Protecting, Maintaining and Improving the Health of All Minnesotans

Revised letter date

Electronically delivered
April 25, 2023

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

RE: CCN: 245495
Cycle Start Date: January 12, 2023

Dear Administrator:

On January 24, 2023, we notified you a remedy was imposed. On February 16, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 24, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 6, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 24, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 6, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 24, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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

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Revised letter date

Electronically delivered

April 25, 2023

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

Re: Reinspection Results
Event ID: N4U212

Dear Administrator:

On February 16, 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 January 12, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 24, 2023

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

RE: CCN: 245495
Cycle Start Date: January 12, 2023

Dear Administrator:

On January 12, 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 delivered CMS-2567, whereby significant corrections are required.

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(ies) 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:

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 12, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 12, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 12, 2023.

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 $11,292; 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.

If you have not achieved substantial compliance by April 12, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Emeralds At Grand Rapids Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 12, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

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. 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 an "E" tag), i.e., the plan of correction should be directed to:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division 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 July 12, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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) 565-9462

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.

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

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

Nursing Home Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

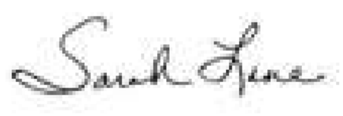
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	C 01/12/2023

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 1/12/23, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be NOT IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H54957376C (MN00089961) with deficiencies cited at F580, F690, F880. 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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		2/3/23

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

Electronically Signed | 02/01/2023

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 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 580	Immediate Corrective Action:	

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F 580	Continued From page 2 facility failed to inform the resident when a physician's appointment was changed for 1 of 1 residents (R1) reviewed for notification of change. Findings include: R1's Admission record printed 1/12/23, indicated R1's diagnoses included paraplegia (paralysis of the legs and lower body), chronic pain, injury of the thoracic spinal cord and bicep muscle, fascia and tendon strain. R1's significant change Minimum Data Set (MDS) dated 12/10/22, indicated R1 was cognitively intact, was able to understand others and make himself understood. R1's hospital interagency transfer orders dated 11/17/22, indicated R1 had a follow up appointment on 11/29/22, at 10:15 a.m. with the orthopedic surgery nurse practitioner (NP). A Care Conference form dated 11/28/22, indicated R1 was worried about transportation to a doctor appointment the following day. The form indicated nursing would work with the health unit coordinator and the information specialist to make sure a ride was secured, and they would follow up with R1. During an interview on 1/12/23, at 9:30 a.m. R1 stated he had a follow up appointment with the orthopedic surgery nurse practitioner (NP) on 11/29/22. On the morning of 11/28/22, R1 asked a nursing unit staff about a ride to the appointment and was informed the appointment was canceled by the health information assistant (HIA)-A. R1 asked HIA-A why the appointment was canceled. HIA-A told R1 she could not find a	F 580	Resident #1 has discharged from facility. Corrective Action as it applies to others: The Change in Resident s Condition or Status Policy was reviewed and remains current. All residents with current appointments will be audited to identify if any appointments have been cancelled/rescheduled without resident notification. Staff involved with setting up resident appointments and/or scheduling transport for residents appointments will be educated on notifying residents of appointments that need to be rescheduled or canceled. Date of Compliance: 2/3/23 Recurrence will be prevented by: Resident appointments and notifications will be audited weekly x3 weeks, and monthly x2 months to ensure that resident is aware of any cancellation or rescheduling of appointments. Audits and findings will be reported to QAPI committee for further recommendations.¿ Corrections will be monitored by: DON/Nurse Managers/Designee	

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F 580	Continued From page 3 ride for R1, so she canceled the appointment. R1 stated he called the orthopedic surgery office and was able to change the in person appointment to a telemedicine (over the telephone) appointment. R1 stated the appointment was time sensitive, and if he had known the facility was unable to get him a ride, he owned a van and could have arranged a ride from family. On 1/12/23, at 2:08 p.m. HIA-A stated she had to reschedule R1's orthopedic surgery follow up appointment because she was unable get ride for R1. HIA-A stated on 11/23/22, the Wednesday before Thanksgiving she canceled the appointment. When asked why she did not inform R1 of not being able to obtain a ride, HIA-A stated the rounding NP was in the facility and she had orders to do. During an interview on 1/12/23, at 2:30 p.m. with the director of nursing (DON), the DON stated R1's orthopedic surgery follow up appointment was canceled due to not being able to get R1 a ride to the appointment. The DON stated R1 should have been notified. A policy was requested and not received.	F 580		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		2/3/23

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F 690	Continued From page 4 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure catheter care was provided for 2 of 3 residents (R1, R2) reviewed for catheter care. Finding include: R1's Admission record printed 1/12/23, indicated R1's diagnoses included paraplegia (paralysis of the legs and lower body), chronic pain, bladder dysfunction, urine retention, injury of the thoracic	F 690	Immediate Corrective Action: R1 and R2 have discharged from the facility.¿ Corrective Action as it applies to others: The Catheter Care Policy was reviewed and remains current. All NAR care sheets will be updated to	

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F 690	Continued From page 5 spinal cord and bicep muscle, fascia and tendon strain. R1's significant change Minimum Data Set (MDS) dated 12/10/22, indicated R1 was cognitively intact, was able to understand others and make himself understood. The MDS indicated R1 did not have behaviors and did not reject cares. The MDS further indicated R1 needed assistance from staff with dressing, toilet use and personal hygiene. R1 had an indwelling catheter and was continent of bowel. A Foley Catheter (an indwelling urinary catheter) Evaluation dated 11/22/22, indicated R1 had a catheter in place upon admission due to being a paraplegic. Interventions included to empty each shift and as needed. R1's care plan dated 11/28/22, indicated R1 had an alteration in elimination. Interventions included R1 required the assistance of one staff with toileting, provide assistance with peri care in the morning, evening and as needed, monitor Foley catheter output, change Foley catheter per policy and catheter care per policy. R1's pocket care plan (the nursing assistants care guides) undated, directed staff to empty the Foley catheter every shift. The pocket care plan lacked direction to provide catheter care. A Care Conference form dated 11/28/22, indicated R1's significant other inquired about routine peri-care. The form indicated nursing was addressing this. Progress notes from 12/22/22, through 1/9/23, indicated the following:	F 690	reflect those residents that have indwelling catheters to help indicate that catheter cares will be needed during ADLs. All nurses and CNAs will be educated on the need to provide catheter care to any residents that have indwelling catheters and will have competencies completed with regards to routine catheter care. Date of Compliance: 2/3/23 Recurrence will be prevented by: A direct observation audit of 2 residents with catheters will be completed weekly x3 weeks, then monthly x2 months to ensure that catheter care is being completed appropriately. Audit findings will be reported to the QAPI committee for further recommendations. ¿ Corrections will be monitored by: DON/Nurse Managers/Designee	

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F 690	Continued From page 6 On 12/22/22, at 2:39 a.m. indicated R1 was alert and oriented. R1 had an indwelling catheter of which was changed today per resident request. A 16F (size) Foley catheter with 10 cubic centimeters (cc) balloon successfully inserted via sterile technique. Urine was draining. No behaviors or concerns were noted. On 12/24/22, at 5:40 a.m. indicated R1 had redness noted to the shaft of his penis. Catheter cares were performed. On 12/31/22 at 11:47 p.m. indicated R1 had an indwelling catheter. Purulent drainage was noted at the tip of his penis. A culture was collected and brought to laboratory. R1 complained of not feeling well, he was just feeling off and having hot and cold flashes. Will continue to monitor and wait on culture results. On 1/4/23, at 4:57 p.m. indicated an order for antibiotics was requested from the provider for new methicillin resistant staphylococcus aureus (MRSA, a staph infection that is difficult to treat because of resistance to some antibiotics and can spread in hospitals, other healthcare facilities and in the community). Will be expedited by another provider tomorrow since prescribing provider is out of office tomorrow. On 1/5/2023, at 11:10 p.m. a skin and wound note indicated R1 was presenting with what appears to be a catheter related pressure sore on the end of his penis. The wound is approximately three centimeters (cm) wide, 10 cm long, and two millimeters (mm) deep, with slight frank red drainage. The area was cleansed the area and a petroleum barrier layer was applied, after	F 690		

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F 690	Continued From page 7 completing peri care. The area did not appear swollen and there was no purulent drainage visible. Request in place to have R1 added to the list to be seen. On 1/7/23, at 12:55 a.m. indicated R1 had an open area on the top of his penis with scant amounts of bleeding noted. The area was cleansed and Bacitracin was applied to penis and scrotum. Dry wipes were placed to reduce friction. The area measured approximately 1.2 cm by 2.2 cm, and 0.2 cm by 0.4 cm on his penis. R1's scrotum appears to have an abrasion with no dressing noted. On 1/8/23, at 2:19 a.m. indicated peri-cares were performed and Bacitracin was applied to an open on R1's penis and scrotum. Dry wipes were used to reduce friction, and scant amounts of bleeding were noted. On 1/9/23 5:34 p.m. R1 was seen by the rounding nurse practitioner (NP) for wound to penis. Orders included to finish out the antibiotic, ulcer at the penis was mostly healed, and just needs to be protected. The NP recommended placing a bordered foam dressing around the catheter that lays over his skin to prevent further pressure. During an interview on 1/12/23, at 9:30 a.m. with R1 with his family member (FM)-A present, R1 stated he did not normally have an indwelling catheter. R1 stated when he was at home, he would straight catheterize himself. R1 stated he had been at the facility for almost a month, and was recovering from surgery on his arm. R1 stated he was supposed to be receiving catheter care, and getting his groin washed. R1 stated this was not done very often. FM-A stated R1's groin	F 690		

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F 690	Continued From page 8 and tip of his penis were red and inflamed, with a white substance coming from his penis. FM-A stated the areas were improving, but then got worse again. FM-A stated on 1/6/23, R1's urinary drainage bag was full of urine and the tubing was full of urine. FM-A stated the urine appeared cloudy with floaters. FM-A and a nursing assistant (NA) helped R1 to bed. R1 stated catheter and peri-care was "hit and miss." Some staff would provide it, depending on what they thought was best. FM-A stated on 12/31/22, registered nurse (RN)-A sampled the drainage from R1's penis and the results were MRSA. R1 also had more blisters on his penis. R1 and FM-A both expressed frustration, and stated they had told multiple staff and nothing had been done. On 1/12/23, at 10:40 a.m. R1's morning cares were observed provided by nursing assistant (NA)-A. NA-A emptied R1's urinary drainage bag into a urinal and emptied the urinal into the toilet. NA-A applied R1's socks. NA-A wet a washcloth in the bathroom and handed the washcloth to R1. R1 washed his face. NA-A used wet wipes and wiped the right side and then the left side of R1's groin. NA-A did not wash R1's penis or catheter tubing. The tip of R1's penis was wrapped with a dressing. R1 stated this was more than what usually happened. NA-A applied barrier cream to R1's groin. The tip of R1's penis was observed to be bright red. NA-A ran the catheter tube through the leg of the pants. NA-A used a wet wipe to clean R1's buttocks and applied barrier cream to R1's buttocks. NA-A placed the lift sling under R1 and pulled up R1's pants while R1 rolled from side to side. NA-A then ran out of wet wipes, and wet a washcloth and finished cleaning R1. NA-A removed R1's pants. NA-A entered the closet and picked out a clean pair of pants. NA-A then went	F 690		

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F 690	Continued From page 9 into the bathroom and retrieved a washcloth and a towel. At 11:06 a.m. NA-B entered R1's room. NA-A ran the catheter tubing through R1's pants and applied R1's pants. R1 rolled side to side, NA-A and NA-B pulled up R1's pants and adjusted the lift sling. NA-A moved the lift to the bed. NA-B put on R1's shoes. NA-B attached the sling to the lift. NA-A used the hand controls and lifted and moved R1 into the wheelchair. NA-A gave R1 a shirt. On 1/12/23, at 11:20 a.m. NA-A stated he did not have the pocket care plan with him. NA-A stated he did not use the pocket care plan because he knew the residents' cares from working at the facility for the past two weeks. NA-A stated he did not do catheter care because the nurses took care of the residents' catheters. R2's Admission record printed 1/12/23, indicated R2's diagnoses included urine retention and neuromuscular dysfunction of the bladder. R2's care plan dated 9/20/22, indicated R2 was alert and orientated. R2 had an alteration in elimination. R2 needed the assistance of one to two staff with toileting. The care plan directed to provide peri-cares in the morning, evening and as needed. Monitor Foley catheter output, change the Foley catheter per policy, and Foley catheter care per policy. R2's pocket care plan undated, indicated R2 had a catheter for bladder, and directed staff to empty every shift. The pocket care plan lacked direction to provide catheter care. On 1/12/23, at 1:38 p.m. R2 stated catheter care was rarely provided, and varied depending on the	F 690		

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F 690	Continued From page 10 staff. R2 stated catheter care was completed approximately three to four times a week. During an interview on 1/12/23, at 1:47 p.m. NA-B and NA-C were interviewed. NA-B stated catheter care was done when providing resident cares. If the pocket care plan did not direct to do catheter care, you did it anyway because that was how they were taught. NA-C stated the way they were taught for men, was retract the foreskin of the penis and clean away from the tip of the penis. During an interview with on 1/12/23, at 1:55 p.m. licensed practical nurse (LPN)-A stated the NAs were supposed to be doing peri-care and catheter cleaning care as R1 was unable to provide it himself. LPN-A further stated it was awkward for R1 to ask for peri-care and catheter care because of his younger age. During an interview on 1/12/23, at 2:30 p.m. with the director of nursing (DON), the office assistant (OA)-A, and the registered nurse consultant (RNC)-A, the DON stated catheter care was to be done as all NAs and licensed staff were trained during schooling, it was a standard of care. The DON stated catheter care should be done with cares by the NAs. The DON stated catheter care should be listed on the pocket care plans, and if it was not, it should be done as a standard of care. RNC-A stated the policy was generic, and did not state when to complete catheter care but it was a standard of practice. The DON verified R1 and R2 had catheters since admission to the facility. During an interview 1/12/23, at 2:31 p.m. NA-D stated he used the pocket care plan,. NA-D stated he emptied and, measured the urine in the drainage bag and reported the amount to the	F 690		

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F 690	Continued From page 11 nurse. NA-D was asked when and how catheter care was done. NA-D stated catheter care was done with peri-care and taking care not to pull on the catheter. The facility's Catheter Care, Urinary policy dated 9/14, directed the purpose of the procedure was to prevent catheter associated urinary tract infections. For a male resident use a washcloth with warm soap and water to cleanse around the meatus using circular strokes from the meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the same technique. Use a clean washcloth with warm water and soap to cleanse the catheter from the insertion site to approximately four inches outward.	F 690		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		2/3/23

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F 880	Continued From page 12 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 13 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper personal protective equipment (PPE) use and hand hygiene was performed for 1 of 1 residents (R1) observed during resident cares. Finding include: R1's Admission record printed 1/12/23, indicated R1's diagnoses included paraplegia (paralysis of the legs and lower body), chronic pain, bladder dysfunction, urine retention, injury of the thoracic spinal cord and bicep muscle, fascia and tendon strain. R1's significant change Minimum Data Set (MDS) dated 12/10/22, indicated R1 was cognitively intact, was able to understand others and make himself understood. R1 did not have behaviors and did not reject cares. R1 needed assistance from staff with dressing, toilet use and personal hygiene. A progress note dated 12/31/22, at 11:47 p.m. indicated R1 had an indwelling catheter. Purulent drainage was noted at the tip of his penis. A culture was collected and brought to laboratory. R1 complained of not feeling well, he was just feeling off and having hot and cold flashes. The	F 880	Immediate Corrective Action: Resident #1 has discharged from facility. NAR responsible for breach in PPE was immediately removed from floor and re-educated with competency training completed to ensure they understood the PPE process. Corrective Action as it applies to others: The Hand Hygiene Policy and Personal Protective Equipment Policy were reviewed and remain current. All staff will received education on handwashing and appropriate use of PPE utilizing return competency training. Date of Compliance: 2/3/23 Recurrence will be prevented by: Audits on hand hygiene will be completed daily on all shifts for 1 week, and then weekly until 100% compliance is demonstrated to ensure that handwashing is being completed appropriately.	

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F 880	Continued From page 14 facility would continue to monitor and wait on culture results. A progress note dated 1/4/23, at 4:57 p.m. indicated an order for antibiotics was requested from the provider for new methicillin resistant staphylococcus aureus (MRSA, a staph infection that is difficult to treat because of resistance to some antibiotics and can spread in hospitals, other healthcare facilities and in the community). 1/12/23, 9:30 a.m. a sign on R1's room door indicated R1 was on contact precautions. The sign directed everyone must clean their hands before entering and when leaving the room. Put on gloves before entry, and discard gloves before exiting the room. Put on a gown before entering the room, and discard the gown before exiting the room. Do not wear the same gloves and gown to care for more than one person. On 1/12/23, at 10:40 a.m. R1's morning cares were observed provided by nursing assistant (NA)-A. NA-A was wearing gloves, a mask and eye protection, and brought the mechanical lift into R1's room. NA-A did not donn a gown. NA-A emptied R1's urinary drainage bag into a urinal and emptied the urinal into the toilet. NA-A did not change his gloves or wash or sanitize his hands. NA-A applied R1's socks. NA-A wet a washcloth in the bathroom and handed the washcloth to R1. R1 washed his face. NA-A used wet wipes and wiped the right side and then the left side of R1's groin. NA-A applied barrier cream to R1's groin. NA-A did not change his gloves or wash or sanitize his hands. NA-A ran the catheter tube through the leg of the pants. NA-A used a wet wipe to clean R1's buttocks and applied barrier cream to R1's buttocks. NA-A did not change his	F 880	Audits on appropriate use of PPE will be completed on all shifts 4 times a week for one week, and then twice weekly until 100% compliance is demonstrated to ensure that staff at utilizing PPE appropriately. Audit findings will be reported to the QAPI committee for further recommendations. Corrections will be monitored by: DON/Designee	

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F 880	Continued From page 15	F 880		

gloves or wash or sanitize his hands. NA-A placed the lift sling under R1 and pulled up R1's pants while R1 rolled from side to side. R1 had a bowel movement. NA-A cleaned the bowel movement using wet wipes. NA-A then ran out of wet wipes. NA-A wet a washcloth and finished cleaning R1 and removed R1's pants. NA-A did not change his gloves or wash or sanitize his hands. NA-A entered the closet and picked out a clean pair of pants. NA-A then went into the bathroom and retrieved a washcloth and a towel. At 11:06 a.m. NA-B entered R1's room wearing a gown, gloves, a mask and eye protection. NA-A ran the catheter tubing through R1's pants and applied R1's pants. R1 rolled side to side and NA-A and NA-B pulled up R1's pants and adjusted the lift sling. NA-A did not change his gloves or wash or sanitize his hands. NA-A moved the over bed table, moved R1's wheelchair by the handles, moved the over bed table again and moved lift to the bed. NA-B put on R1's shoes. NA-A opened the room door with the handle, removed his gloves and exited room. NA-A did not wash or sanitize his hands. NA-A quickly went down the hall and returned with a lift battery. NA-A did not wash or sanitize his hands and donned new gloves. NA-B attached the sling to the lift. NA-A used the hand controls and lifted and moved R1 into the wheelchair. NA-A moved the lift, moved the bedding and gave R1 a shirt. NA-A did not change his gloves or wash or sanitize his hands. NA-A opened the room door with the door handle, picked up the bedding and soiled linen and then picked up the trash. NA-A moved the lift out of the room wearing the same gloves. NA-A exited the room, walked down the hall and around a corner to the linen and trash cans. After placing the linen and trash into the cans, NA-A removed his gloves. NA-A did not

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F 880	Continued From page 16 wash or sanitize his hands and applied new gloves. On 1/12/23, at 11:20 a.m. NA-A verified he did not wear a gown while caring for R1, and did not change his gloves or wash or sanitize hands as noted above. NA-A stated he usually does, but was in a hurry. During an interview on 1/12/23, at 2:30 p.m. with the director of nursing (DON), the office assistant (OA)-A, and the registered nurse consultant (RNC)-A, RNC-A stated it would be expected of staff to wear the proper PPE, change their gloves and wash or sanitize their hands appropriately to prevent the spread of infection. The facility's Handwashing/Hand Hygiene policy dated 8/19, directed the facility considered hand hygiene the primary means to prevent the spread of infections. All personnel would follow the handwashing/hand hygiene procedures to help prevent the spread of infections to residents, visitors and other personnel. Wash hands with soap and water when hands are visibly soiled and after contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella and C. difficile. The policy included hand sanitizer or soap and water should be used before and after direct contact with residents, before and after handling an invasive device such as urinary catheters, before moving from a contaminated body site to a clean body site during resident care, after contact with a resident ' s intact skin, after contact with blood or bodily fluids, after removing gloves, before and after entering isolation precaution settings, and hand hygiene was the final step after removing and disposing of	F 880		

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F 880	Continued From page 17 personal protective equipment.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 24, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: N4U211

Dear Administrator:

The above facility was surveyed on January 12, 2023 through January 12, 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.

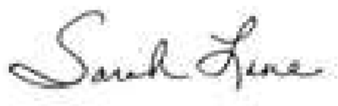
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

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

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

Please feel free to call me with any questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00299	A. BUILDING: _____ B. WING _____	C 01/12/2023

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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 1/12/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H54957376C (MN00089961) with licensing orders issued at 144.651 Subd.10, 4658.0520 Subp. 2A, 4658.0800 Subp. 3 The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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 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		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement	2 265		2/3/23

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2 265	Continued From page 2 policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to inform the resident when a physician's appointment was changed for 1 of 1 residents (R1) reviewed for notification of change.	2 265	Immediate Corrective Action: Resident #1 has discharged from facility. Corrective Action as it applies to others:	

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2 265	Continued From page 3 Findings include: R1's Admission record printed 1/12/23, indicated R1's diagnoses included paraplegia (paralysis of the legs and lower body), chronic pain, injury of the thoracic spinal cord and bicep muscle, fascia and tendon strain. R1's significant change Minimum Data Set (MDS) dated 12/10/22, indicated R1 was cognitively intact, was able to understand others and make himself understood. R1's hospital interagency transfer orders dated 11/17/22, indicated R1 had a follow up appointment on 11/29/22, at 10:15 a.m. with the orthopedic surgery nurse practitioner (NP). A Care Conference form dated 11/28/22, indicated R1 was worried about transportation to a doctor appointment the following day. The form indicated nursing would work with the health unit coordinator and the information specialist to make sure a ride was secured, and they would follow up with R1. During an interview on 1/12/23, at 9:30 a.m. R1 stated he had a follow up appointment with the orthopedic surgery nurse practitioner (NP) on 11/29/22. On the morning of 11/28/22, R1 asked a nursing unit staff about a ride to the appointment and was informed the appointment was canceled by the health information assistant (HIA)-A. R1 asked HIA-A why the appointment was canceled. HIA-A told R1 she could not find a ride for R1, so she canceled the appointment. R1 stated he called the orthopedic surgery office and was able to change the in person appointment to a telemedicine (over the telephone) appointment. R1 stated the appointment was time sensitive,	2 265	The Change in Resident s Condition or Status Policy was reviewed and remains current. All residents with current appointments will be audited to identify if any appointments have been cancelled/rescheduled without resident notification. Staff involved with setting up resident appointments and/or scheduling transport for residents appointments will be educated on notifying residents of appointments that need to be rescheduled or canceled. Date of Compliance: 2/3/23 Recurrence will be prevented by: Resident appointments and notifications will be audited weekly x3 weeks, and monthly x2 months to ensure that resident is aware of any cancellation or rescheduling of appointments. Audits and findings will be reported to QAPI committee for further recommendations.¿ Corrections will be monitored by: DON/Nurse Managers/Designee	

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2 265	Continued From page 4 and if he had known the facility was unable to get him a ride, he owned a van and could have arranged a ride from family. On 1/12/23, at 2:08 p.m. HIA-A stated she had to reschedule R1's orthopedic surgery follow up appointment because she was unable get ride for R1. HIA-A stated on 11/23/22, the Wednesday before Thanksgiving she canceled the appointment. When asked why she did not inform R1 of not being able to obtain a ride, HIA-A stated the rounding NP was in the facility and she had orders to do. During an interview on 1/12/23, at 2:30 p.m. with the director of nursing (DON), the DON stated R1's orthopedic surgery follow up appointment was canceled due to not being able to get R1 a ride to the appointment. The DON stated R1 should have been notified. A policy was requested and not received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents were informed when changes were made regarding their health care.The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all residents received proper notification of appointment changes. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 265		

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2 265	Continued From page 5 (21) days.	2 265		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure catheter care was provided for 2 of 3 residents (R1, R2) reviewed for catheter care. Finding include: R1's Admission record printed 1/12/23, indicated R1's diagnoses included paraplegia (paralysis of the legs and lower body), chronic pain, bladder dysfunction, urine retention, injury of the thoracic spinal cord and bicep muscle, fascia and tendon strain. R1's significant change Minimum Data Set (MDS) dated 12/10/22, indicated R1 was cognitively intact, was able to understand others and make himself understood. The MDS indicated R1 did not have behaviors and did not reject cares. The MDS further indicated R1 needed assistance from staff with dressing, toilet use and personal hygiene. R1 had an indwelling catheter and was continent of bowel.	2 835	Immediate Corrective Action: R1 and R2 have discharged from the facility.¿ Corrective Action as it applies to others: The Catheter Care Policy was reviewed and remains current. All NAR care sheets will be updated to reflect those residents that have indwelling catheters to help indicate that catheter cares will be needed during ADLs. All nurses and CNAs will be educated on the need to provide catheter care to any residents that have indwelling catheters and will have competencies completed with regards to routine catheter care. Date of Compliance: 2/3/23 Recurrence will be prevented by:	2/3/23

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2 835	Continued From page 6 A Foley Catheter (an indwelling urinary catheter) Evaluation dated 11/22/22, indicated R1 had a catheter in place upon admission due to being a paraplegic. Interventions included to empty each shift and as needed. R1's care plan dated 11/28/22, indicated R1 had an alteration in elimination. Interventions included R1 required the assistance of one staff with toileting, provide assistance with peri care in the morning, evening and as needed, monitor Foley catheter output, change Foley catheter per policy and catheter care per policy. R1's pocket care plan (the nursing assistants care guides) undated, directed staff to empty the Foley catheter every shift. The pocket care plan lacked direction to provide catheter care. A Care Conference form dated 11/28/22, indicated R1's significant other inquired about routine peri-care. The form indicated nursing was addressing this. Progress notes from 12/22/22, through 1/9/23, indicated the following: On 12/22/22, at 2:39 a.m. indicated R1 was alert and oriented. R1 had an indwelling catheter of which was changed today per resident request. A 16F (size) Foley catheter with 10 cubic centimeters (cc) balloon successfully inserted via sterile technique. Urine was draining. No behaviors or concerns were noted. On 12/24/22, at 5:40 a.m. indicated R1 had redness noted to the shaft of his penis. Catheter cares were performed. On 12/31/22 at 11:47 p.m. indicated R1 had an	2 835	A direct observation audit of 2 residents with catheters will be completed weekly x3 weeks, then monthly x2 months to ensure that catheter care is being completed appropriately. Audit findings will be reported to the QAPI committee for further recommendations. ¿ Corrections will be monitored by: DON/Nurse Managers/Designee	

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2 835	Continued From page 7 indwelling catheter. Purulent drainage was noted at the tip of his penis. A culture was collected and brought to laboratory. R1 complained of not feeling well, he was just feeling off and having hot and cold flashes. Will continue to monitor and wait on culture results. On 1/4/23, at 4:57 p.m. indicated an order for antibiotics was requested from the provider for new methicillin resistant staphylococcus aureus (MRSA, a staph infection that is difficult to treat because of resistance to some antibiotics and can spread in hospitals, other healthcare facilities and in the community). Will be expedited by another provider tomorrow since prescribing provider is out of office tomorrow. On 1/5/2023, at 11:10 p.m. a skin and wound note indicated R1 was presenting with what appears to be a catheter related pressure sore on the end of his penis. The wound is approximately three centimeters (cm) wide, 10 cm long, and two millimeters (mm) deep, with slight frank red drainage. The area was cleansed the area and a petroleum barrier layer was applied, after completing peri care. The area did not appear swollen and there was no purulent drainage visible. Request in place to have R1 added to the list to be seen. On 1/7/23, at 12:55 a.m. indicated R1 had an open area on the top of his penis with scant amounts of bleeding noted. The area was cleansed and Bacitracin was applied to penis and scrotum. Dry wipes were placed to reduce friction. The area measured approximately 1.2 cm by 2.2 cm, and 0.2 cm by 0.4 cm on his penis. R1's scrotum appears to have an abrasion with no dressing noted.	2 835		

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2 835	Continued From page 8 On 1/8/23, at 2:19 a.m. indicated peri-cares were performed and Bacitracin was applied to an open on R1's penis and scrotum. Dry wipes were used to reduce friction, and scant amounts of bleeding were noted. On 1/9/23 5:34 p.m. R1 was seen by the rounding nurse practitioner (NP) for wound to penis. Orders included to finish out the antibiotic, ulcer at the penis was mostly healed, and just needs to be protected. The NP recommended placing a bordered foam dressing around the catheter that lays over his skin to prevent further pressure. During an interview on 1/12/23, at 9:30 a.m. with R1 with his family member (FM)-A present, R1 stated he did not normally have an indwelling catheter. R1 stated when he was at home, he would straight catheterize himself. R1 stated he had been at the facility for almost a month, and was recovering from surgery on his arm. R1 stated he was supposed to be receiving catheter care, and getting his groin washed. R1 stated this was not done very often. FM-A stated R1's groin and tip of his penis were red and inflamed, with a white substance coming from his penis. FM-A stated the areas were improving, but then got worse again. FM-A stated on 1/6/23, R1's urinary drainage bag was full of urine and the tubing was full of urine. FM-A stated the urine appeared cloudy with floaters. FM-A and a nursing assistant (NA) helped R1 to bed. R1 stated catheter and peri-care was "hit and miss." Some staff would provide it, depending on what they thought was best. FM-A stated on 12/31/22, registered nurse (RN)-A sampled the drainage from R1's penis and the results were MRSA. R1 also had more blisters on his penis. R1 and FM-A both expressed frustration, and stated they had told multiple staff and nothing had been done.	2 835		

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2 835	Continued From page 9 On 1/12/23, at 10:40 a.m. R1's morning cares were observed provided by nursing assistant (NA)-A. NA-A emptied R1's urinary drainage bag into a urinal and emptied the urinal into the toilet. NA-A applied R1's socks. NA-A wet a washcloth in the bathroom and handed the washcloth to R1. R1 washed his face. NA-A used wet wipes and wiped the right side and then the left side of R1's groin. NA-A did not wash R1's penis or catheter tubing. The tip of R1's penis was wrapped with a dressing. R1 stated this was more than what usually happened. NA-A applied barrier cream to R1's groin. The tip of R1's penis was observed to be bright red. NA-A ran the catheter tube through the leg of the pants. NA-A used a wet wipe to clean R1's buttocks and applied barrier cream to R1's buttocks. NA-A placed the lift sling under R1 and pulled up R1's pants while R1 rolled from side to side. NA-A then ran out of wet wipes, and wet a washcloth and finished cleaning R1. NA-A removed R1's pants. NA-A entered the closet and picked out a clean pair of pants. NA-A then went into the bathroom and retrieved a washcloth and a towel. At 11:06 a.m. NA-B entered R1's room. NA-A ran the catheter tubing through R1's pants and applied R1's pants. R1 rolled side to side, NA-A and NA-B pulled up R1's pants and adjusted the lift sling. NA-A moved the lift to the bed. NA-B put on R1's shoes. NA-B attached the sling to the lift. NA-A used the hand controls and lifted and moved R1 into the wheelchair. NA-A gave R1 a shirt. On 1/12/23, at 11:20 a.m. NA-A stated he did not have the pocket care plan with him. NA-A stated he did not use the pocket care plan because he knew the residents' cares from working at the facility for the past two weeks. NA-A stated he did not do catheter care because the nurses took	2 835		

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2 835	Continued From page 10 care of the residents' catheters. R2's Admission record printed 1/12/23, indicated R2's diagnoses included urine retention and neuromuscular dysfunction of the bladder. R2's care plan dated 9/20/22, indicated R2 was alert and orientated. R2 had an alteration in elimination. R2 needed the assistance of one to two staff with toileting. The care plan directed to provide peri-cares in the morning, evening and as needed. Monitor Foley catheter output, change the Foley catheter per policy, and Foley catheter care per policy. R2's pocket care plan undated, indicated R2 had a catheter for bladder, and directed staff to empty every shift. The pocket care plan lacked direction to provide catheter care. On 1/12/23, at 1:38 p.m. R2 stated catheter care was rarely provided, and varied depending on the staff. R2 stated catheter care was completed approximately three to four times a week. During an interview on 1/12/23, at 1:47 p.m. NA-B and NA-C were interviewed. NA-B stated catheter care was done when providing resident cares. If the pocket care plan did not direct to do catheter care, you did it anyway because that was how they were taught. NA-C stated the way they were taught for men, was retract the foreskin of the penis and clean away from the tip of the penis. During an interview with on 1/12/23, at 1:55 p.m. licensed practical nurse (LPN)-A stated the NAs were supposed to be doing peri-care and catheter cleaning care as R1 was unable to provide it himself. LPN-A further stated it was awkward for R1 to ask for peri-care and catheter care because	2 835		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 835	Continued From page 11 of his younger age. During an interview on 1/12/23, at 2:30 p.m. with the director of nursing (DON), the office assistant (OA)-A, and the registered nurse consultant (RNC)-A, the DON stated catheter care was to be done as all NAs and licensed staff were trained during schooling, it was a standard of care. The DON stated catheter care should be done with cares by the NAs. The DON stated catheter care should be listed on the pocket care plans, and if it was not, it should be done as a standard of care. RNC-A stated the policy was generic, and did not state when to complete catheter care but it was a standard of practice. The DON verified R1 and R2 had catheters since admission to the facility. During an interview 1/12/23, at 2:31 p.m. NA-D stated he used the pocket care plan,. NA-D stated he emptied and, measured the urine in the drainage bag and reported the amount to the nurse. NA-D was asked when and how catheter care was done. NA-D stated catheter care was done with peri-care and taking care not to pull on the catheter. The facility's Catheter Care, Urinary policy dated 9/14, directed the purpose of the procedure was to prevent catheter associated urinary tract infections. For a male resident use a washcloth with warm soap and water to cleanse around the meatus using circular strokes from the meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the same technique. Use a clean washcloth with warm water and soap to cleanse the catheter from the insertion site to approximately four inches outward.	2 835		

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2 835	Continued From page 12 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all staff provided catheter care. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 835		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper personal protective equipment (PPE) use and hand hygiene was performed for 1 of 1 residents (R1) observed during resident cares. Finding include: R1's Admission record printed 1/12/23, indicated R1's diagnoses included paraplegia (paralysis of the legs and lower body), chronic pain, bladder	21385	Immediate Corrective Action: Resident #1 has discharged from facility. NAR responsible for breach in PPE was immediately removed from floor and re-educated with competency training completed to ensure they understood the PPE process. Corrective Action as it applies to others:	2/3/23

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21385	Continued From page 13 dysfunction, urine retention, injury of the thoracic spinal cord and bicep muscle, fascia and tendon strain. R1's significant change Minimum Data Set (MDS) dated 12/10/22, indicated R1 was cognitively intact, was able to understand others and make himself understood. R1 did not have behaviors and did not reject cares. R1 needed assistance from staff with dressing, toilet use and personal hygiene. A progress note dated 12/31/22, at 11:47 p.m. indicated R1 had an indwelling catheter. Purulent drainage was noted at the tip of his penis. A culture was collected and brought to laboratory. R1 complained of not feeling well, he was just feeling off and having hot and cold flashes. The facility would continue to monitor and wait on culture results. A progress note dated 1/4/23, at 4:57 p.m. indicated an order for antibiotics was requested from the provider for new methicillin resistant staphylococcus aureus (MRSA, a staph infection that is difficult to treat because of resistance to some antibiotics and can spread in hospitals, other healthcare facilities and in the community). 1/12/23, 9:30 a.m. a sign on R1's room door indicated R1 was on contact precautions. The sign directed everyone must clean their hands before entering and when leaving the room. Put on gloves before entry, and discard gloves before exiting the room. Put on a gown before entering the room, and discard the gown before exiting the room. Do not wear the same gloves and gown to care for more than one person. On 1/12/23, at 10:40 a.m. R1's morning cares	21385	The Hand Hygiene Policy and Personal Protective Equipment Policy were reviewed and remain current. All staff will received education on handwashing and appropriate use of PPE utilizing return competency training. Date of Compliance: 2/3/23 Recurrence will be prevented by: Audits on hand hygiene will be completed daily on all shifts for 1 week, and then weekly until 100% compliance is demonstrated to ensure that handwashing is being completed appropriately. Audits on appropriate use of PPE will be completed on all shifts 4 times a week for one week, and then twice weekly until 100% compliance is demonstrated to ensure that staff at utilizing PPE appropriately. Audit findings will be reported to the QAPI committee for further recommendations. Corrections will be monitored by: DON/Designee	

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21385	Continued From page 14 were observed provided by nursing assistant (NA)-A. NA-A was wearing gloves, a mask and eye protection, and brought the mechanical lift into R1's room. NA-A did not donn a gown. NA-A emptied R1's urinary drainage bag into a urinal and emptied the urinal into the toilet. NA-A did not change his gloves or wash or sanitize his hands. NA-A applied R1's socks. NA-A wet a washcloth in the bathroom and handed the washcloth to R1. R1 washed his face. NA-A used wet wipes and wiped the right side and then the left side of R1's groin. NA-A applied barrier cream to R1's groin. NA-A did not change his gloves or wash or sanitize his hands. NA-A ran the catheter tube through the leg of the pants. NA-A used a wet wipe to clean R1's buttocks and applied barrier cream to R1's buttocks. NA-A did not change his gloves or wash or sanitize his hands. NA-A placed the lift sling under R1 and pulled up R1's pants while R1 rolled from side to side. R1 had a bowel movement. NA-A cleaned the bowel movement using wet wipes. NA-A then ran out of wet wipes. NA-A wet a washcloth and finished cleaning R1 and removed R1's pants. NA-A did not change his gloves or wash or sanitize his hands. NA-A entered the closet and picked out a clean pair of pants. NA-A then went into the bathroom and retrieved a washcloth and a towel. At 11:06 a.m. NA-B entered R1's room wearing a gown, gloves, a mask and eye protection. NA-A ran the catheter tubing through R1's pants and applied R1's pants. R1 rolled side to side and NA-A and NA-B pulled up R1's pants and adjusted the lift sling. NA-A did not change his gloves or wash or sanitize his hands. NA-A moved the over bed table, moved R1's wheelchair by the handles, moved the over bed table again and moved lift to the bed. NA-B put on R1's shoes. NA-A opened the room door with the handle, removed his gloves and exited room.	21385		

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21385	Continued From page 15 NA-A did not wash or sanitize his hands. NA-A quickly went down the hall and returned with a lift battery. NA-A did not wash or sanitize his hands and donned new gloves. NA-B attached the sling to the lift. NA-A used the hand controls and lifted and moved R1 into the wheelchair. NA-A moved the lift, moved the bedding and gave R1 a shirt. NA-A did not change his gloves or wash or sanitize his hands. NA-A opened the room door with the door handle, picked up the bedding and soiled linen and then picked up the trash. NA-A moved the lift out of the room wearing the same gloves. NA-A exited the room, walked down the hall and around a corner to the linen and trash cans. After placing the linen and trash into the cans, NA-A removed his gloves. NA-A did not wash or sanitize his hands and applied new gloves. On 1/12/23, at 11:20 a.m. NA-A verified he did not wear a gown while caring for R1, and did not change his gloves or wash or sanitize hands as noted above. NA-A stated he usually does, but was in a hurry. During an interview on 1/12/23, at 2:30 p.m. with the director of nursing (DON), the office assistant (OA)-A, and the registered nurse consultant (RNC)-A, RNC-A stated it would be expected of staff to wear the proper PPE, change their gloves and wash or sanitize their hands appropriately to prevent the spread of infection. The facility's Handwashing/Hand Hygiene policy dated 8/19, directed the facility considered hand hygiene the primary means to prevent the spread of infections. All personnel would follow the handwashing/hand hygiene procedures to help prevent the spread of infections to residents, visitors and other personnel. Wash hands with	21385		

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21385	Continued From page 16 soap and water when hands are visibly soiled and after contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella and C. difficile. The policy included hand sanitizer or soap and water should be used before and after direct contact with residents, before and after handling an invasive device such as urinary catheters, before moving from a contaminated body site to a clean body site during resident care, after contact with a resident ' s intact skin, after contact with blood or bodily fluids, after removing gloves, before and after entering isolation precaution settings, and hand hygiene was the final step after removing and disposing of personal protective equipment. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure staff who cared for residents under precautions donned the required personal protective equipment. The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all staff followed proper hand hygiene and glove use practices. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		