DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
October 25, 2023

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

RE: CCN: 245495
Cycle Start Date: October 13, 2023

Dear Administrator:

On October 13, 2023, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On October 13, 2023, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 9, 2023.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 9, 2023, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 9, 2023, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 13, 2023. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information,

you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Emeralds At Grand Rapids LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 13, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/ or "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
Midtown Square
3333 Division Street, Suite 212
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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 13, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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,

Kamala Fike-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@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 10/13/2023

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 10/11/23 through 10/13/23, 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. The following complaints were reviewed with NO deficiencies cited: H54956223C (MN97374) Deficient practice was identified related to incidental finding with deficiencies cited at F609, F610 and F689 cited at immediate jeopardy (IJ). The IJ began on 9/30/23, when R1 verbalized his intent to leave the facility, left on 9/30/23, without staff knowledge and was returned to the facility by two strangers. He was found on a busy four lane highway with a small cut on his nose. Additionally, within two hours of R1's return to the facility, R1 wanted to return home. The facility did not implement interventions to keep him safe but let R1 leave on his own even though the facility assessed him unsafe in the community alone. The administrator and senior nurse consultant were notified of the IJ on 10/12/23, at 3:33 p.m.. The IJ was removed on 10/13/23 2:35 p.m., but noncompliance remained at the lower scope and severity level D, with no actual harm with potential for more than minimal harm that was not immediate jeopardy. 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/26/2023

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 000	Continued From page 1 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(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §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	F 609		10/27/23

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F 609	Continued From page 2 by: Based on interview and document review the facility failed to report an elopement to state agency (SA) for 1 of 1 residents (R1) who eloped from the facility without staff knowledge. Findings include: R1's Admission Record indicated he admitted to the facility on 9/28/23 with a diagnosis that included: Syncope, epilepsy, history of traumatic brain injury (TBI) and repeated falls. R1's Elopement Risk Evaluation dated 9/28/23, identified a habit/history of wandering or attempts to leave the unit or building, pacing or agitated behavior and indicated he was ambulatory. The evaluation indicated R1 was at risk for elopement and identified the use of a WanderGuard. R1's Brief Interview for Mental Status dated 9/30/23, identified a score of six which indicated severe cognitive impairment. R1's facility Progress Note dated 9/30/23, 2:33 p.m. indicated R1 was found on the side of the highway headed south. A younger guy and his female friend brought resident back to the facility. R1 did not have a WanderGuard due to not being able to get an order for one. During interview on 10/11/23, at approximately 3:00 p.m. the administrator stated R1 had been sent to the emergency department during his stay. The administrator said the hospital told the facility R1 was his own decision maker and could decide if he wanted to leave. On 10/13/23, at 2:38 p.m. the administrator said the elopement was not reported to the SA because the hospital staff said he was his own decision maker even though the facility had assessed R1 as an elopement risk	F 609	Immediate Corrective Action: Resident #1 has discharged from facility. Corrective Action as it applies to others: The Abuse Prohibition/Vulnerable Adult Policy was reviewed and remains current. All resident incidents and grievances from the last 30 days will be audited to determine if they need to be reported per policy. Administrator will be educated on Abuse Prohibition/Vulnerable Adult Policy in regard to incidents that need to be reported, and elopement policy. Date of Compliance: 10/27/23 Recurrence will be prevented by: All resident instances and grievances will be audited weekly x3 weeks, and monthly x2 months to identify if allegations involving abuse, neglect, exploitation, or mistreatment were reported per regulation. Audit results will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Administrator/Designee	

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F 609	Continued From page 3 with cognitive impairment.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 thoroughly investigate an elopement for 1 of 1 residents (R1) who left the facility without staff knowledge and was found by two strangers on the highway. Findings include: R1's Admission Record indicated he admitted to the facility on 9/28/23, with diagnosis that included: Syncope, epilepsy, history of traumatic brain injury (TBI) and repeated falls. R1's Elopement Risk Evaluation dated 9/28/23, identified a habit/history of wandering or attempts	F 610	Immediate Corrective Action: Resident #1 has discharged from facility. Corrective Action as it applies to others: The Abuse Prohibition/Vulnerable Adult Policy was reviewed and remains current. All resident incidents and grievances from the last 30 days will be audited to determine if they needed to be reported per policy, and if they were investigated thoroughly.	10/27/23

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F 610	Continued From page 4 to leave the unit or building, pacing or agitated behavior and indicated he was ambulatory. The evaluation indicated R1 was at risk for elopement and identified the use of a WanderGuard. R1's Brief Interview for Mental Status dated 9/30/23, identified a score of six which indicated severe cognitive impairment. R1's facility Progress Note dated 9/30/23, 2:33 p.m. indicated R1 was found on the side of the highway headed south. A younger guy and his female friend brought resident back to the facility. R1 did not have a WanderGuard due to not being able to get an order for one. Hospital stated that he does not pose a risk to self or others. R1 had small skin gash on the right side of his nose. R1's medical record lacked evidence staff or other residents interviews had been conducted to determine when R1 had last been seen in the facility. The record further lacked information related to how far away R1 was from the facility when he was found by the passers by or how the strangers identified R1 as a resident of a nursing facility. During interview on 10/11/23, at 2:22 p.m. RN-A stated she was on call when R1 eloped from the facility. RN-A said R1 got to the facility on 9/28/23, and said R1 wanted to leave so he was sent to the ED on Friday. RN-A stated an elopement assessment was done and because he wanted to leave a WanderGuard had been placed. RN-A stated the next day she spoke with the hospital nurse and learned R1 had some sundowning and he needed to be watched. RN-A said the WanderGuard had been removed when R1 went to the ED because he said he was not coming back. RN-A stated the ED sent R1 back	F 610	Administrator, Nurse Leadership, and Social Services will be educated on Abuse Prohibition/Vulnerable Adult Policy in regard to Investigation/Protection. Date of Compliance: 10/27/23 Recurrence will be prevented by: Resident incidents will be audited weekly x3 weeks, and monthly x2 months to identify if allegations involving abuse, neglect, exploitation, or mistreatment were investigated thoroughly. Audit results will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Administrator/Designee	

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F 610	Continued From page 5 to the facility and she had been told the hospital said R1 was "his own person" and was not an elopement risk. RN-A said after R1 eloped from the facility she had asked why the WanderGuard had not been on when R1 eloped. RN-A said staff told her the administrator and director of nursing (DON) said he was his own person and did not need one. RN-A further stated she had no idea how R1 ended up out on the highway and confirmed the WanderGuard was put back on after R1 had returned to the facility following the elopement. During interview on 10/11/23, at approximately 3:00 p.m. the administrator stated the day after R1 admitted to the facility he was sent to the ED due to behaviors. She said when he returned the hospital said he was his own decision maker and could decide if he wanted to leave. The administrator said on Saturday 10/30/23, R1 decided to leave and was found on the highway by two people and they brought him back to the facility. The administrator stated they did not know how long R1 had been gone and R1 was not really able to tell them. On 10/13/23, at 2:39 p.m. the administrator said the incident was not thoroughly investigated due to the information received from the hospital that R1 was his own person and could choose to leave even though the facility had assessed R1 to be at risk. Facility Abuse Prohibition/Vulnerable Adult Policy dated 8/2023, indicated The facility's investigation team will review all incident reports regarding residents including those that indicate an injury of unknown origin, abuse, neglect, misappropriation of resident property, or involuntary seclusion no later than the next working day following the incident. The investigation team will determine if	F 610		

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F 610	Continued From page 6 further investigation is needed. The investigation team will continue the investigation. Investigation may include interviewing staff, residents, or other witnesses to the incident. Corrective action based on the investigation will be completed (e.g., change of procedure, training, discipline or discharge of staff, etc.). Facility Abuse Prohibition/Vulnerable Adult Policy dated 8/2023, indicated incidents that must be reported to the SA included elopement. All staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin (including suspicious bruises, skin tears, or other injuries), misappropriation of resident property, or involuntary seclusion. A completed incident report will be routed per facility procedure. Suspicion of Neglect, Exploitation, or Misappropriation of resident property must be reported to OHFC online reporting process not later than 2 hours if the incident resulted in serious bodily injury. If the suspected Neglect, Exploitation, or Misappropriation of resident property did not result in serious bodily injury, the reports must be made within 24 hours.	F 610		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		10/13/23

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	245495	A. BUILDING _____ B. WING _____	C 10/13/2023

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F 689	Continued From page 7 by: Based on interview and document review the facility failed to maintain resident safety when a resident (R1) who was assessed to be at risk for elopement verbalized his intent to leave the facility, left without staff knowledge and was returned to the facility by two strangers. Further, R1 was allowed to discharge home against medical advice from the facility even though he had been assessed to have cognitive impairment and admitted due to recurrent falls. This resulted in an immediate Jeopardy (IJ) situation for R1. The IJ began on 9/30/23, when R1 left the facility without staff knowledge. R1 was found by two strangers on a highly-trafficked four lane highway with a cut on his nose. Additionally, within two hours of R1' s return to the facility, R1 wanted to return home. The facility did not implement interventions to keep him safe and assisted R1 leave on his own even though the facility assessed him unsafe in the community alone. The administrator and senior nurse consultant (SNC) were notified of the IJ on 10/12/23, at 3:33 p.m.. The IJ was removed on 10/13/23, at 2:35 p.m., but noncompliance remained at the lower scope and severity level D, with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: R1's Admission Record indicated he admitted to the facility on 9/28/23. R1's diagnosis included: Syncope, epilepsy, history of traumatic brain injury (TBI) and repeated falls. R1's hospital History and Physical dated 9/27/23, identified a past medical history of diabetes	F 689	Immediate Corrective Action: Resident #1 has discharged from facility. Corrective Action as it applies to others: The Elopement and Discharge Planning Policies were reviewed and remain current. All residents at risk for elopement were reviewed to ensure that they have an elopement risk assessment completed and that all appropriate interventions are in place. All nursing staff responsible for admissions/readmissions to facility are being educated on need to complete an elopement risk assessment on admit per facility nursing assessment grid and to immediately put appropriate interventions into place per Elopement Policy. If a resident is found to have wandering behaviors on return from the hospital, the resident will have a Wanderguard placed immediately on resident until IDT team can re-evaluate resident to determine if Wanderguard is appropriate or can be removed safely with other interventions. This education will be completed verbally before their next working shift. Education also included that risk will be assessed by facility nursing staff only and not outside staff who are not medical providers (only MD/CNP/PA.) All staff were educated on how to identify	

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F 689	Continued From page 8 mellitus type 2, hypertension, chronic kidney disease, memory deficit/dementia, seizure disorder and multiple other medical issues and was was brought to the emergency room after he went to get the mail and passed out. R1's Admission/ Initial Data Collection Form dated 9/28/23, indicated he admitted to the facility on 9/28/23, at 1:00 p.m. The form indicated R1 used a walker for ambulation and required supervision. R1's fall history, pain, skin and communication were not assessed. R1's Elopement Risk Evaluation dated 9/28/23, identified a habit/history of wandering or attempts to leave the unit or building, pacing or agitated behavior, and indicated he was ambulatory. The evaluation indicated R1 was at risk for elopement and identified the use of a Wanderguard. R1's Brief Interview for Mental Status dated 9/30/23, identified a score of six which indicated severe cognitive impairment. R1's facility Progress Notes identified the following: Note written 9/29/23, at 8:09 a.m. indicated R1 was unaware of his own name and asked writer "is that me?" Writer told resident "yes, that's your name." R1 had been busy in the morning and had been wandering around wing one, entering other resident rooms, trying to go out emergency exit and trying to go to the wing onse courtyard. Resident had required a 1:1 in the morning. Note written 9/29/23, at 8:33 a.m. indicated R1 had been exit seeking in the evening and wanting to walk home. R1 thought his his house is nearby.	F 689	residents at risk for elopement. The education includes checking the elopement binder located on wing 2 nurses station or care plan. All staff responsible for discharges (clinical leadership, administrator, social services) were educated on the need to assess the cognitive ability of the resident by use of the BIMS or other specialized cognitive testing and assessment of physical ability from nursing and therapy recommendations while discharge planning to ensure that a safe discharge plan is ensured for the resident before they leave the facility. If a resident has cognitive deficits and/or physical limitations, the facility will involve outside support systems (family, friends, volunteers, guardians, POA, etc) to assist the resident with decision making to ensure that resident will discharge safely. The Discharge Planning Policy will be reviewed. This education was completed verbally before the staff member s next working shift. If a resident wishes to leave AMA, the following will occur: Facility staff member will discuss with resident/caregiver/family the reasons they wish to leave facility. Facility staff will work to try to resolve the underlying reason why resident wishes to leave facility. Facility staff will attempt to get	

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F 689	Continued From page 9 R1 said he would just walk out the door and a Wanderguard was placed on his left ankle. R1 was restless during the night, going into other resident rooms, opening doors, looking to go home, looking for his boots, digging around in drawers in room and into his roommate's belongings. R1 had been exit seeking into the morning and came out of the of unit looking for a way to get out. When attempting to redirect, R1 began yelling at staff and appeared he was going to push right past staff. R1 started yelling for staff to call the police and let them take him out of here. R1 walked down the hallway toward the staff entrance and oncoming staff was able to redirect him back onto the unit. R1 had been a 1:1 with staff member since. Note written 9/29/23, at 8:55 a.m. indicated R1 was sent to the emergency department (ED) due to hypotension. R1 was offered bed hold and refused and stated he wanted to look elsewhere. A second note written at 9:15 a.m. indicated R1 discharged. At 7:40 p.m. Progress Note indicated R1 returned from the ED in a pleasant mood. 9/30/23, at 2:19 a.m. note indicated from 10:15 p.m. to 11:15 p.m. R1 was pleasant and calm, sitting in a chair and eating snacks in a common area. R1 then began wandering and exit seeking, requesting a bus to come pick him up. R1 was easily redirectable and continued to wander around wing one and wing two common area. At 11:40 p.m. nursing assistant (NA) assisted R1 into bed as he appeared tired and agreed to lying down. At midnight NA and writer happened to be in the wing one hall and heard commotion and yelling coming from R1's room. When staff entered, R1 was on roommate's side of curtain and was pulling on roommate's walker.	F 689	orders/support set up for resident from provider before resident wishes to leave facility. If resident continues to wish to leave facility, staff member will attempt to discuss a compromise with resident to leave facility when outside resources are more readily available such as during the business day, beginning and not end of the working week, etc so that these resources (county workers, primary providers, residents friends/family/neighbors, etc) are more readily available to be contacted by facility staff to notify that resident is leaving facility. If a resident does leave facility, facility staff must file a MAARC report and notify provider immediately. All staff responsible for discharges (clinical leadership, administrator, social services) were educated on the need to file a MAARC report and notifying provider immediately after a resident leaves AMA. This education was completed verbally before the staff member s next working shift. Date of Compliance: 10/13/23 Recurrence will be prevented by: Residents will be audited weekly x3 weeks, and monthly x2 months to identify all residents at risk for elopement were	

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F 689	Continued From page 10 Roommate was yelling and had his foot hooked on walker handle, in an attempt to prevent R1 from taking it. Writer was able to verbally redirect R1 into letting go of walker and coming back onto door side of room. R1 then began to yell that the walker belonged to him. The NA was standing near the doorway and asked R1 to calm down. R1 then lunged at NA with both fists and struck NA in the upper chest. Writer called 911 and R1 went into the hall where he was provided a wheel chair. R1 was calm at that time and accepted the chair. Police officer arrived first and was familiar with R1. When officer was interviewing R1 he stated that he would "beat down that worker again if he had to". R1 was pleasant and calm throughout emergency responders assisting him. R1 was sent back to the ED but was discharged back to the facility as he was calm and pleasant at the ED. 9/30/23, at 1:35 p.m. note indicated R1 was very pleasant with staff all of shift. R1 was exhibiting some confusion of place and time. No other concerns or behaviors at this time. 9/30/23, at 2:01 p.m. note indicated per registered nurse (RN), staff to apply Wanderguard. Wanderguard placed on left ankle. 2:33 p.m. documentation indicated R1 was found on the side of the highway headed south. A younger guy and his female friend brought resident back to the facility. R1 did not have a Wanderguard due to not being able to get an order for one. Hospital stated that he does not pose a risk to self or others. R1 had a cut on the right side of his nose and no other obvious signs of injury. R1 was very adamant that he wanted to leave.	F 689	reviewed to ensure that they have an elopement risk assessment completed and that all appropriate interventions are in place. All residents who leave AMA will be audited to ensure that all steps were taken to attempt to set up a safe discharge plan. This will occur weekly x3 weeks, and monthly x2 months. Audit results will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Administrator/Designee.	

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F 689	Continued From page 11 9/30/23, 2:58 p.m. notes indicated Resident signed AMA (against medical advice) discharge paperwork. Administrator and two nurses spoke with resident about risks. 9/30/23, late entry note indicated R1 had expressed the want to leave the facility and return home to his house. Writer was notified of this via phone call by facility staff. Writer spoke to resident via phone call with two nurses present in room. Resident was explained the AMA discharge process - that the facility could not help him if he left and no medication could be sent with. R1 gave a verbal understanding of this and wanted to leave. Resident signed AMA discharge paperwork. Writer notified resident case worker and Grand Rapids Police department of resident leaving AMA. Case worker stated she would be up the next day to check on R1. She did have a chance to talk to R1 via phone call and get information from him. During interview on 10/11/23, at 2:22 p.m. RN-A stated she was on call when R1 eloped and subsequently discharged from the facility. RN-A said R1 got to the facility on 9/28/23, and said they did some assessments but he wanted to leave so he was sent to the ED on Friday. RN-A stated an elopement assessment was done and because he wanted to leave a Wanderguard was placed. RN-A stated the next day she spoke with the hospital nurse and learned R1 had some sundowning and he needed to be watched. RN-A said the Wanderguard was removed when R1 went to the ED because he said he was not coming back. RN-A stated the ED sent R1 back to the facility and was told the hospital said R1 was "his own person" and was not an elopement risk. RN-A said at the time of the progress note dated 9/30/23, at 2:01 p.m. she had asked why	F 689		

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F 689	Continued From page 12 the Wanderguard had not been on when R1 eloped. RN-A said staff told her the administrator and director of nursing (DON) said he was his own person and did not need one. RN-A said the Wanderguard had been replaced following the elopement. RN-A further stated she had no idea how R1 ended up out on the highway and confirmed the Wanderguard was not put back on until he had returned to the facility following the elopement. On 10/11/23, at approximately 3:00 p.m. the administrator stated R1 admitted to the facility on Thursday 9/28/23, and left AMA 3 days later. The administrator said R1 had been sent to the hospital due to behaviors and hospital staff said R1 was his own decision maker and could leave if he wanted to so a Wanderguard had not been replaced after R1 had been sent to the ED. The administrator said R1 ended up leaving on Saturday and was found on the highway by people passing by and was brought back. The administrator stated she had received a call from staff reporting what had happened and staff had told her the DON said R1 did not need a Wanderguard even though the facility had assessed R1 to be at risk for elopement. The administrator said she had spoken to R1 on the phone and he was adamant he wanted to go home and check on his cat and check his mail. The administrator said she had called R1's case worker to let her know and called the police who told her to call 211 (United Way 211 Hotline connects Central Minnesotans to local resources 24/7) to get him a ride home. At 3:16 p.m. the DON stated a Wanderguard was not placed on R1 after he returned from the hospital because he had not signed a bed hold	F 689		

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F 689	Continued From page 13 and the hospital said he was his own decision maker. The DON said she understood there had been some confusion about wether or not R1 was appropriate for a Wanderguard. The DON said the corporate nurse was involved and said if R1 began exit seeking and could not be redirected they would look at placing the wanderguard again. The DON said she had not heard anything more and then found out R1 had eloped and was found out on the highway. The administrator who was present during the interview said they did not feel any education or training was necessary because R1 had discharged. On 10/11/23, at 4:11 p.m. the administrator said on 10/30/23, at 2:22 p.m. she had sent a text message to the DON asking her to complete education with staff related to completing an elopement assessment, facility assessment verses hospital assessment and asked her to complete audits but it had not been followed through on. On 10/12/23, at 10:03 a.m. R1's case worker (CW) stated she had spoken to several staff over the course of R1's stay at the facility. The CW stated the last conversation she had with the facility they said R1 was distressed and wanted to go home and they could not keep him there because he was his own decision maker and said they were trying to find resources to get him home. The CW said the facility told her they called the police who said they were not a taxi service so the facility called 211. The CW said she spoke to R1 on the phone about going home and said she would check in with him later in the day. She said she spoke with R1 about his panic button and R1 also said someone who lived with him would be home. The CW said when she	F 689		

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F 689	Continued From page 14 called R1 later that evening he told her he had to walk to a church near his home to get an extra set of keys and said he had fallen and someone from the church brought him home. The CW said R1 also said he did not have any food at home and she went and picked him up to go get some food. The CW stated R1 had been a client of their agency for a while and said he also received home health services. The CW said from a safety standpoint she did not think R1 was physically safe to be discharged home. The CW said when she had spoken to the hospital staff while R1 was in the ED she told them her recommendation was he go back to the facility. She said R1 had a history of a TBI and did not have a dementia diagnosis but had memory issues and said she felt he was medically fragile. During interview on 10/12/23, at 11:07 a.m. the administrator said she had not been part of the discussion with hospital staff who reported R1 was able to decide if he wanted to leave the facility. The administrator said the regional director of operations (RDO) and the corporate social service consultant had been in contact with the hospital. The administrator said when R1 left AMA she had not contacted a physician or R1's home health agency, only the case worker and the police who said they were not a taxi. On 10/12/23, at 11:20 a.m. the RDO and administrator were interviewed. The RDO said her understanding was R1 had demonstrated to the facility staff he did not want to be at the facility. The RDO said her conversation with the hospital staff was that R1 did not want to be there and was showing signs of agitation and combativeness. The RDO said hospital staff told her R1 did not need to be in the hospital and the	F 689		

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F 689	Continued From page 15 facility needed to take him back. She said the hospital staff said R1 had agreed to come back however, when he was at the facility he was trying to leave. The RDO said hospital staff told her R1 was his own person and the physicians said he was able to make his own decisions. The administrator said the facility referred to the physician to determine if R1 was safe to go home. The SNC, also present said she felt they should be able to trust the physician that R1 was alert and oriented. The SNC said she did not talk to the physician. The SNC said they felt R1 was clinically stable to go home because he had been stable enough to return to the facility. The SNC said they had concerns initially that maybe R1 was not cognitively intact and couldn't sign the admission agreement. She said hospital staff said he was fine and was his own person and that he was just anxious. During interview on 10/13/23, at 1:59 p.m. NA-A stated she had worked with R1 on the day he admitted to the facility and said he seemed fine. NA-A stated she worked with R1 again a day later and said he had been in and out of rooms and said when she opened the linen closet R1 had been in there and had cabinets open and items were rearranged. NA-A said R1 had also rearranged his room. She said R1 had been restless and walking around so she sat with him most the the shift. NA-A stated R1 was unsteady at his baseline when ambulating. NA-A said R1's wanderguard had been cut off when he went to the hospital but she did not know why. At 2:01 p.m. NA-B stated she had worked the weekend R1 was at the facility. NA-B said she was aware he had been combative and had been going in and out of rooms. NA-B said she had	F 689		

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F 689	Continued From page 16 assisted the ambulance staff on one of R1's hospital returns and said he had not been combative, angry or aggressive and been joking around. At 2:16 p.m. licensed practical nurse (LPN)-A said when R1 was at the facility he was very confused and followed her around. LPN-A said she had to have R1 sit with her because he was very unsteady. LPN-A said she was there when R1 returned from the ED and said she didn't notice any behaviors and said he was easily re-directed but said he thought she was his ex-girlfriend. Facility Elopement Policy dated 6/2023, indicated Monarch Healthcare Management is committed to provide a safe environment for all residents. Assure that each resident is assessed on an ongoing basis and has appropriate safety precautions in place. Facility Discharge Planning Policy dated 11/2016, indicated the purpose of a discharge plan is to provide the resident with needed care and services, and to work out an acceptable solution for all concerned. Discharge planning is done to assure continuity of care to meet the needs of a resident returning to independent living in the community or discharged to another facility or institution when and if possible. The IJ was removed on 10/13/23, at 2:35 p.m. when it was verified through interview and document review the facility reassessed all residents at risk for elopement and provided education related to elopement to all facility staff including a plan to educate oncoming staff prior to the next shift worked. Elopement education included the facilities responsibility to perform	F 689		

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F 689	Continued From page 17 their own assessment of residents and not utilize information passed on by outside agencies. The facility further educated all management staff on procedures to implement prior to allowing a resident to discharge AMA including involvement of outside support services and physician notification.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 25, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: KJJG11

Dear Administrator:

The above facility was surveyed on October 11, 2023 through October 13, 2023 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
Midtown Square
3333 Division Street, Suite 212
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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@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 10/13/2023

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 10/11/23 through 10/13/23, 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 was issued. Please indicate in your electronic plan of correction you	2 000		

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

Electronically Signed | 10/26/23

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed. H54956223C (MN97374) with no licensing order issued. Deficient practice was identified related to incidental finding with a licensing order issued at (0830). 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. 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		

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2 000	Continued From page 2 the Minnesota 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. 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 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. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to maintain resident safety when a resident (R1) who was assessed to be at risk for elopement verbalized his intent to leave the facility, left without staff knowledge and was returned to the facility by two strangers. Further, R1 was allowed to discharge home against medical advice from the facility even though he	2 830	Corrected	10/13/23

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2 830	Continued From page 3 had been assessed to have cognitive impairment and admitted due to recurrent falls. This resulted in an immediate Jeopardy (IJ) situation for R1. The IJ began on 9/30/23, when R1 left the facility without staff knowledge. R1 was found by two strangers on a highly-trafficked four lane highway with a cut on his nose. Additionally, within two hours of R1' s return to the facility, R1 wanted to return home. The facility did not implement interventions to keep him safe and assisted R1 leave on his own even though the facility assessed him unsafe in the community alone. The administrator and senior nurse consultant (SNC) were notified of the IJ on 10/12/23, at 3:33 p.m.. The IJ was removed on 10/13/23, at 2:35 p.m., but noncompliance remained at the lower scope and severity level D, with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: R1's Admission Record indicated he admitted to the facility on 9/28/23. R1's diagnosis included: Syncope, epilepsy, history of traumatic brain injury (TBI) and repeated falls. R1's hospital History and Physical dated 9/27/23, identified a past medical history of diabetes mellitus type 2, hypertension, chronic kidney disease, memory deficit/dementia, seizure disorder and multiple other medical issues and was was brought to the emergency room after he went to get the mail and passed out. R1's Admission/ Initial Data Collection Form dated 9/28/23, indicated he admitted to the facility on 9/28/23, at 1:00 p.m. The form indicated R1 used a walker for ambulation and required	2 830		

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2 830	Continued From page 4 supervision. R1's fall history, pain, skin and communication were not assessed. R1's Elopement Risk Evaluation dated 9/28/23, identified a habit/history of wandering or attempts to leave the unit or building, pacing or agitated behavior, and indicated he was ambulatory. The evaluation indicated R1 was at risk for elopement and identified the use of a Wanderguard. R1's Brief Interview for Mental Status dated 9/30/23, identified a score of six which indicated severe cognitive impairment. R1's facility Progress Notes identified the following: Note written 9/29/23, at 8:09 a.m. indicated R1 was unaware of his own name and asked writer "is that me?" Writer told resident "yes, that's your name." R1 had been busy in the morning and had been wandering around wing one, entering other resident rooms, trying to go out emergency exit and trying to go to the wing onse courtyard. Resident had required a 1:1 in the morning. Note written 9/29/23, at 8:33 a.m. indicated R1 had been exit seeking in the evening and wanting to walk home. R1 thought his his house is nearby. R1 said he would just walk out the door and a Wanderguard was placed on his left ankle. R1 was restless during the night, going into other resident rooms, opening doors, looking to go home, looking for his boots, digging around in drawers in room and into his roommate's belongings. R1 had been exit seeking into the morning and came out of the of unit looking for a way to get out. When attempting to redirect, R1 began yelling at staff and appeared he was going to push right past staff. R1 started yelling for staff	2 830		

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2 830	Continued From page 5 to call the police and let them take him out of here. R1 walked down the hallway toward the staff entrance and oncoming staff was able to redirect him back onto the unit. R1 had been a 1:1 with staff member since. Note written 9/29/23, at 8:55 a.m. indicated R1 was sent to the emergency department (ED) due to hypotension. R1 was offered bed hold and refused and stated he wanted to look elsewhere. A second note written at 9:15 a.m. indicated R1 discharged. At 7:40 p.m. Progress Note indicated R1 returned from the ED in a pleasant mood. 9/30/23, at 2:19 a.m. note indicated from 10:15 p.m. to 11:15 p.m. R1 was pleasant and calm, sitting in a chair and eating snacks in a common area. R1 then began wandering and exit seeking, requesting a bus to come pick him up. R1 was easily redirectable and continued to wander around wing one and wing two common area. At 11:40 p.m. nursing assistant (NA) assisted R1 into bed as he appeared tired and agreed to lying down. At midnight NA and writer happened to be in the wing one hall and heard commotion and yelling coming from R1's room. When staff entered, R1 was on roommate's side of curtain and was pulling on roommate's walker. Roommate was yelling and had his foot hooked on walker handle, in an attempt to prevent R1 from taking it. Writer was able to verbally redirect R1 into letting go of walker and coming back onto door side of room. R1 then began to yell that the walker belonged to him. The NA was standing near the doorway and asked R1 to calm down. R1 then lunged at NA with both fists and struck NA in the upper chest. Writer called 911 and R1 went into the hall where he was provided a wheel chair. R1 was calm at that time and accepted the chair. Police	2 830		

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2 830	Continued From page 6 officer arrived first and was familiar with R1. When officer was interviewing R1 he stated that he would "beat down that worker again if he had to". R1 was pleasant and calm throughout emergency responders assisting him. R1 was sent back to the ED but was discharged back to the facility as he was calm and pleasant at the ED. 9/30/23, at 1:35 p.m. note indicated R1 was very pleasant with staff all of shift. R1 was exhibiting some confusion of place and time. No other concerns or behaviors at this time. 9/30/23, at 2:01 p.m. note indicated per registered nurse (RN), staff to apply Wanderguard. Wanderguard placed on left ankle. 2:33 p.m. documentation indicated R1 was found on the side of the highway headed south. A younger guy and his female friend brought resident back to the facility. R1 did not have a Wanderguard due to not being able to get an order for one. Hospital stated that he does not pose a risk to self or others. R1 had a cut on the right side of his nose and no other obvious signs of injury. R1 was very adamant that he wanted to leave. 9/30/23, 2:58 p.m. notes indicated Resident signed AMA (against medical advice) discharge paperwork. Administrator and two nurses spoke with resident about risks. 9/30/23, late entry note indicated R1 had expressed the want to leave the facility and return home to his house. Writer was notified of this via phone call by facility staff. Writer spoke to resident via phone call with two nurses present in room. Resident was explained the AMA discharge process - that the facility could not help him if he left and no medication could be sent with. R1 gave a verbal understanding of this	2 830		

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2 830	Continued From page 7 and wanted to leave. Resident signed AMA discharge paperwork. Writer notified resident case worker and Grand Rapids Police department of resident leaving AMA. Case worker stated she would be up the next day to check on R1. She did have a chance to talk to R1 via phone call and get information from him. During interview on 10/11/23, at 2:22 p.m. RN-A stated she was on call when R1 eloped and subsequently discharged from the facility. RN-A said R1 got to the facility on 9/28/23, and said they did some assessments but he wanted to leave so he was sent to the ED on Friday. RN-A stated an elopement assessment was done and because he wanted to leave a Wanderguard was placed. RN-A stated the next day she spoke with the hospital nurse and learned R1 had some sundowning and he needed to be watched. RN-A said the Wanderguard was removed when R1 went to the ED because he said he was not coming back. RN-A stated the ED sent R1 back to the facility and was told the hospital said R1 was "his own person" and was not an elopement risk. RN-A said at the time of the progress note dated 9/30/23, at 2:01 p.m. she had asked why the Wanderguard had not been on when R1 eloped. RN-A said staff told her the administrator and director of nursing (DON) said he was his own person and did not need one. RN-A said the Wanderguard had been replaced following the elopement. RN-A further stated she had no idea how R1 ended up out on the highway and confirmed the Wanderguard was not put back on until he had returned to the facility following the elopement. On 10/11/23, at approximately 3:00 p.m. the administrator stated R1 admitted to the facility on Thursday 9/28/23, and left AMA 3 days later. The	2 830		

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2 830	Continued From page 8 administrator said R1 had been sent to the hospital due to behaviors and hospital staff said R1 was his own decision maker and could leave if he wanted to so a Wanderguard had not been replaced after R1 had been sent to the ED. The administrator said R1 ended up leaving on Saturday and was found on the highway by people passing by and was brought back. The administrator stated she had received a call from staff reporting what had happened and staff had told her the DON said R1 did not need a Wanderguard even though the facility had assessed R1 to be at risk for elopement. The administrator said she had spoken to R1 on the phone and he was adamant he wanted to go home and check on his cat and check his mail. The administrator said she had called R1's case worker to let her know and called the police who told her to call 211 (United Way 211 Hotline connects Central Minnesotans to local resources 24/7) to get him a ride home. At 3:16 p.m. the DON stated a Wanderguard was not placed on R1 after he returned from the hospital because he had not signed a bed hold and the hospital said he was his own decision maker. The DON said she understood there had been some confusion about wether or not R1 was appropriate for a Wanderguard. The DON said the corporate nurse was involved and said if R1 began exit seeking and could not be redirected they would look at placing the wanderguard again. The DON said she had not heard anything more and then found out R1 had eloped and was found out on the highway. The administrator who was present during the interview said they did not feel any education or training was necessary because R1 had discharged. On 10/11/23, at 4:11 p.m. the administrator said	2 830		

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2 830	Continued From page 9 on 10/30/23, at 2:22 p.m. she had sent a text message to the DON asking her to complete education with staff related to completing an elopement assessment, facility assessment verses hospital assessment and asked her to complete audits but it had not been followed through on. On 10/12/23, at 10:03 a.m. R1's case worker (CW) stated she had spoken to several staff over the course of R1's stay at the facility. The CW stated the last conversation she had with the facility they said R1 was distressed and wanted to go home and they could not keep him there because he was his own decision maker and said they were trying to find resources to get him home. The CW said the facility told her they called the police who said they were not a taxi service so the facility called 211. The CW said she spoke to R1 on the phone about going home and said she would check in with him later in the day. She said she spoke with R1 about his panic button and R1 also said someone who lived with him would be home. The CW said when she called R1 later that evening he told her he had to walk to a church near his home to get an extra set of keys and said he had fallen and someone from the church brought him home. The CW said R1 also said he did not have any food at home and she went and picked him up to go get some food. The CW stated R1 had been a client of their agency for a while and said he also received home health services. The CW said from a safety standpoint she did not think R1 was physically safe to be discharged home. The CW said when she had spoken to the hospital staff while R1 was in the ED she told them her recommendation was he go back to the facility. She said R1 had a history of a TBI and did not have a dementia diagnosis but had memory issues and said she	2 830		

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2 830	Continued From page 10 felt he was medically fragile. During interview on 10/12/23, at 11:07 a.m. the administrator said she had not been part of the discussion with hospital staff who reported R1 was able to decide if he wanted to leave the facility. The administrator said the regional director of operations (RDO) and the corporate social service consultant had been in contact with the hospital. The administrator said when R1 left AMA she had not contacted a physician or R1's home health agency, only the case worker and the police who said they were not a taxi. On 10/12/23, at 11:20 a.m. the RDO and administrator were interviewed. The RDO said her understanding was R1 had demonstrated to the facility staff he did not want to be at the facility. The RDO said her conversation with the hospital staff was that R1 did not want to be there and was showing signs of agitation and combativeness. The RDO said hospital staff told her R1 did not need to be in the hospital and the facility needed to take him back. She said the hospital staff said R1 had agreed to come back however, when he was at the facility he was trying to leave. The RDO said hospital staff told her R1 was his own person and the physicians said he was able to make his own decisions. The administrator said the facility referred to the physician to determine if R1 was safe to go home. The SNC, also present said she felt they should be able to trust the physician that R1 was alert and oriented. The SNC said she did not talk to the physician. The SNC said they felt R1 was clinically stable to go home because he had been stable enough to return to the facility. The SNC said they had concerns initially that maybe R1 was not cognitively intact and couldn't sign the admission agreement. She said hospital staff said	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 _____	C 10/13/2023

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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2 830	Continued From page 11 he was fine and was his own person and that he was just anxious. During interview on 10/13/23, at 1:59 p.m. NA-A stated she had worked with R1 on the day he admitted to the facility and said he seemed fine. NA-A stated she worked with R1 again a day later and said he had been in and out of rooms and said when she opened the linen closet R1 had been in there and had cabinets open and items were rearranged. NA-A said R1 had also rearranged his room. She said R1 had been restless and walking around so she sat with him most the the shift. NA-A stated R1 was unsteady at his baseline when ambulating. NA-A said R1's wanderguard had been cut off when he went to the hospital but she did not know why. At 2:01 p.m. NA-B stated she had worked the weekend R1 was at the facility. NA-B said she was aware he had been combative and had been going in and out of rooms. NA-B said she had assisted the ambulance staff on one of R1's hospital returns and said he had not been combative, angry or aggressive and been joking around. At 2:16 p.m. licensed practical nurse (LPN)-A said when R1 was at the facility he was very confused and followed her around. LPN-A said she had to have R1 sit with her because he was very unsteady. LPN-A said she was there when R1 returned from the ED and said she didn't notice any behaviors and said he was easily re-directed but said he thought she was his ex-girlfriend. Facility Elopement Policy dated 6/2023, indicated Monarch Healthcare Management is committed to provide a safe environment for all residents. Assure that each resident is assessed on an	2 830		

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2 830	Continued From page 12 ongoing basis and has appropriate safety precautions in place. Facility Discharge Planning Policy dated 11/2016, indicated the purpose of a discharge plan is to provide the resident with needed care and services, and to work out an acceptable solution for all concerned. Discharge planning is done to assure continuity of care to meet the needs of a resident returning to independent living in the community or discharged to another facility or institution when and if possible. The IJ was removed on 10/13/23, at 2:35 p.m. when it was verified through interview and document review the facility reassessed all residents at risk for elopement and provided education related to elopement to all facility staff including a plan to educate oncoming staff prior to the next shift worked. Elopement education included the facilities responsibility to perform their own assessment of residents and not utilize information passed on by outside agencies. The facility further educated all management staff on procedures to implement prior to allowing a resident to discharge AMA including involvement of outside support services and physician notification. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to appropriate supervision to prevent elopement or respond to exit-seeking behavior. The DON or designee could also and ensure appropriate comprehensive assessments and interventions were developed and implemented for all residents with the potential to be affected. The DON or designee could re-educate all staff on policies and procedures, changes to care plans, and the	2 830		

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2 830	Continued From page 13 results of assessments for those identified at risk for exit-seeking behaviors and elopement. The DON or designee could develop a system for evaluating and monitoring consistent implementation of policies and procedures and audit to prevent potential elopements and/identify exit-seeking behaviors. The DON or designee could also ensure staff perform a comprehensive assessment or root cause analysis as needed to ensure interventions are effective, in place and re-evaluated as often as necessary. The results of those measurable audits should be routinely brought to the facility's Quality Assurance Performance Improvement (QAPI) committee to determine ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		