DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 30, 2022

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

RE: CCN: 245495
Cycle Start Date: October 11, 2022

Dear Administrator:

On November 8, 2022, 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, 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

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Electronically delivered

November 30, 2022

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

Re: Reinspection Results
Event ID: I5T512

Dear Administrator:

On November 8, 2022 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 October 11, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any 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

Electronically delivered
October 20, 2022

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

RE: CCN: 245495
Cycle Start Date: October 11, 2022

Dear Administrator:

On October 11, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, 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 January 11, 2023 (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 April 11, 2023 (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,

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

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 10/11/2022

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 On 10/6/22, through 10/11/22, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be NOT in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be UNSUBSTANTIATED: H54955017C (MN87384). The following complaint was found to be SUBSTANTIATED: H54955028C (MN86434), however, NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be SUBSTANTIATED: H54954951 (MN87472) with deficiencies cited at F609. 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. 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		11/1/22

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

Electronically Signed | 10/28/2022

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.

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F 609	Continued From page 1 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure incidents of potential neglect were reported immediately, within two hours, to the State Agency (SA) for 1 of 3 residents (R1) reviewed for allegations of neglect of care. R1's Diagnosis Report dated 10/12/22, indicated R1's diagnoses included paraplegia (paralysis of the legs and lower body) and cerebral infarction (stroke).	F 609	1.Facility will review current reported and unreported incidents since last survey to identify any incidents that needed a vulnerable adult report filed. 2.Facility will review current reported and unreported incidents since last survey to identify any incidents that needed a vulnerable adult report filed. 3.All staff members will be educated on reporting incidents of potential neglect	

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

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F 609	Continued From page 2 R1's admission Minimum Data Set (MDS) assessment dated 7/7/22, indicated R1 was cognitively intact, did not have behaviors and did not reject cares. R1 was totally dependent on staff with bed mobility, transfers, dressing, toilet use and personal hygiene. R1 was independent with locomotion and required a wheelchair for mobility. R1's care plan dated 7/18/22, indicated R1 would tend to stay in bed per his choice. R1 enjoyed working on his computer and iPad. A Physician's Order progress note dated 9/26/22, indicated R1 was seen by the nurse practitioner (NP)-A for a burn to the right thigh. NP-A discussed with R1 the hazard of having an electrical box (power strip) in the bed with him. R1 would not allow this to be removed during the visit with NP-A. NP-A documented this needed to be addressed immediately by the facility administrative staff and maintenance as having the electrical box (power strip) in bed with him could cause direct harm and injury to R1 and others. Discussed with R1 that this could cause a fire and electrocution. The facility's Incident Review and Analysis dated 10/11/22, indicated on 9/25/22, at 5:30 p.m. R1 received a burn. Causal factors indicated R1 had a power strip in his bed with the covers over the top of it. R1 had four things plugged into the power strip. Staff members think one of the charging blocks had gotten too hot and caused a blister on R1's right thigh. There were no sparks or burned blankets noted at the time of the incident. The potentially malfunctioning power strip was removed. Interventions included R1 was referred to NP-A to be seen on 9/26/22. R1's	F 609	immediately to the administrator or designee. 4.Facility will audit all reported and unreported incidents to identify any incidents that needed a vulnerable adult report filed. Audits will be conducted weekly x4 weeks, and monthly x2 weeks. Audit reports will be reported to QAPI for further recommendations.	

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F 609	Continued From page 3 room was audited and R1 agreed to have the power strip secured to the bedside table and understood it could not be placed in bed with him. A vulnerable adult report was not filed. The incident was reviewed by the interdisciplinary team (IDT). On 10/10/22, at 2:56 p.m. an interview was conducted with NP-A. NP -A stated she received a visit request form from the facility to evaluate R1 for a burn on the upper right thigh. NP-A stated she was told the burn was from a power strip R1 kept in his bed. The request form indicated R1 was incontinent of urine and when R1's incontinent brief became saturated, urine spilled over onto the power box with power cords plugged in. The power cords were from R1's cell phone and laptop computer. NP-A stated she included in her visit notes that this needed to be addressed immediately by the facility administrative staff and maintenance, as this could cause direct harm and injury to the resident and others. NP-A stated when she returned to the facility on 10/6/22, while walking by R1's room, she observed the power strip with three devices plugged into the USB ports, in R1's bed along the right side where R1 had received the burn. NP-A stated her concern was for R1, R1's roommate who was also wheelchair bound and the other 60 residents in the facility due to the power strip starting a fire in R1's bed. NP-A further stated R1 received a second degree burn from the power strip. On 10/10/22, at 12:37 p.m. an interview was conducted with the director of nursing (DON) and the administrator. The administrator stated she was notified of the incident via text message on 9/26/22, at approximately 5:30 a.m. by a night	F 609		

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F 609	Continued From page 4 shift nurse. The incident was discussed with the corporate consultant and it was decided to not report the incident to the state agency because R1's care plan was being followed and the power strip was R1's own personal equipment. The facility's Abuse Prohibition/Vulnerable Adult Plan policy dated 4/11/22, indicated incidents to be reported to the state agency included avoidable accidents. The policy indicated avoidable accidents were when an accident occurred because the facility failed to identify environmental hazards. Evaluate or analyze the hazards and risks to eliminate them if possible. If not possible, identify and implement measures to reduce the hazard or risk as much as possible. This included all serious injuries of which were determined to be avoidable based on the criteria. Examples of serious injury included burns. The policy further indicated suspected neglect, exploitation or misappropriation of a resident's property must be reported to the state agency no later than two hours if the incident resulted in serious bodily injury.	F 609		

Electronically delivered
October 20, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: I5T511

Dear Administrator:

The above facility was surveyed on October 6, 2022 through October 11, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

Please feel free to call me with any 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 10/11/2022

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/6/22, through 10/11/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following complaint was found to be	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 UNSUBSTANTIATED: H54955017C (MN87384). The following complaint was found to be SUBSTANTIATED: H54955028C (MN86434), however, NO licensing orders were issued. The following complaints were found to be SUBSTANTIATED: H54954951 (MN87472) with licensing orders issued at 626.557 Subp 3. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or	21980		11/1/22

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

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21980	Continued From page 2 (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure incidents of potential neglect were reported immediately, within two hours, to the State Agency (SA) for 1 of 3 residents (R1) reviewed for allegations of neglect of care.	21980	1. Facility will review current reported and unreported incidents since last survey to identify any incidents that needed a vulnerable adult report filed. 2. Facility will review current reported and	

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	00299	A. BUILDING: _____ B. WING _____	C 10/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21980	Continued From page 3 R1's Diagnosis Report dated 10/12/22, indicated R1's diagnoses included paraplegia (paralysis of the legs and lower body) and cerebral infarction (stroke). R1's admission Minimum Data Set (MDS) assessment dated 7/7/22, indicated R1 was cognitively intact, did not have behaviors and did not reject cares. R1 was totally dependent on staff with bed mobility, transfers, dressing, toilet use and personal hygiene. R1 was independent with locomotion and required a wheelchair for mobility. R1's care plan dated 7/18/22, indicated R1 would tend to stay in bed per his choice. R1 enjoyed working on his computer and iPad. A Physician's Order progress note dated 9/26/22, indicated R1 was seen by the nurse practitioner (NP)-A for a burn to the right thigh. NP-A discussed with R1 the hazard of having an electrical box (power strip) in the bed with him. R1 would not allow this to be removed during the visit with NP-A. NP-A documented this needed to be addressed immediately by the facility administrative staff and maintenance as having the electrical box (power strip) in bed with him could cause direct harm and injury to R1 and others. Discussed with R1 that this could cause a fire and electrocution. The facility's Incident Review and Analysis dated 10/11/22, indicated on 9/25/22, at 5:30 p.m. R1 received a burn. Causal factors indicated R1 had a power strip in his bed with the covers over the top of it. R1 had four things plugged into the power strip. Staff members think one of the charging blocks had gotten too hot and caused a	21980	unreported incidents since last survey to identify any incidents that needed a vulnerable adult report filed. 3. All staff members will be educated on reporting incidents of potential neglect immediately to the administrator or designee. 4. Facility will audit all reported and unreported incidents to identify any incidents that needed a vulnerable adult report filed. Audits will be conducted weekly x4 weeks, and monthly x2 weeks. Audit reports will be reported to QAPI for further recommendations.	

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21980	Continued From page 4 blister on R1's right thigh. There were no sparks or burned blankets noted at the time of the incident. The potentially malfunctioning power strip was removed. Interventions included R1 was referred to NP-A to be seen on 9/26/22. R1's room was audited and R1 agreed to have the power strip secured to the bedside table and understood it could not be placed in bed with him. A vulnerable adult report was not filed. The incident was reviewed by the interdisciplinary team (IDT). On 10/10/22, at 2:56 p.m. an interview was conducted with NP-A. NP -A stated she received a visit request form from the facility to evaluate R1 for a burn on the upper right thigh. NP-A stated she was told the burn was from a power strip R1 kept in his bed. The request form indicated R1 was incontinent of urine and when R1's incontinent brief became saturated, urine spilled over onto the power box with power cords plugged in. The power cords were from R1's cell phone and laptop computer. NP-A stated she included in her visit notes that this needed to be addressed immediately by the facility administrative staff and maintenance, as this could cause direct harm and injury to the resident and others. NP-A stated when she returned to the facility on 10/6/22, while walking by R1's room, she observed the power strip with three devices plugged into the USB ports, in R1's bed along the right side where R1 had received the burn. NP-A stated her concern was for R1, R1's roommate who was also wheelchair bound and the other 60 residents in the facility due to the power strip starting a fire in R1's bed. NP-A further stated R1 received a second degree burn from the power strip. On 10/10/22, at 12:37 p.m. an interview was	21980		

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21980	Continued From page 5 conducted with the director of nursing (DON) and the administrator. The administrator stated she was notified of the incident via text message on 9/26/22, at approximately 5:30 a.m. by a night shift nurse. The incident was discussed with the corporate consultant and it was decided to not report the incident to the state agency because R1's care plan was being followed and the power strip was R1's own personal equipment. The facility's Abuse Prohibition/Vulnerable Adult Plan policy dated 4/11/22, indicated incidents to be reported to the state agency included avoidable accidents. The policy indicated avoidable accidents were when an accident occurred because the facility failed to identify environmental hazards. Evaluate or analyze the hazards and risks to eliminate them if possible. If not possible, identify and implement measures to reduce the hazard or risk as much as possible. This included all serious injuries of which were determined to be avoidable based on the criteria. Examples of serious injury included burns. The policy further indicated suspected neglect, exploitation or misappropriation of a resident's property must be reported to the state agency no later than two hours if the incident resulted in serious bodily injury. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and implement policies and procedures regarding reporting allegations of neglect. The administrator or designee could educate staff. The administrator or designee could complete routine audits and report to the Quality Assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		

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