibited wandering behaviors. NA-B stated staff were expected to visually check on R1 every 15 minutes to ensure safety. NA-B stated when R1 exhibits wandering behaviors staff were directed to walk with her and attempt to redirect, offer to call her family, and offer different activities. NA-B stated R1 had "wandered outside without staff" and had a fall in the courtyard where another resident's family found her. Further, NA-B stated R1 did not obtain any injuries from the fall and had a WanderGuard on at the time of the incident, but NA-B stated she did not recall hearing the WanderGuard system alarming and alerting staff of R1's exit of the building. In addition, NA-B stated she was aware of the incident that occurred on 6/8/24, when R1 was able to exit the building without staff's knowledge and was able to get through the fence in the courtyard.<br><br>On 6/20/24 at 9:14 a.m., NA-C stated R1 had impaired cognition and would exhibit wandering | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 7<br>behaviors. NA-C stated most often when R1 was wandering she was looking for her family, and her family would often come to the facility which was beneficial. Further, NA-C stated R1 required a 1-1 staff often due to wandering behaviors to ensure R1 was safe and "not getting out" of the facility. NA-C stated she was working on 6/8/24, the day of R1's incident where she exited the building, and NA-C stated at approximately 3:30 p.m., she observed R1 through the window walking outside of another wing on the unit, without her walker. NA-C stated she notified registered nurse (RN)-A, who ran down the hallway to get R1 back into the facility. Further, NA-C stated once R1 was back inside the building, NA-C checked the doors on R1's unit and noted one of the two courtyard doors was alarming and NA-C shut it off. NA-C stated she exited through that door and into the secured courtyard and walked to the fence and shook the fence when NA-C noted the fence was loose and R1 could have got through a gap in the fence. NA-C stated R1 was assessed, and no injuries were noted, and R1 was sent to the emergency room for further evaluation where she was diagnosed with a urinary tract infection. In addition, NA-C stated there were two doors that lead to the secured courtyard, one of the doors WanderGuard system does not work at this time and had recently been blocked off following R1's incident.<br><br>On 6/20/24 at 9:38 p.m., RN-A stated R1 was confused and would often exit seek and wander the facility asking to leave. RN-A stated R1 had a WanderGuard on due to elopement risk and staff were directed to visually check on R1 every 15 minutes, offer snacks and beverages, listen to music, or have R1 sit close to the nursing medication cart if R1 was exhibiting any | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 8<br>wandering or exit seeking behaviors. RN-A stated she was R1's floor nurse on 6/8/24, and R1 was sitting by RN-A medication cart when RN-A went to administer medications to another resident and was then notified by NA-C that R1 was outside of the facility. RN-A ran outside of the facility to retrieve R1 and bring her back inside, R1 was observed wearing socks on her feet and no walker. RN-A assessed R1 for injury and none were noted at that time, and R1 kept stating she wanted to go home. Further, RN-A stated there were two doors that leads to the secured courtyard, the door located in the dining room was known to have a broken or malfunctioning WanderGuard system on it, and RN-A stated that was the door R1 would always use to go out into the courtyard with family and was also the closed door to RN-A's medication cart and the last known location of R1 on the day of the incident. RN-A stated there was no WanderGuard alarm sounding at the time of the event that would have alerted staff of R1's exit of the facility, so RN-A determined R1 had exited through the door in the dining room and out into the courtyard where R1 must have climbed through a gap in the metal fence. RN-A stated since this incident, management had since blocked the exit from the dining room into the courtyard and residents can now only exit through the other door.<br><br>On 6/20/24 at 10:30 a.m., maintenance director (MD)-A stated the WanderGuard system on the doors were monitored by maintenance and checked for functioning weekly. MD-A stated the door to exit into the courtyard in the dining room had been broken for approximately a month and a half. Further, MD-A stated the front door's WanderGuard alarm had failed, so MD-A swapped the front door with the door in the dining | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 9<br>room because the courtyard was secured, and residents were unable to leave. MD-A reviewed WanderGuard functioning logs and confirmed the courtyard door in the dining room was identified as E9 on the logs and stated between 5/14/24 and 5/21/24 the WanderGuard alarm was switched with the front door, 6/3/24 the E9 door had failed functioning and no alternative alarm was placed, on 6/11/24 the log and function check were not completed, and on 6/17/24 the E9 door was marked as pass which would be inaccurate as the alarm system had not been fixed at the time of the survey. MD-A stated he was aware of R1's exit from the building without staff's knowledge and assumed R1 had exited through the E9 door due to the alarm not functioning, and she got through the metal fence which had been addressed and fixed.<br><br>On 6/20/24 at 10:53 a.m., RN-B stated if a resident was identified as an elopement risk a WanderGuard would be placed on the resident and if the resident were to attempt to leave or exit the facility the WanderGuard system would alert staff by an alarm. RN-B stated the door to the courtyard through the dining room had a WanderGuard system, however the alarm system had not been working for a couple weeks now and that exit was now blocked as of last week. Further, RN-B stated R1 was at risk for eloping and falls due to cognition. RN-B stated she was R1's nurse the day R1 had fallen outside by the Gazebo on 6/1/24, and RN-B stated she was alerted of R1's fall by another family member. RN-B stated she went out into the courtyard and observed R1 on the ground, she had on gripper socks and R1 did not have her walker with her. RN-B stated R1 had not obtained any injuries and R1 must have exited through the courtyard door | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 10<br>in the dining room because there was not a WanderGuard alarm going off at the time of the fall.<br><br>On 6/20/24 at 11:23 a.m., RN-C stated maintenance staff were expected to monitor the exit doors for WanderGuard functioning and confirmed the door to the courtyard from the dining room was not functioning for a couple weeks now and the door was now blocked and not in use. RN-C stated R1 was confused and impulsive and exhibited behaviors of wandering and combativeness. RN-C stated R1 had a fall on 6/1/24, out in the courtyard and RN-C was unsure how R1 got out into the courtyard but believed R1 had exited through the dining room door into the courtyard without staff's knowledge and stated the IDT had not investigated the fall.<br><br>On 6/20/24 at 1:21 p.m., administrator stated the WanderGuard system on the courtyard door in the dining room was switched with the front door alarm that was broken and the IDT determined the front door was priority because the courtyard was secured by the fence. Administrator stated the facility was working on the repair of the door alarm but did not have any alternative alarm on the door until the alarm was able to get fixed. Administrator confirmed staff did not assess the fence to ensure the fence was secure prior to making the decision to leave the door without a functioning WanderGuard system. Further, administrator stated she completed the investigation for R1's incident that occurred on 6/8/24. Administrator stated there were no witnesses to R1 exiting the facility, so it was inconclusive to which door she exited from but did confirm there were no reports from staff of the WanderGuard system alarming at the time of the | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 11<br>event. In addition, administrator stated all falls were reviewed in the IDT meeting but there was not an investigation completed as to how R1 was able to exit the facility on 6/1/24, without staff's knowledge, and resulted in a fall.<br><br>On 6/20/24 at 2:00 p.m., director of nursing (DON) stated any resident was able to go out into the courtyard since the courtyard was secured. DON stated R1 had severe dementia and would not be appropriate to be out in the courtyard without staff's knowledge as R1 was at risk for falls and elopement. DON confirmed R1's fall on 6/1/24, was not investigated and DON was unsure how R1 was able to get out into the courtyard without staff's knowledge. Further, DON stated the courtyard door through the dining room was not working and maintenance was in the process of fixing and the door was now blocked and residents were unable to use at the time.<br><br>Review of facility policy titled Elopement Policy dated 6/23, revealed a specific system had been developed to notify staff that an external door had been opened in an area accessible to residents. The facility would identify such environmental hazards such as entrances, stairwells, or exits that pose a foreseeable danger to residents who wander or have an exit seeking behavior. The facility would implement interventions to minimize these risks and hazards as appropriate.<br><br>AND<br><br>R1's significant change Minimal Data Set (MDS) dated 6/17/24, indicated R1 had diagnoses which included vascular dementia, anxiety and R1 had | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 12<br>severely impaired cognition. Further, MDS indicated R1 had two or more falls with no injury and one fall with injury.<br><br>R1's care plan as of 6/18/24, indicated R1 was at risk for falls related to diagnosis of vascular dementia with other behavioral disturbance and heart failure. R1's care plan directed staff to encourage resident to wear skid free footwear, utilize a 2-wheeled walker for ambulation, and non-skid strips to floor in bathroom.<br><br>On 6/18/24 at 11:45 a.m., R1 was observed sitting at a table in the dining room in a standard chair accompanied by FM-A, who was seated on R1's 4-wheeled walker. R1 was observed to independently stand up from the chair and was wearing one gripper sock and the other was barefoot. Social Services (SS)-A assisted R1 to ensure she was able to ambulate away from the table and chair without losing balance, and R1 walked out of the dining room with FM-A utilizing the 4-wheeled walker and only one gripper sock on.<br><br>On 6/18/24 at 8:44 a.m., NA-A stated R1 was at risk for falls and had fallen many times since admitting to the facility, and staff were direct to ensure R1 had gripper socks or shoes on since she was unsteady while ambulating, remind R1 to use one of her walkers, either the 2-wheeled or 4-wheeled walker, with assistance while ambulating.<br><br>On 6/20/24 at 8:58 a.m., NA-B stated R1 required a lot of staff prompting to completed activities of daily living (ADLs) and required a 4-wheeled walker for ambulation. Further, NA-B stated R1 was at risk for falls and staff were directed to | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 13 | F 689 | | |

ensure R1 always had gripper socks on, which R1 was compliant with and would not remove them, and visually check on R1 every 15 minutes to ensure safety.

On 6/20/24 at 9:38 a.m., RN-A stated R1 required the use of a 4-wheeled walker to ambulate and would often forget to grab her walker and forgets to apply the brakes on the walker prior to sitting on the seat. RN-A stated she was a high fall risk and staff were directed to visually check on R1 every 15 minutes, ensure she had on non-slip footwear, cues to utilize her walker, low bed and reminders to use call light for assistance.

On 6/20/24 at 11:04 a.m., R1 was observed at the nursing station sitting on the seat of her 4-wheeled walker, brakes locked, and wearing gray slipper socks. Further, there was not non-skid strips on R1's bathroom floor.

On 6/20/24 at 11:23 a.m., RN-C stated R1 was at risk for falls and staff were expected to utilize the 2-wheeled walker or the 4-wheeled walker, had a psychiatric referral with some medication changes, ensure the proper footwear, offer walks in the courtyard, and assisting R1 was tasks. RN-C stated following a fall in R1's bathroom, non-skin strips was the intervention determined by the interdisciplinary team (IDT) but did not get implemented.

On 6/20/24 at 2:00 p.m., DON stated following a fall, the IDT would meet to discuss the root cause of the fall and determine an appropriate intervention to prevent future falls. Further, the DON stated the intervention would be implemented following the IDT meeting and the managers on the unit would be expected to follow

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 14<br>up the next day to determine if the intervention was effective.<br><br>Review of facility policy titled Fall Prevention and Management dated 2/24, indicated staff would monitor and document the resident's response to and the effectiveness of interventions put in place to prevent further falls for 72 hours post fall. Further, if the resident continued to fall, staff would re-evaluate the situation and whether it was appropriate to continue or change the current interventions. | F 689 | | |

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
July 1, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: YQHS11

Dear Administrator:

The above facility was surveyed on June 18, 2024 through June 20, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00299 | A. BUILDING: _____ B. WING _____ | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 6/18/24 and 6/20/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed | 2 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00299 | A. BUILDING: _____ B. WING _____ | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 000 | Continued From page 1<br>these orders and identify the date when they will be completed.<br><br>The following complaint was reviewed. H54954412C (MN00103977) with a licensing order issued at 0830.<br><br>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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.<br><br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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 | 2 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00299 | A. BUILDING: _____ B. WING _____ | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 000 | Continued From page 2<br>the Minnesota<br><br>Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.<br><br>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. | 2 000 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure physician orders to obtain a Basic Metabolic Panel (BMP), and Urine Analysis (UA)/Urine Culture (UC) with susceptibility and sensitivity, timely (R1), who was diagnosed with a urinary tract infection (UTI) | 2 830 | Corrected. | 7/12/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00299 | A. BUILDING: _____ B. WING _____ | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 3<br>Findings include:<br><br>R1's significant change Minimal Data Set (MDS) dated 6/17/24, indicated R1 had diagnoses which included vascular dementia, anxiety and R1 had severely impaired cognition.<br><br>R1's progress note dated 6/3/24, revealed R1 was evaluated by the physician related to nursing requested resident to be seen regarding her agitation, behaviors, and multiple falls. Resident had fallen 7 times since her admission. Resident is disoriented to place and time. Physician discussed with family who stated resident smelt like urine and her room smelled of strong urine. Further, family reported resident frequently would get a urinary tract infection (UTI) and exhibited behaviors and more confusion when she had a UTI. New orders were as follows, Basic Metabolic Panel (BMP), and Urine Analysis (UA)/Urine Culture (UC) with susceptibility and sensitivity.<br><br>R1's Active Order from Aeris Medical Group dated 6/3/24, revealed R1's physician ordered a BMP, UA)/UC with susceptibility and sensitivity. The order was signed by the physician on 6/7/24.<br><br>R1's After Visit Summary dated 6/8/24, revealed R1 was evaluated due to altered mental status and was diagnosed with acute cystitis (infection in the bladder) with hematuria.<br><br>On 6/18/24 at 12:51 p.m., family member (FM)-B stated R1 had a history of UTIs and would often show signs of confusion, hallucinations, unsteady on feet, and strong-smelling odor. Further, FM-B stated R1 was sent to the emergency room and diagnosed with a UTI recently.<br><br>On 6/20/24 at 11:35 a.m., registered nurse | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00299 | A. BUILDING: _____ B. WING _____ | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 4<br><br>(RN)-C stated R1's nurse practitioner (NP) spoke to RN-C regarding ordering a UA/UC and BMP labs following the NP's evaluation on 6/3/24. RN-C stated NP communicated the orders verbally, and RN-C confirmed she did not follow-up on them and no evidence of the order in R1's record. Further, RN-C stated NP wrote another order on 6/11/24, wanting the results of the UA/UC and the BMP. RN-C stated staff were expected to contact the NP if the staff do not receive the order. Further, RN-C stated R1 was diagnosed and treated for a UTI following her emergency room visit on 6/8/24, she was noted to have had increased behaviors and the UTI could have contributed to R1's incident of leaving the facility without staff's knowledge as well as the falls R1 was having.<br><br>On 6/20/24 at 2:00 p.m., director of nursing stated R1 was "very incontinent" and would often urinate on the floor in her room. DON stated she spoke with R1's NP regarding the need to rule out a UTI due to behaviors and I know NP was going to order a UA/UC. Further, DON confirmed she was not aware the UA/UC was not obtained, and a BMP lab was not completed either. DON stated the NP ordered the UA/UC and BMP on 6/3/24, however the facility did not receive the written order until 6/8/24 and R1 had already been to the emergency room and was diagnosed with a UTI there after completing a UA/UC. In addition, DON stated if staff were aware the NP ordered a UA/UA, they would be expected to follow up on getting the order timelier.<br><br>Review of facility policy titled Medication and Treatment Orders dated 2/24, indicated verbal orders must be recorded in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00299 | A. BUILDING: _____ B. WING _____ | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 5<br>the time of the order.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered
August 1, 2024

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

RE: CCN: 245495
Cycle Start Date: June 20, 2024

Dear Administrator:

On July 23, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance.  Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308  Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

August 1, 2024

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

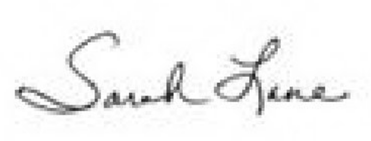
Re: Reinspection Results
Event ID:  YQHS12

Dear Administrator:

On July 23, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 20, 2024.  At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308  Fax: 651-215-9697
Email: sarah.lane@state.mn.us

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
July 1, 2024

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

RE: CCN: 245495
Cycle Start Date: June 20, 2024

Dear Administrator:

On June 20, 2024, a survey was completed at your facility by the Minnesota Department 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

## DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by September 20, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 20, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc:  Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>On 6/18/24 and 6/20/24, a standard abbreviated survey was conducted at your facility. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaint was reviewed. H54954412C (MN00103977) with a deficiency issued at F684 and F689.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced | F 684 | | 7/12/24 |

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

Electronically Signed | 07/10/2024

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 1<br>by:<br>Based on interview and document review, the facility failed to ensure physician orders to obtain a Basic Metabolic Panel (BMP), and Urine Analysis (UA)/Urine Culture (UC) with susceptibility and sensitivity, timely for 1 of 3 residents (R1) reviewed, who was diagnosed with a urinary tract infection (UTI)<br><br>Findings include:<br><br>R1's significant change Minimal Data Set (MDS) dated 6/17/24, indicated R1 had diagnoses which included vascular dementia, anxiety and R1 had severely impaired cognition.<br><br>R1's progress note dated 6/3/24, revealed R1 was evaluated by the physician related to nursing requested resident to be seen regarding her agitation, behaviors, and multiple falls. Resident had fallen 7 times since her admission. Resident is disoriented to place and time. Physician discussed with family who stated resident smelt like urine and her room smelled of strong urine. Further, family reported resident frequently would get a urinary tract infection (UTI) and exhibited behaviors and more confusion when she had a UTI. New orders were as follows, Basic Metabolic Panel (BMP), and Urine Analysis (UA)/Urine Culture (UC) with susceptibility and sensitivity.<br><br>R1's Active Order from Aeris Medical Group dated 6/3/24, revealed R1's physician ordered a BMP, UA)/UC with susceptibility and sensitivity. The order was signed by the physician on 6/7/24.<br><br>R1's After Visit Summary dated 6/8/24, revealed R1 was evaluated due to altered mental status and was diagnosed with acute cystitis (infection in | F 684 | Immediate Corrective Action:<br><br>R1 discharged from facility 6/27/24.<br><br>Corrective Action as it applies to others:<br><br>All residents will have lab orders reviewed for the last 2 weeks to identify orders were completed.<br><br>Nurses will be educated on facility policy “Medication and Treatment Orders”, and completing ordered labs in a timely manner.<br><br>Recurrence will be prevented by:<br><br>Audits will be conducted weekly x3 weeks on physician lab orders, and order completion/ follow-up. Audits and findings will be reported to QAPI committee for further recommendations.¿<br><br>Corrections will be monitored by: Director of Nursing or Designee | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 2<br>the bladder) with hematuria.<br><br>On 6/18/24 at 12:51 p.m., family member (FM)-B stated R1 had a history of UTIs and would often show signs of confusion, hallucinations, unsteady on feet, and strong-smelling odor. Further, FM-B stated R1 was sent to the emergency room and diagnosed with a UTI recently.<br><br>On 6/20/24 at 11:35 a.m., registered nurse (RN)-C stated R1's nurse practitioner (NP) spoke to RN-C regarding ordering a UA/UC and BMP labs following the NP's evaluation on 6/3/24. RN-C stated NP communicated the orders verbally, and RN-C confirmed she did not follow-up on them and no evidence of the order in R1's record. Further, RN-C stated NP wrote another order on 6/11/24, wanting the results of the UA/UC and the BMP. RN-C stated staff were expected to contact the NP if the staff do not receive the order. Further, RN-C stated R1 was diagnosed and treated for a UTI following her emergency room visit on 6/8/24, she was noted to have had increased behaviors and the UTI could have contributed to R1's incident of leaving the facility without staff's knowledge as well as the falls R1 was having.<br><br>On 6/20/24 at 2:00 p.m., director of nursing stated R1 was "very incontinent" and would often urinate on the floor in her room. DON stated she spoke with R1's NP regarding the need to rule out a UTI due to behaviors and I know NP was going to order a UA/UC. Further, DON confirmed she was not aware the UA/UC was not obtained, and a BMP lab was not completed either. DON stated the NP ordered the UA/UC and BMP on 6/3/24, however the facility did not receive the written order until 6/8/24 and R1 had already been to the | F 684 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 3<br>emergency room and was diagnosed with a UTI there after completing a UA/UC. In addition, DON stated if staff were aware the NP ordered a UA/UA, they would be expected to follow up on getting the order timelier.<br><br>Review of facility policy titled Medication and Treatment Orders dated 2/24, indicated verbal orders must be recorded in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order. | F 684 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide adequate supervision for 1 of 3 residents (R1) reviewed, who was cognitively impaired and able to leave the building without staff's knowledge into the courtyard which resulted in a fall and being able to exit the secured area. In addition, the facility failed to implement fall interventions for 1 of 3 residents (R1), who was at high risk for falls.<br><br>Findings include:<br><br>R1's significant change Minimal Data Set (MDS) | F 689 | Immediate Corrective Action:<br><br>R1 discharged from facility 6/27/24.<br><br>Corrective Action as it applies to others:<br><br>Wanderguard door alarm was replaced on dining room courtyard door on 6/26/24.<br><br>Fall interventions for falls occurring in the last 2 weeks will be audited for fall intervention completion. | 7/12/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 4<br>dated 6/17/24, indicated R1 had diagnoses which included vascular dementia, anxiety and R1 had severely impaired cognition. Further, MDS indicated R1 had two or more falls with no injury and one fall with injury.<br><br>R1's care plan as of 6/18/24, indicated R1 had an alteration in cognition related to dementia and R1's daughter assists with decision making. R1 had a history of consistent wandering, pacing, agitation, restlessness/anxiousness, hallucinations, and history of eloping the facility. Due to these behaviors, R1 was at high risk for falls. Further, R1's care plan identified R1 was at risk for elopement and directed staff to offer resident chocolate and diet coke when agitated or anxious, monitor and document exit seeking behaviors, WanderGuard was in place and would be monitored for proper functioning, door alarms answered promptly, and R1 would be invited to activities of their choosing.<br><br>Review of R1's Incident Review and Analysis dated 6/1/24 at 10:44 a.m., indicated R1 was found on the ground next to the gazebo in the locked and gates courtyard. R1 was noted to be confuses and unable to tell staff what she was doing. After review of the fall, the interdisciplinary team implemented staff were to offer and assist resident with walks in the courtyard.<br><br>Review of R1's Incident Review and Analysis dated 6/8/24 at 4:30 p.m., revealed R1 was observed by nursing assistant (NA) walking outside wing 3 windows. Staff members responded immediately to direct resident back inside. Upon investigation, R1 went into the secured courtyard, and pushed on the gate to the fence and was able to exit through the fence. | F 689 | Elopement Policy reviewed, and remains current. Maintenance Department will be educated on accurately completing wanderguard door audits, and elopement policy.<br><br>Fall Prevention and Management policy reviewed and remains current. IDT team responsible for completing fall incident review and analysis will be educated on fall prevention and management policy.<br><br>Recurrence will be prevented by:<br><br>Maintenance will monitor wanderguard door functionality weekly x 3 weeks. Fall intervention implementation will be audited weekly x 3 weeks, and then monthly x2 months. Audits and findings will be reported to QAPI committee for further recommendations.¿<br><br>Corrections will be monitored by:<br>Administrator or Designee | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 5<br>Following the incident, the following interventions were implemented by the IDT: R1 was sent to the emergency department for clinical evaluation, psychiatric provider to evaluate R1 on 6/12/24, remain on 15- minute checks, new elopement assessment completed, and skin check was completed with no injuries noted.<br><br>Review of facility's Logbook Documentation, which was to check operation of door monitors and patient wandering system, indicated on 5/14/24 door E9 (the door in the dining room to exit into the courtyard) passed the inspection, on 5/21/24 E9 door failed the inspection, on 5/30/24 and 6/3/24 E9 door was marked as NA (not applicable), on 6/11/24 the inspection was not completed, and on 6/17/24 E9 door was marked as passed the inspection.<br><br>On 6/18/24 at 12:15 p.m., R1 was observed laying in her bed accompanied by family member (FM)-A. R1 was noted to have one gripper sock on and the other bare foot. Further, there was a WanderGuard observed on her right ankle.<br><br>On 6/18/24 at 12:15 p.m., FM-A stated R1 had left the facility without staff's knowledge "a couple times", but did not get far. FM-A was unsure about the details of the incidents. Further, FM-A stated R1 has had a few falls with no major injuries however, FM-A felt R1 had improved within the last two weeks due to new medication changes.<br><br>On 6/18/24 at 12:51 p.m., FM-B stated R1's cognitive impairment and behaviors were new as of most recent surgery when she had anesthesia. FM-B stated since admission to the facility R1 had required a WanderGuard due to wandering | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 6<br>and exiting the facility.<br><br>On 6/20/24 at 8:42 a.m., R1 was observed in the commons area by the nursing station, sitting in a stationary chair and appeared to be sleeping. R1 had a 4-wheeled walker next to her.<br><br>On 6/20/24 at 8:44 a.m., NA-A stated R1 was confused and would often exhibit wandering behaviors and staff were to visually check on R1 every 15 minutes to ensure safety. NA-A stated she was aware R1 exited the facility without staff knowledge but was unsure of details of the incident.<br><br>On 6/20/24 at 8:58 a.m., NA-B stated R1 required a lot of staff prompting to completed activities of daily living (ADLs) and exhibited wandering behaviors. NA-B stated staff were expected to visually check on R1 every 15 minutes to ensure safety. NA-B stated when R1 exhibits wandering behaviors staff were directed to walk with her and attempt to redirect, offer to call her family, and offer different activities. NA-B stated R1 had "wandered outside without staff" and had a fall in the courtyard where another resident's family found her. Further, NA-B stated R1 did not obtain any injuries from the fall and had a WanderGuard on at the time of the incident, but NA-B stated she did not recall hearing the WanderGuard system alarming and alerting staff of R1's exit of the building. In addition, NA-B stated she was aware of the incident that occurred on 6/8/24, when R1 was able to exit the building without staff's knowledge and was able to get through the fence in the courtyard.<br><br>On 6/20/24 at 9:14 a.m., NA-C stated R1 had impaired cognition and would exhibit wandering | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 7<br>behaviors. NA-C stated most often when R1 was wandering she was looking for her family, and her family would often come to the facility which was beneficial. Further, NA-C stated R1 required a 1-1 staff often due to wandering behaviors to ensure R1 was safe and "not getting out" of the facility. NA-C stated she was working on 6/8/24, the day of R1's incident where she exited the building, and NA-C stated at approximately 3:30 p.m., she observed R1 through the window walking outside of another wing on the unit, without her walker. NA-C stated she notified registered nurse (RN)-A, who ran down the hallway to get R1 back into the facility. Further, NA-C stated once R1 was back inside the building, NA-C checked the doors on R1's unit and noted one of the two courtyard doors was alarming and NA-C shut it off. NA-C stated she exited through that door and into the secured courtyard and walked to the fence and shook the fence when NA-C noted the fence was loose and R1 could have got through a gap in the fence. NA-C stated R1 was assessed, and no injuries were noted, and R1 was sent to the emergency room for further evaluation where she was diagnosed with a urinary tract infection. In addition, NA-C stated there were two doors that lead to the secured courtyard, one of the doors WanderGuard system does not work at this time and had recently been blocked off following R1's incident.<br><br>On 6/20/24 at 9:38 p.m., RN-A stated R1 was confused and would often exit seek and wander the facility asking to leave. RN-A stated R1 had a WanderGuard on due to elopement risk and staff were directed to visually check on R1 every 15 minutes, offer snacks and beverages, listen to music, or have R1 sit close to the nursing medication cart if R1 was exhibiting any | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 8<br>wandering or exit seeking behaviors. RN-A stated she was R1's floor nurse on 6/8/24, and R1 was sitting by RN-A medication cart when RN-A went to administer medications to another resident and was then notified by NA-C that R1 was outside of the facility. RN-A ran outside of the facility to retrieve R1 and bring her back inside, R1 was observed wearing socks on her feet and no walker. RN-A assessed R1 for injury and none were noted at that time, and R1 kept stating she wanted to go home. Further, RN-A stated there were two doors that leads to the secured courtyard, the door located in the dining room was known to have a broken or malfunctioning WanderGuard system on it, and RN-A stated that was the door R1 would always use to go out into the courtyard with family and was also the closed door to RN-A's medication cart and the last known location of R1 on the day of the incident. RN-A stated there was no WanderGuard alarm sounding at the time of the event that would have alerted staff of R1's exit of the facility, so RN-A determined R1 had exited through the door in the dining room and out into the courtyard where R1 must have climbed through a gap in the metal fence. RN-A stated since this incident, management had since blocked the exit from the dining room into the courtyard and residents can now only exit through the other door.<br><br>On 6/20/24 at 10:30 a.m., maintenance director (MD)-A stated the WanderGuard system on the doors were monitored by maintenance and checked for functioning weekly. MD-A stated the door to exit into the courtyard in the dining room had been broken for approximately a month and a half. Further, MD-A stated the front door's WanderGuard alarm had failed, so MD-A swapped the front door with the door in the dining | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 9<br>room because the courtyard was secured, and residents were unable to leave. MD-A reviewed WanderGuard functioning logs and confirmed the courtyard door in the dining room was identified as E9 on the logs and stated between 5/14/24 and 5/21/24 the WanderGuard alarm was switched with the front door, 6/3/24 the E9 door had failed functioning and no alternative alarm was placed, on 6/11/24 the log and function check were not completed, and on 6/17/24 the E9 door was marked as pass which would be inaccurate as the alarm system had not been fixed at the time of the survey. MD-A stated he was aware of R1's exit from the building without staff's knowledge and assumed R1 had exited through the E9 door due to the alarm not functioning, and she got through the metal fence which had been addressed and fixed.<br><br>On 6/20/24 at 10:53 a.m., RN-B stated if a resident was identified as an elopement risk a WanderGuard would be placed on the resident and if the resident were to attempt to leave or exit the facility the WanderGuard system would alert staff by an alarm. RN-B stated the door to the courtyard through the dining room had a WanderGuard system, however the alarm system had not been working for a couple weeks now and that exit was now blocked as of last week. Further, RN-B stated R1 was at risk for eloping and falls due to cognition. RN-B stated she was R1's nurse the day R1 had fallen outside by the Gazebo on 6/1/24, and RN-B stated she was alerted of R1's fall by another family member. RN-B stated she went out into the courtyard and observed R1 on the ground, she had on gripper socks and R1 did not have her walker with her. RN-B stated R1 had not obtained any injuries and R1 must have exited through the courtyard door | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 10<br>in the dining room because there was not a WanderGuard alarm going off at the time of the fall.<br><br>On 6/20/24 at 11:23 a.m., RN-C stated maintenance staff were expected to monitor the exit doors for WanderGuard functioning and confirmed the door to the courtyard from the dining room was not functioning for a couple weeks now and the door was now blocked and not in use. RN-C stated R1 was confused and impulsive and exhibited behaviors of wandering and combativeness. RN-C stated R1 had a fall on 6/1/24, out in the courtyard and RN-C was unsure how R1 got out into the courtyard but believed R1 had exited through the dining room door into the courtyard without staff's knowledge and stated the IDT had not investigated the fall.<br><br>On 6/20/24 at 1:21 p.m., administrator stated the WanderGuard system on the courtyard door in the dining room was switched with the front door alarm that was broken and the IDT determined the front door was priority because the courtyard was secured by the fence. Administrator stated the facility was working on the repair of the door alarm but did not have any alternative alarm on the door until the alarm was able to get fixed. Administrator confirmed staff did not assess the fence to ensure the fence was secure prior to making the decision to leave the door without a functioning WanderGuard system. Further, administrator stated she completed the investigation for R1's incident that occurred on 6/8/24. Administrator stated there were no witnesses to R1 exiting the facility, so it was inconclusive to which door she exited from but did confirm there were no reports from staff of the WanderGuard system alarming at the time of the | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 11<br>event. In addition, administrator stated all falls were reviewed in the IDT meeting but there was not an investigation completed as to how R1 was able to exit the facility on 6/1/24, without staff's knowledge, and resulted in a fall.<br><br>On 6/20/24 at 2:00 p.m., director of nursing (DON) stated any resident was able to go out into the courtyard since the courtyard was secured. DON stated R1 had severe dementia and would not be appropriate to be out in the courtyard without staff's knowledge as R1 was at risk for falls and elopement. DON confirmed R1's fall on 6/1/24, was not investigated and DON was unsure how R1 was able to get out into the courtyard without staff's knowledge. Further, DON stated the courtyard door through the dining room was not working and maintenance was in the process of fixing and the door was now blocked and residents were unable to use at the time.<br><br>Review of facility policy titled Elopement Policy dated 6/23, revealed a specific system had been developed to notify staff that an external door had been opened in an area accessible to residents. The facility would identify such environmental hazards such as entrances, stairwells, or exits that pose a foreseeable danger to residents who wander or have an exit seeking behavior. The facility would implement interventions to minimize these risks and hazards as appropriate.<br><br>AND<br><br>R1's significant change Minimal Data Set (MDS) dated 6/17/24, indicated R1 had diagnoses which included vascular dementia, anxiety and R1 had | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 12<br>severely impaired cognition. Further, MDS indicated R1 had two or more falls with no injury and one fall with injury.<br><br>R1's care plan as of 6/18/24, indicated R1 was at risk for falls related to diagnosis of vascular dementia with other behavioral disturbance and heart failure. R1's care plan directed staff to encourage resident to wear skid free footwear, utilize a 2-wheeled walker for ambulation, and non-skid strips to floor in bathroom.<br><br>On 6/18/24 at 11:45 a.m., R1 was observed sitting at a table in the dining room in a standard chair accompanied by FM-A, who was seated on R1's 4-wheeled walker. R1 was observed to independently stand up from the chair and was wearing one gripper sock and the other was barefoot. Social Services (SS)-A assisted R1 to ensure she was able to ambulate away from the table and chair without losing balance, and R1 walked out of the dining room with FM-A utilizing the 4-wheeled walker and only one gripper sock on.<br><br>On 6/18/24 at 8:44 a.m., NA-A stated R1 was at risk for falls and had fallen many times since admitting to the facility, and staff were direct to ensure R1 had gripper socks or shoes on since she was unsteady while ambulating, remind R1 to use one of her walkers, either the 2-wheeled or 4-wheeled walker, with assistance while ambulating.<br><br>On 6/20/24 at 8:58 a.m., NA-B stated R1 required a lot of staff prompting to completed activities of daily living (ADLs) and required a 4-wheeled walker for ambulation. Further, NA-B stated R1 was at risk for falls and staff were directed to | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 13 | F 689 | | |

ensure R1 always had gripper socks on, which R1 was compliant with and would not remove them, and visually check on R1 every 15 minutes to ensure safety.

On 6/20/24 at 9:38 a.m., RN-A stated R1 required the use of a 4-wheeled walker to ambulate and would often forget to grab her walker and forgets to apply the brakes on the walker prior to sitting on the seat. RN-A stated she was a high fall risk and staff were directed to visually check on R1 every 15 minutes, ensure she had on non-slip footwear, cues to utilize her walker, low bed and reminders to use call light for assistance.

On 6/20/24 at 11:04 a.m., R1 was observed at the nursing station sitting on the seat of her 4-wheeled walker, brakes locked, and wearing gray slipper socks. Further, there was not non-skid strips on R1's bathroom floor.

On 6/20/24 at 11:23 a.m., RN-C stated R1 was at risk for falls and staff were expected to utilize the 2-wheeled walker or the 4-wheeled walker, had a psychiatric referral with some medication changes, ensure the proper footwear, offer walks in the courtyard, and assisting R1 was tasks. RN-C stated following a fall in R1's bathroom, non-skin strips was the intervention determined by the interdisciplinary team (IDT) but did not get implemented.

On 6/20/24 at 2:00 p.m., DON stated following a fall, the IDT would meet to discuss the root cause of the fall and determine an appropriate intervention to prevent future falls. Further, the DON stated the intervention would be implemented following the IDT meeting and the managers on the unit would be expected to follow

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245495 | A. BUILDING _____ B. WING _____ | C 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 14<br>up the next day to determine if the intervention was effective.<br><br>Review of facility policy titled Fall Prevention and Management dated 2/24, indicated staff would monitor and document the resident's response to and the effectiveness of interventions put in place to prevent further falls for 72 hours post fall. Further, if the resident continued to fall, staff would re-evaluate the situation and whether it was appropriate to continue or change the current interventions. | F 689 | | |

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
July 1, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: YQHS11

Dear Administrator:

The above facility was surveyed on June 18, 2024 through June 20, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00299 | A. BUILDING: _____ B. WING _____ | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 6/18/24 and 6/20/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed | 2 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00299 | A. BUILDING: _____ B. WING _____ | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 000 | Continued From page 1<br>these orders and identify the date when they will be completed.<br><br>The following complaint was reviewed. H54954412C (MN00103977) with a licensing order issued at 0830.<br><br>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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.<br><br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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 | 2 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00299 | A. BUILDING: _____ B. WING _____ | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 000 | Continued From page 2<br>the Minnesota<br><br>Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.<br><br>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. | 2 000 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure physician orders to obtain a Basic Metabolic Panel (BMP), and Urine Analysis (UA)/Urine Culture (UC) with susceptibility and sensitivity, timely (R1), who was diagnosed with a urinary tract infection (UTI) | 2 830 | Corrected. | 7/12/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00299 | A. BUILDING: _____ B. WING _____ | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 3<br>Findings include:<br><br>R1's significant change Minimal Data Set (MDS) dated 6/17/24, indicated R1 had diagnoses which included vascular dementia, anxiety and R1 had severely impaired cognition.<br><br>R1's progress note dated 6/3/24, revealed R1 was evaluated by the physician related to nursing requested resident to be seen regarding her agitation, behaviors, and multiple falls. Resident had fallen 7 times since her admission. Resident is disoriented to place and time. Physician discussed with family who stated resident smelt like urine and her room smelled of strong urine. Further, family reported resident frequently would get a urinary tract infection (UTI) and exhibited behaviors and more confusion when she had a UTI. New orders were as follows, Basic Metabolic Panel (BMP), and Urine Analysis (UA)/Urine Culture (UC) with susceptibility and sensitivity.<br><br>R1's Active Order from Aeris Medical Group dated 6/3/24, revealed R1's physician ordered a BMP, UA)/UC with susceptibility and sensitivity. The order was signed by the physician on 6/7/24.<br><br>R1's After Visit Summary dated 6/8/24, revealed R1 was evaluated due to altered mental status and was diagnosed with acute cystitis (infection in the bladder) with hematuria.<br><br>On 6/18/24 at 12:51 p.m., family member (FM)-B stated R1 had a history of UTIs and would often show signs of confusion, hallucinations, unsteady on feet, and strong-smelling odor. Further, FM-B stated R1 was sent to the emergency room and diagnosed with a UTI recently.<br><br>On 6/20/24 at 11:35 a.m., registered nurse | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00299 | A. BUILDING: _____ B. WING _____ | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 4<br><br>(RN)-C stated R1's nurse practitioner (NP) spoke to RN-C regarding ordering a UA/UC and BMP labs following the NP's evaluation on 6/3/24. RN-C stated NP communicated the orders verbally, and RN-C confirmed she did not follow-up on them and no evidence of the order in R1's record. Further, RN-C stated NP wrote another order on 6/11/24, wanting the results of the UA/UC and the BMP. RN-C stated staff were expected to contact the NP if the staff do not receive the order. Further, RN-C stated R1 was diagnosed and treated for a UTI following her emergency room visit on 6/8/24, she was noted to have had increased behaviors and the UTI could have contributed to R1's incident of leaving the facility without staff's knowledge as well as the falls R1 was having.<br><br>On 6/20/24 at 2:00 p.m., director of nursing stated R1 was "very incontinent" and would often urinate on the floor in her room. DON stated she spoke with R1's NP regarding the need to rule out a UTI due to behaviors and I know NP was going to order a UA/UC. Further, DON confirmed she was not aware the UA/UC was not obtained, and a BMP lab was not completed either. DON stated the NP ordered the UA/UC and BMP on 6/3/24, however the facility did not receive the written order until 6/8/24 and R1 had already been to the emergency room and was diagnosed with a UTI there after completing a UA/UC. In addition, DON stated if staff were aware the NP ordered a UA/UA, they would be expected to follow up on getting the order timelier.<br><br>Review of facility policy titled Medication and Treatment Orders dated 2/24, indicated verbal orders must be recorded in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00299 | A. BUILDING: _____ B. WING _____ | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE EMERALDS AT GRAND RAPIDS LLC | 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 5<br>the time of the order.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |