DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 5, 2024

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

RE: CCN: 245495
Cycle Start Date: December 1, 2023

Dear Administrator:

On December 29, 2023, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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Electronically delivered

January 5, 2024

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

Re: Reinspection Results
Event ID: 1MR812

Dear Administrator:

On December 29, 2023 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 December 1, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 13, 2023

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

RE: CCN: 245495
Cycle Start Date: December 1, 2023

Dear Administrator:

On December 1, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
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 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 March 1, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 1, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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 12/01/2023

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 11/30/23, through 12/1/23, 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 complaint was reviewed: H54957322C (MN00098612). Deficient practice was identified related to incidental finding with deficiencies cited at F609 and F610. 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(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	F 609		12/21/23

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

Electronically Signed | 12/19/2023

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 609	Continued From page 1 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 report allegations of misappropriation of resident property to the State Agency (SA) within 24 hours of the allegation for 1 of 3 residents (R1) reviewed for drug diversion. Findings include: A facility reported incident (FRI), submitted 11/16/23 at 5:49 p.m., identified an incident occurred on 11/15/23 at 2:00 a.m. R1 reported to staff when licensed practical nurse (LPN)-A administered him his 2:00 a.m. oxycodone (opioid) medication the pill lacked an overall taste (not the normal bitter taste), and he experienced increased pain on those nights. R1 indicated	F 609	Immediate Corrective Action: Director of Nursing was educated on Abuse Prohibition/Vulnerable Adult Policy in regard to incidents that need to be reported. 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.	

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F 609	Continued From page 2 similar incidents were present for "awhile," but he was unable to provide a direct timeline; however, reported he noticed increased pain over the last couple days. Further, he explained when he received his 2:00 a.m. medications he would sleep a couple hours and wake up in "extreme pain." The FRI identified alleged non-fiduciary financial exploitation related to medication theft. R1's Minimum Data Set (MDS), dated 8/31/23, indicated R1 was cognitively intact and free of communication impairments. In addition, R1 was administered opioid (narcotic/pain) medication seven days a week. When interviewed on 11/30/23 at 11:08 a.m., R1 identified LPN-A administered him "something else other than the oxy (oxycodone)." He explained LPN-A provided him with medications consistently approximately three to four days a week since his room change in August, and every time LPN-A provided him with pain pills "they were not working." When he questioned LPN-A on the pain medication, LPN-A told him the pill was oxycodone; however, the "oxycodone" pill administered lacked the normal bitter taste, was slightly larger, did not dissolve as fast, in which his pain response was ineffective, and his sleep cycle was different. He indicated he lacked this concern when other nurses administered the oxycodone. It took him a couple months to figure out why he experienced different medication reactions when LPN-A worked, and after he suspected LPN-A administered him something other than oxycodone, he saved four to five of the administered pills. He explained he did not update staff of his suspicions right away as he worried staff would alert LPN-A of his concerns. When he started to become concerned about the	F 609	Administrator, Director of Nursing, and Social Services, and clinical management team will be educated on Abuse Prohibition/Vulnerable Adult Policy in regard to incidents that need to be reported. 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 medication(s) LPN-A potentially provided him in place of the oxycodone, with thoughts the replacement medication was a sleeping pill, he updated registered nurse (RN)-A around "three in the afternoon," on an unremembered day, and provided RN-A with the saved pills. Almost immediately after, the director of nursing (DON) followed-up with him and encouraged him to save the proceeding night's medication to verify the pill administered. The following morning, he provided the DON with the 2:00 a.m. pill LPN-A administered. Staff indicated the pill was not oxycodone but appeared to be a sleeping pill. R1 identified his pain currently was managed and he lacked any additional medication administration concerns. During an interview on 11/30/23 at 1:06 p.m., RN-A stated R1 asked her, on an unremembered day, if there was a generic form of oxycodone as LPN-A administered him pills that tasted different. R1 provided her with pills he identified LPN-A administered to him. After her assessment of the pills, she felt they were 5 milligrams of melatonin (over the counter sleep aide). RN-A confirmed R1 was not ordered melatonin. RN-A stated R1's hands, when he updated her of his concerns, "were killing him." RN-A explained she updated the DON right after she finished with R1. When interviewed on 11/30/23 at 3:21 p.m., the DON stated RN-A updated her on a Wednesday [11/15/23] that R1 noticed a difference in his medications. During her immediate follow-up with R1, R1 reported he felt LPN-A administered him something in place of his oxycodone. He provided pills to her and explained the differences when LPN-A versus other nurses administered the oxycodone. After her review of the medication	F 609		

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F 609	Continued From page 4 cart narcotic box oxycodone, R1's other medications, and stock medications, it appeared as if the pill was melatonin. Shortly after, she updated the administrator and the corporate nurse consultant (NC)-A. Despite R1's LPN-A allegations, and the DON's interview explanation that misappropriation of property was abuse and thus required SA reporting within two hours, a decision was made to not report the allegation to the SA right away. The DON explained R1 was unsure as to how long he suspected the incorrect medication administration, or the dates related to the pills he supplied her, and thus they lacked sufficient evidence to support the allegation "100 percent" against only LPN-A. An additional decision was made to ask R1 to visualize the pills LPN-A administered him that night to potentially collect this needed sufficient evidence before they identified LPN-A as an AP of medication theft. The DON stated, the next morning, R1 provided her with two pills, one from the 8:00 p.m. medication pass and the other from the 2:00 a.m. pass. These were determined to not be the documented oxycodone. The DON explained after "quite a bit of investigation," the allegation was filed Thursday [11/16/23 - approximately 27 hours after the initial allegation]. During an interview on 11/30/23 at 3:52 p.m., the administrator stated, on 11/15/23, she was not in the facility and thus the DON updated her via phone on R1's allegation. She explained she instructed the DON to contact NC-A. After, she was updated that NC-A directed the allegation did not require reporting at that time as more information was required. The administrator stated she expected abuse, which included misappropriation of property, to be reported to the SA within two hours of the allegation.	F 609		

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F 609	Continued From page 5 During a follow-up interview on 12/1/23 at 11:13 a.m., the administrator stated, on 11/15/23 around 3:00 p.m. - 3:30 p.m., the DON initially contacted her via phone about R1's allegation. She explained she was not involved with the initial decisions and/or investigation related to the allegation or any directed follow-up as the DON and NC-A worked together being she was not within the facility. When interviewed on 12/1/23 at 11:35 a.m., NC-A stated abuse allegations were required to be reported to the SA within two hours, which included allegations of drug diversion, if the facility could identify by description or name the alleged perpetrator. She explained the DON contacted her "the day before they reported it," possible during the afternoon hours, about R1's allegation. She indicated R1 was not 100 percent sure LPN-A switched his medications or specific time frames/dates when R1 kept pills, and the pills R1 provided were degraded. She indicated she was aware LPN-A worked that night; however, she directed staff to report back to her in the morning if they were able to compile additional information such as that nights administered pills. The next morning, it was determined the pills were not oxycodone. She explained had R1 been able to better identify LPN-A [on 11/15/23] as the alleged perpetrator, she would have directed staff differently on reporting. An Abuse Prohibition/Vulnerable Adult Policy, dated August 2023, identified a purpose to protect residents against abuse by anyone and to promptly report all incidents of alleged or suspected abuse. The policy indicated incidents	F 609		

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F 609	Continued From page 6 of misappropriation of resident property must be reported to the SA online abuse reporting portal no later than two hours if the incident resulted in serious bodily injury and no later than 24 hours if the incident did not result in serious bodily injury.	F 609		
F 610 SS=E	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 protect facility residents from potential abuse when they allowed an alleged perpetrator (AP) (licensed practical nurse (LPN)-A) to work after an allegation of misappropriation of resident property (drug diversion). This had the potential to affect all seven residents who resided on Wing 3, who were ordered opioid (narcotic/pain) medication(s).	F 610	Immediate Corrective Action: (LPN)-A is no longer employed with the Emeralds at Grand Rapids. Corrective Action as it applies to others: The Abuse Prohibition/Vulnerable Adult Policy was reviewed and remains current.	12/21/23

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F 610	Continued From page 7 Findings include: A facility reported incident (FRI), submitted 11/16/23 at 5:49 p.m., identified an incident occurred on 11/15/23 at 2:00 a.m. R1 reported to staff when LPN-A administered him his 2:00 a.m. oxycodone (opioid) medication the pill lacked an overall taste (not the normal bitter taste), and he experienced increased pain on those nights. R1 indicated similar incidents were present for 'awhile,' but he was unable to provide a direct timeline; however, reported he noticed increased pain over the last couple days. Further, he explained when he received his 2:00 a.m. medications he would sleep a couple hours and wake up in "extreme pain." The FRI identified alleged non-fiduciary financial exploitation related to medication theft. LPN-A's provided timecard, indicated LPN-A clocked in on 11/15/23 at 6:03 p.m. and clocked out on 11/16/23 at 6:01 a.m. R1's Minimum Data Set (MDS), dated 8/31/23, indicated R1 was cognitively intact and free of communication impairments. In addition, R1 was administered opioid (narcotic/pain) medication seven days a week. R1's diagnoses included supraventricular tachycardia (too fast heartbeat) and heart failure (decreased heart pumping). When interviewed on 11/30/23 at 11:08 a.m., R1 identified LPN-A administered him "something else other than the oxy (oxycodone)." He explained LPN-A provided him with medications consistently approximately three to four days a week since his room change in August, and every time LPN-A provided him with pain pills "they were not working." When he questioned LPN-A	F 610	All resident incidents and grievances from the last 30 days will be audited to ensure that a thorough investigation was completed to determine if issues need to be reported. Administrator and Director of Nursing will be educated on Abuse Prohibition/Vulnerable Adult Policy regarding investigating incidents and grievances thoroughly to ensure incident is reported if appropriate. Date of Compliance: 12/21/23 Recurrence will be prevented by: All resident instances and grievances will be audited weekly x3 weeks, and monthly x2 months to ensure that all incidents and grievances were thoroughly investigated and reported if appropriate. Audit results will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Administrator/Designee	

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

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F 610	Continued From page 8 on the pain medication, LPN-A told him the pill was oxycodone; however, the "oxycodone" pill administered lacked the normal bitter taste, was slightly larger, did not dissolve as fast, in which his pain response was ineffective, and his sleep cycle was different. He indicated he lacked this concern when other nurses administered the oxycodone. It took him a couple months to figure out why he experienced different medication reactions when LPN-A worked, and after he suspected LPN-A administered him something other than oxycodone, he saved four to five of the administered pills. He explained he did not update staff of his suspicions right away as he worried staff would alert LPN-A of his concerns. When he started to become concerned about the medication(s) LPN-A potentially provided him in place of the oxycodone, with thoughts the replacement medication was a sleeping pill, he updated staff and turned over the saved pills. The director of nursing (DON) followed-up with him and encouraged him to save the proceeding night's medication to verify the pill administered. The following morning, he provided the DON with the 2:00 a.m. pill LPN-A administered. Staff indicated the pill was not oxycodone but appeared to be a sleeping pill. R1 identified his pain currently was managed and he lacked any additional medication administration concerns. When interviewed on 11/30/23 at 3:21 p.m. the DON stated during her follow-up with R1, R1 explained he felt LPN-A administered him something in place of his oxycodone. He provided the saved pills to her and explained the differences when LPN-A versus other nurses administered the oxycodone. After her review of the med cart narcotic box oxycodone, R1's other medications, and stock medications, it appeared	F 610		

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	245495	A. BUILDING _____ B. WING _____	C 12/01/2023

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F 610	Continued From page 9 as if the pill was melatonin. Shortly after, she updated the administrator and the corporate nurse consultant (NC)-A. The DON stated misappropriation of property was abuse; however, as R1 was unsure as to how long he suspected the incorrect medication administration, or the dates related to the pills he supplied her, they lacked sufficient evidence to support the allegation "100 percent" against only LPN-A. A decision was made to ask R1 to visualize the pills LPN-A administered him that night to potentially collect sufficient evidence before they identified LPN-A as an AP of medication theft. The DON stated, the next morning, R1 provided her with two pills, one from the 8:00 p.m. medication pass and the other from the 2:00 a.m. pass. These were determined to not be the documented oxycodone. The DON explained after "quite a bit of investigation," the allegation was filed Thursday [11/16/23] and LPN-A was suspended. During an interview on 11/30/23 at 3:52 p.m., the administrator stated, on 11/15/23, she was not within the facility and thus the DON updated her via phone on R1's allegations. She explained she instructed the DON to contact NC-A. After, she was updated that NC-A directed the allegation required more investigation before the allegation could be confirmed as staff were unable to figure out if something happened or not. She explained if an allegation was reported by resident, and they were able to provide a name and details, then the AP would be suspended pending investigation. She explained she really did not have a lot of knowledge on 11/15/23 of the situation and was unaware LPN-A was scheduled to work that night. She stated "looking back" she would not have allowed LPN-A to work that night as there was a	F 610		

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F 610	Continued From page 10 risk of LPN-A doing the same actions with R1 or other residents. On 12/1/23 at 10:51 a.m., the DON was interviewed for follow-up. She indicated residents were protected after allegations of abuse typically by suspending the AP; however, this decision depended on the severity of the allegation. She explained after R1's allegation, she, and NC-A "wanted to be sure before we started accusing [LPN-A]," and that is why she asked R1 to save any medication(s) that concerned him that night when LPN-A worked. R1 was questioned to his comfort level of this plan, to which he indicated he had no concerns with LPN-A providing him medications that night and he would save any medications that he felt were not oxycodone. She denied documentation of this conversation. She and NC-A discussed potential risk(s) of harm associated with any missed pain medication for R1 in which R1 could potentially have increased pain, potential withdrawals, and a decreased pulse in relation to his heart condition if provided an unknown medication; however, due to lack of sufficient initial evidence there was not a high enough risk to suspend LPN-A right away. She did not feel LPN-A would cause intentional harm that night "other than the med[ication] itself." When interviewed on 12/1/23 at 11:35 a.m., NA-C stated when abuse allegations were reported and an AP was identified by description or name, the AP was expected to be suspended pending an investigation. She explained the DON contacted her on [11/15/23], in which R1, who she identified was interviewable, alleged LPN-A potentially switched his medications; however, he was not 100 percent confident and was unable to provide specific time frames/dates of the kept pills. In	F 610		

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F 610	Continued From page 11 addition, the pills R1 provided were degraded, thus staff were unable to determine if the incident[s] even occurred due to lack of sufficient proof. She indicated she was aware LPN-A worked that night; however, explained without a full investigation, and confirmed medication identification, all nurses who worked that shift would have had to be suspended. Due to this, she directed staff to report back to her in the morning if they were able to compile additional information, such as that nights administered pills, for improved identification. The next morning, it was determined the pills were not oxycodone. When questioned on resident protections implemented on 11/15/23, she indicated had R1 been able to provide specific initial details related to his allegation, the protection would have been to suspend LPN-A right away. Due to this, the plan was for R1 to call another nurse immediately that night if he felt he was provided incorrect medication in which he would then ask to have the DON immediately updated. She indicated R1 waited until the morning to update the DON. During a follow-up interview on 12/1/23 at 11:56 a.m., R1 indicated he was okay with the plan to save any pills LPN-A administered to him that concerned him and then hand those over to the DON the following morning. He was not overly concerned with increased pain as he "knew it was coming" and he "[could] suffer through it," but he was concerned with the medication used to resemble the oxycodone. This concern was elevated by thoughts that he could have been administered heart pills. He explained he had an enlarged aorta and because he was too high of a risk the condition was inoperable. He explained because of this concern, he decided to not take	F 610		

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F 610	Continued From page 12 the pills that night and would spit them out after LPN-A left the room. R1 reiterated LPN-A was the only one he suspected switched out his oxycodone for something else and this was the person he reported to staff. An Abuse Prohibition/Vulnerable Adult Policy, dated August 2023, identified a purpose to protect residents against abuse by anyone. The policy directed immediately, upon learning of an incident, staff were to take necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter was investigated. If the incident was staff to resident alleged or suspected abuse, the staff was to be immediately suspended until the investigation was completed and human resources (HR) was notified.	F 610		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 13, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 1MR811

Dear Administrator:

The above facility was surveyed on November 30, 2023 through December 1, 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 _____	12/01/2023

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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 11/30/23, through 12/1/23, a complaint survey was conducted at your facility by a surveyor 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 have reviewed this order and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed. H54957322C (MN00098612). Deficient practice was identified related to incidental finding with a licensing order issued at 1980. 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 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 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		
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 (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.	21980		12/21/23

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21980	Continued From page 3 (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 report allegations of misappropriation of resident property to the State Agency (SA) within 24 hours of the allegation for 1 of 3 residents (R1) reviewed for drug diversion. Findings include: A facility reported incident (FRI), submitted 11/16/23 at 5:49 p.m., identified an incident occurred on 11/15/23 at 2:00 a.m. R1 reported to staff when licensed practical nurse (LPN)-A administered him his 2:00 a.m. oxycodone (opioid) medication the pill lacked an overall taste (not the normal bitter taste), and he experienced increased pain on those nights. R1 indicated	21980	Corrected.	

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21980	Continued From page 4 similar incidents were present for "awhile," but he was unable to provide a direct timeline; however, reported he noticed increased pain over the last couple days. Further, he explained when he received his 2:00 a.m. medications he would sleep a couple hours and wake up in "extreme pain." The FRI identified alleged non-fiduciary financial exploitation related to medication theft. R1's Minimum Data Set (MDS), dated 8/31/23, indicated R1 was cognitively intact and free of communication impairments. In addition, R1 was administered opioid (narcotic/pain) medication seven days a week. When interviewed on 11/30/23 at 11:08 a.m., R1 identified LPN-A administered him "something else other than the oxy (oxycodone)." He explained LPN-A provided him with medications consistently approximately three to four days a week since his room change in August, and every time LPN-A provided him with pain pills "they were not working." When he questioned LPN-A on the pain medication, LPN-A told him the pill was oxycodone; however, the "oxycodone" pill administered lacked the normal bitter taste, was slightly larger, did not dissolve as fast, in which his pain response was ineffective, and his sleep cycle was different. He indicated he lacked this concern when other nurses administered the oxycodone. It took him a couple months to figure out why he experienced different medication reactions when LPN-A worked, and after he suspected LPN-A administered him something other than oxycodone, he saved four to five of the administered pills. He explained he did not update staff of his suspicions right away as he worried staff would alert LPN-A of his concerns. When he started to become concerned about the medication(s) LPN-A potentially provided him in	21980		

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21980	Continued From page 5 place of the oxycodone, with thoughts the replacement medication was a sleeping pill, he updated registered nurse (RN)-A around "three in the afternoon," on an unremembered day, and provided RN-A with the saved pills. Almost immediately after, the director of nursing (DON) followed-up with him and encouraged him to save the proceeding night's medication to verify the pill administered. The following morning, he provided the DON with the 2:00 a.m. pill LPN-A administered. Staff indicated the pill was not oxycodone but appeared to be a sleeping pill. R1 identified his pain currently was managed and he lacked any additional medication administration concerns. During an interview on 11/30/23 at 1:06 p.m., RN-A stated R1 asked her, on an unremembered day, if there was a generic form of oxycodone as LPN-A administered him pills that tasted different. R1 provided her with pills he identified LPN-A administered to him. After her assessment of the pills, she felt they were 5 milligrams of melatonin (over the counter sleep aide). RN-A confirmed R1 was not ordered melatonin. RN-A stated R1's hands, when he updated her of his concerns, "were killing him." RN-A explained she updated the DON right after she finished with R1. When interviewed on 11/30/23 at 3:21 p.m., the DON stated RN-A updated her on a Wednesday [11/15/23] that R1 noticed a difference in his medications. During her immediate follow-up with R1, R1 reported he felt LPN-A administered him something in place of his oxycodone. He provided pills to her and explained the differences when LPN-A versus other nurses administered the oxycodone. After her review of the medication cart narcotic box oxycodone, R1's other medications, and stock medications, it appeared	21980		

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21980	Continued From page 6 as if the pill was melatonin. Shortly after, she updated the administrator and the corporate nurse consultant (NC)-A. Despite R1's LPN-A allegations, and the DON's interview explanation that misappropriation of property was abuse and thus required SA reporting within two hours, a decision was made to not report the allegation to the SA right away. The DON explained R1 was unsure as to how long he suspected the incorrect medication administration, or the dates related to the pills he supplied her, and thus they lacked sufficient evidence to support the allegation "100 percent" against only LPN-A. An additional decision was made to ask R1 to visualize the pills LPN-A administered him that night to potentially collect this needed sufficient evidence before they identified LPN-A as an AP of medication theft. The DON stated, the next morning, R1 provided her with two pills, one from the 8:00 p.m. medication pass and the other from the 2:00 a.m. pass. These were determined to not be the documented oxycodone. The DON explained after "quite a bit of investigation," the allegation was filed Thursday [11/16/23 - approximately 27 hours after the initial allegation]. During an interview on 11/30/23 at 3:52 p.m., the administrator stated, on 11/15/23, she was not in the facility and thus the DON updated her via phone on R1's allegation. She explained she instructed the DON to contact NC-A. After, she was updated that NC-A directed the allegation did not require reporting at that time as more information was required. The administrator stated she expected abuse, which included misappropriation of property, to be reported to the SA within two hours of the allegation. During a follow-up interview on 12/1/23 at 11:13 a.m., the administrator stated, on 11/15/23	21980		

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 _____	12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21980	Continued From page 7 around 3:00 p.m. - 3:30 p.m., the DON initially contacted her via phone about R1's allegation. She explained she was not involved with the initial decisions and/or investigation related to the allegation or any directed follow-up as the DON and NC-A worked together being she was not within the facility. When interviewed on 12/1/23 at 11:35 a.m., NC-A stated abuse allegations were required to be reported to the SA within two hours, which included allegations of drug diversion, if the facility could identify by description or name the alleged perpetrator. She explained the DON contacted her "the day before they reported it," possible during the afternoon hours, about R1's allegation. She indicated R1 was not 100 percent sure LPN-A switched his medications or specific time frames/dates when R1 kept pills, and the pills R1 provided were degraded. She indicated she was aware LPN-A worked that night; however, she directed staff to report back to her in the morning if they were able to compile additional information such as that nights administered pills. The next morning, it was determined the pills were not oxycodone. She explained had R1 been able to better identify LPN-A [on 11/15/23] as the alleged perpetrator, she would have directed staff differently on reporting. An Abuse Prohibition/Vulnerable Adult Policy, dated August 2023, identified a purpose to protect residents against abuse by anyone and to promptly report all incidents of alleged or suspected abuse. The policy indicated incidents of misappropriation of resident property must be reported to the SA online abuse reporting portal no later than two hours if the incident resulted in serious bodily injury and no later than 24 hours if	21980		

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21980	Continued From page 8 the incident did not result in serious bodily injury. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. Those audits should be ongoing and random after compliance is determined by QAPI to ensure compliance is being maintained. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		