MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Grand Village
923 Hale Lake Pointe
Grand Rapids
Itasca County

Report #: H5368024

Date: August 5, 2014

Date of Visit: January 29, 2014
Time of Visit: 6:00 a.m. – 2:00 p.m.

By: DeeAnn Hogenson, R.N., Special Investigator

Type of Facility: ☒ Nursing Home ☐ HHA ☐ Home Care Provider/Assisted Living
☐ SLF ☐ ICF/IID ☐ Home Care
☐ Hospital ☐ Other: _____

☒ Facility Self Report ☐ Complaint

Allegation(s): **It is alleged** that neglect occurred when staff failed to seek emergency medical attention for a resident when the resident had a change in condition. The resident declined and expired.

An unannounced visit was made at this facility and an investigation was conducted under:

☑ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☐ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☑ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☐ State Licensing Rules for Home Care (MN Rules Chapter 4668)

☐ State Licensing Rules for Home Care (MN Rules Chapter 4668)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Based on a preponderance of the evidence, neglect is substantiated. The resident was delivered gastric tube feedings while improperly positioned causing emesis and aspiration. In addition, the resident was not provided emergency medical treatment after aspirating the feeding formula.

The resident received continuous gastric tube feedings, was non-ambulatory and had difficulty expressing needs and comprehending others. The resident's physician order was to keep the head of the bed elevated to 75 degrees while tube feeding formula was being delivered. In addition, the resident could have pleasure foods orally in pureed form if assisted by staff; the resident was to be in an upright position for feeding.

The resident was placed in a Q-Foam chair to evaluate if an effective pain relief intervention. The resident was positioned in a V shape with the head up approximately 45 degrees and the thighs at approximately 80 degrees and then the knees bent as if reclining. The Q-Foam chair was sometimes used as a comfort measure for residents although, had not been used by this resident in the past. The facility did not obtain a physician's order to use the Q-Foam chair and the resident could not get out of the chair without assistance from staff.

The resident appeared comfortable in the chair and remained in the chair during dinner. The resident consumed half of a pureed meal in addition to the continuous tube feedings at 65 milliliters (ml) per hour. Staff assisted the resident several times to reposition throughout the shift because the resident slid down and became "scrunched up" in the chair. The resident remained in the chair into the night shift. The resident was in the Q-Foam chair with the tube feeding connected at the midnight check and appeared to be his/her normal self. At the 2:00 a.m. check, the resident appeared weaker and more lethargic. Sometime between the 2:00 a.m. and 4:00 a.m. checks, the resident had vomited and the resident's shirt was saturated with tube feeding formula. The nurse and nurse supervisor were notified and the resident was assisted into the bed. The resident's lungs sounded congested and the resident's pulse, blood pressure and respiratory rate were all elevated after vomiting. The resident became more lethargic, cold to touch and breathing became shallower. The employee stated the nurse supervisor was kept updated on the resident's condition. The resident's vital signs were not rechecked even though the resident's vital signs were elevated. The nursing supervisor did not notify the physician because the nurse supervisor perceived the resident to be stable.

During the shift change from nights to days; the resident was found unresponsive with labored breathing three hours after having vomited tube-feeding formula and it appeared that the resident was actively dying. The resident's family was then notified and the resident died shortly after the family was notified.

The resident's physician was interviewed regarding proper positioning of a resident to receive gastric tube feeding and stated it would be cause for concern if tube feeding was running while a resident was in the Q-Foam chair. The physician stated the position a resident would be in (head and legs elevated) could increase the intra-abdominal pressure of a resident and cause vomiting; increasing the risk for aspiration pneumonitis.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ individual(s) and/or ☒ facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility did not have a policy for the use of the Q-foam chair nor did the gastric tube feeding policy address the use of a Q-foam as it relates to positioning for gastric administration of nutrition. The facility had not provided training to the staff in the use of a Q-foam chair. Several staff had observed the resident's change in condition.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) – Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No If no, specify: _____
(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☐ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☐ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated
"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records
☐ Medication Administration Records
☒ Facility Incident Reports
☐ ADL (Activities of Daily Living) Flow Sheets
☒ Physician Orders
☒ Nurses Notes
☐ Activities Reports
☐ Therapy and/or Ancillary Services Records
☐ Skin Assessments
☒ Care Guide
☐ Treatment Sheets
☒ Physician Progress Notes
☐ Laboratory and X-ray Reports
☐ Social Service Notes
☐ Meal Intake Records
☐ Weight Records
☒ Assessments
☒ Care Plan Records

Other pertinent medical records:

☐ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☒ Death Certificate
☐ Police Report

Additional facility records:

☐ Resident/Family Council Minutes
☒ Staff Time Sheets, Schedules, etc.
☒ Facility Internal Investigation Reports
☐ Call Light Audits
☒ Personnel Records/Background Check, etc.
☒ Facility In-service Records
☒ Facility Policies and Procedures
☐ Other, specify: _____

Number of additional resident(s) reviewed: 1

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ◉ Yes ○ No ○ N/A Specify: _____

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation: ○ Yes ◉ No ○ N/A Specify: Expired

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 3

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: _____

Physician interviewed: ◉ Yes ○ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ○ Yes , date subpoena was issued _____ ○ No

Were contacts made with any of the following:
☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☒ Other: Specify Medical Director

Observations were conducted related to:

☐ Wound Care ☒ Medication Pass ☐ Meals

☐ Personal Care ☒ Dignity/Privacy Issues ☐ Restorative Care

☒ Nursing Services ☐ Safety Issues ☐ Facility Tour

☐ Infection Control ☐ Cleanliness ☐ Injury

☒ Use of Equipment ☐ Transfers ☐ Incontinence

☐ Call Light ☐ Other: _____

Was any involved equipment inspected: ◉ Yes ○ No ○ N/A

Was equipment being operated in safe manner: ◉ Yes ○ No ○ N/A

Were photographs taken: ◉ Yes ○ No Specify: _____

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administrators
Minnesota Board of Nursing
Grand Rapids City Attorney
Grand Rapids Police Department
Itasca County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 04/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted on February 24, 2014 to investigate case #H5368024. As a result, the following deficiencies are issued.	F 000	The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157	**F157 – SS G** **Notification of changes.** **Grand Village adheres to the requirement as follows; must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is--** **(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;**	

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shawna Johnson — TITLE: Executive Director — (X6) DATE: 5/16/14

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excluded from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued am participation.

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F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the physician of a change in condition for 1 of 3 residents (R1) who had developed an increase in heart rate, respirations, blood pressure and lung congestion after vomiting. Actual harm occurred as the resident continued to decline and died three and a half hours later without the physician being notified of the change. Findings include: R1's record of admission dated 1/1/2014 established R1 had diagnoses that included: craniotomy, intracerebral hemorrhage, hemiparesis, encephalopathy and dysphasia. R1 had difficulty expressing needs, required assist of two and a mechanical lift for transfers, and assist of one to two for all areas of dressing, bathing and grooming. R1 received nutrition via gastric (G)-tube however, could have some foods orally for pleasure if assisted by staff. The short term care plan dated 1/5/2014	F 157	**(B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);** **(C) A need to alter treatment significantly (i.e., 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 §483.12(a).** **(ii) The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is--** **(A) A change in room or roommate assignment as specified in §483.15(e)(2); or** **(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.**	

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F 157	Continued From page 2 identified interventions for tube feeding that included: continuous tube feeding at 65 milliliters (ml) per hour, head of bed elevated to 75 degrees, check placement of G-tube prior to administration, respiratory monitoring and notify physician with concerns. The interdisciplinary progress (IDP) notes dated 1/10/2014 at 4:58 a.m. provided information that R1 had a change in condition when staff found R1 with liquid tube feeding saturating R1's shirt and neck at approximately 3:30 a.m. on 1/10/2014. Licensed practical nurse (LPN)-E documented it appeared R1 had "fluid overload." R1's lung sounds were congested and R1's heart rate (104), respirations (36) and blood pressure (153/90) were all elevated. LPN-E documented registered nurse (RN)-D was notified however; documented she would observe R1 and apprise day shift of the change in condition. LPN-E was interviewed on 2/12/2014 at 2:45 p.m. and established on 1/10/2014 at approximately 3:30 a.m. the feeding tube was hooked up properly to R1 and the pump was working properly as well. LPN-E verified R1 had appeared to have had projectile vomiting with tube feeding saturating the front of his shirt. In addition, LPN-E verified R1's heart rate, respirations and blood pressure were elevated. LPN-E stated R1 was not responsive however, she did not realize this was a change for R1 because she did not know R1's baseline. LPN-E confirmed she did not notify the physician and thought the RN supervisor would do that.	F 157	**(iii) The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.** 1. Corrective Action: A. Staff who provided cares for Resident #1 were interviewed through established process. B. The DON determined staff responsible for reporting change in condition, (RN)-D, in the care of Resident # 1 did have previous education on 11/9/12, 2/9/13, 3/16/13, 4/27/13, 5/17/13, 6/4/13, 7/30/13 and 12/11/13 in relationship to notification of change in condition requirements. C. DON determined through interview the RN responsible at the time of the condition change independently chose not to follow established protocol for documented condition change for Resident #1 despite education and standards for which a prudent RN would have adhered to as a licensed RN in the State of MN.	

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F 157	Continued From page 3 On 2/13/2014 at 2:45 p.m. RN-D was interviewed and stated she had been called to R1's room by LPN-E at 3:35 a.m. on 1/10/2014 and found R1 with tube feeding material on the front of R1's shirt and that "the shirt was pretty wet." RN-D verified R1's heart rate, respirations and blood pressure were elevated as well as having congested lung sounds. RN-D stated she did not notify the physician of R1's change in condition because she felt R1 was stable. On 1/10/2014, LPN-I documented that R1 had a significant change on the night shift with an episode of emesis. R1 showed signs of mottling and a change in skin color. LPN-I recorded R1 had died at 6:55 a.m. on 1/10/2014. On 1/29/2014 at 10:00 a.m. R1's physician was interviewed and stated he was not notified that R1 had a change in condition although was informed that he died. The facility policy titled Change of Condition dated 10/2012 directed staff to report immediately to the physician; if the resident experiences a significant change in heart rate, respirations, blood pressure from the resident's normal limits and had been monitored for 8-24 hours with no improvement. In addition, the policy directed staff to notify the physician immediately with any significant change in condition as determined by a licensed nurse.	F 157	2. Corrective Action as it applies to Other Residents: A. The policy/procedure for condition change and reporting was reviewed post incident and determined to be sufficient. B. The policy/procedure was shared with facility staff on 12/11/13 and again post incident on 01/17/14 and again 05/13/2014 3. Date of Completion: 5/31/14 4. Reoccurrence will be Prevented by: A. Staff education on the policy/procedure and reporting on 1/17/14 and 05/13/2014, upon hire, annually, and as needed. B. Review of condition change by IDT at morning stand up meetings Monday through Friday. C. Registered Nurse (RN)-D was suspended post-incident pending internal investigation on 1/13/14 and employment with Grand Village concluded on 1/17/14. 5. The Correction will be Monitored by: A. DON, CCC & QC or designee.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of	F 221		

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F 221	Continued From page 4 discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure restraints were not used and did not provide the least restrictive device for the shortest amount of time for 1 of 3 residents (R1) when R1 was placed in a Q-foam chair for several hours. R1 could not get out of the chair unassisted. Findings include: R1's record of admission dated 1/1/2014 established R1 had diagnoses that included: craniotomy, intracerebral hemorrhage, hemiparesis, encephalopathy and dysphasia. R1 had difficulty expressing needs, required assist of two and a mechanical lift for transfers, and assist of one to two for all areas of dressing, bathing and grooming. The short term care plan dated 1/5/2014 identified R1 required assist of two staff and the use of a mechanical lift for all transfers. R1 was non-ambulatory and had difficulty with spoken language expression and comprehension. On 1/29/2014 at 7:05 a.m. nurse manager (NM)-C was interviewed and stated R1 had fallen from bed during the night on 1/9/2014 and would frequently try to get out bed and would yell "help me, help me." NM- C established R1 had a long history of having pain and in an effort to provide comfort; she had asked the staff to place R1 in a Q-foam chair for evaluation. She stated the	F 221	B. DON will report summary of condition change to QAPI Committee. **F221 SS – D** **Grand Village adheres to the requirement as follows;** **§483.13(a) Restraints** **The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.** **Intent §483.13(a)** The intent of this requirement is for each person to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical	

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F 221	Continued From page 5 Q-foam chair is often used for comfort measures and she was evaluating R1 for appropriateness of using the chair. She stated the Q-foam chair placed R1 in a V shape with head and thighs elevated and determined the chair was not appropriate for R1 and directed the staff to remove R1 from the chair. NM-C did not verify R1 was removed from the chair. R1 was not able to get out of the Q-foam chair unassisted and no physician order was obtained to use the chair. Nursing Assistant (NA)-J was interviewed on 1/29/2014 at 2:00 p.m. and stated she had never worked with that type of chair before and had not been trained how to use it. NA-J stated on 1/9/2014 at approximately 4:30 p.m. R1 was assisted into the chair and remained in the chair through the evening meal. Later on the evening shift NA-J saw R1 sleeping in the chair and appeared comfortable so she requested permission from the "Bridge nurse" to allow R1 to remain in it. NA-J stated R1 was not removed from the chair during that time. NA-J stated although R1 could not use the call light for assistance; R1 was assisted several times to reposition throughout the shift because he slid down and became "scrunched up" in the chair. NA-J stated R1 stayed in the chair throughout the afternoon shift and she reported to the night shift that R1 was sleeping in the chair. On 2/13/2014 at 10:40 a.m. LPN-H was interviewed and stated R1 was in the Q-foam chair in his room when she started her shift at 2:00 p.m.. LPN-H stated the chair placed R1 in a V position and he could not get out of the chair. LPN-H did not check for a physician's order or establish monitoring documentation for the use of the device.	F 221	symptoms that warrant the use of restraints. **Interpretive Guidelines §483.13(a)** **Definitions of Terms** "Physical Restraints" are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. 1. Corrective Action: A. Staff who placed Resident #1 in a Q-Foam chair were interviewed through established process. B. The DON determined staff involved in the care of Resident # 1, Nurse Manager (RN)-C did have previous education on 3/4/11, 10/1/12, 2/1/13, 5/2/13 and 5/9/13 in relationship to functional assessment, which includes positioning, the use of special equipment and devices up to and including restraints.	

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F 221	Continued From page 6 LPN-E was interviewed on 2/12/2014 at 2:45 p.m. and established that R1 was in the Q-foam chair positioned with his head up and legs up and was in a V shape position when the night shift started on 1/10/2014. LPN-E stated R1 was assisted to bed by two nursing assistants and a mechanical lift at approximately 3:30 a.m. R1 was restrained in the device for approximately 12 hours. The director of nursing was unavailable for interview during the onsite visit. The facility Restraint Policy dated April 2014 established restraints would not be used as a means to control behavior, or maintain a resident with the least amount of effort. When a restraint is used, consultation with appropriate health professionals , such as OT and PT, will occur and be documented. The policy defined a physical restraint as; placing a resident in a chair that prevents rising. In addition, the policy directed that a physician's order would be obtained, staff would receive training for the device, the restraint would be used for the least amount of time, released every two hours and the resident would be repositioned.	F 221	C. DON determined through interview the RN responsible at the time of implementation of a physical restraint (Q-foam chair) chose not to follow established protocol for use of a specialty positioning device/physical restraint (Q-foam chair) for Resident #1 despite education and standards for which a prudent RN would have adhered to as a licensed RN in the State of MN. 2. Corrective Action as it applies to Other Residents: A. The policy/procedure for functional assessment which includes any positioning / safety devises with potential for restraint was reviewed post-incident and found to be sufficient. B. The policy/procedure was shared with facility staff in 2/2014 and again 05/13/2014. 3. Date of Completion: 5/31/14 4. Reoccurrence will be Prevented by: A. Staff education on the policy/procedure and functional assessment 05/13/2014, and	
F 322 SS=G	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was	F 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	C 04/21/2014

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F 322	Continued From page 7 unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide proper positioning to receive tube feedings for 1 of 2 residents (R1) reviewed for gastric feeding. R1 was positioned in a V shape (head up and legs elevated) that increased intra-abdominal pressure causing R1 to vomit and aspirate liquid tube feeding. This resulted in actual harm when R1 experienced respiratory distress and died. Findings include: R1's record of admission dated 1/1/2014 established R1 had diagnoses that included: craniotomy, Intra-cerebral hemorrhage, hemiparesis, encephalopathy and dysphagia. R1 had difficulty expressing needs, required assist of two and a mechanical lift for transfers, and assist of one to two for all areas of dressing, bathing and grooming. R1 received nutrition via gastric (G)-tube however, could have some pureed foods orally for pleasure if assisted by staff.	F 322	upon hire, annually, and as needed. B. Review of functional assessment will be conducted prior to and/or at admission. Comprehensive functional assessment will be completed within 14 days of admission, at the initial care conference an IDT review of the functional assessment will be reviewed and revisions with focus on assistive devices and accident prevention. IDT will review all with restraint order at morning stand up meetings Monday through Friday. 5. The Correction will be Monitored by: A. DON, MDS Nurses & QC or designee. B. DON will report summary of condition change to QAPI Committee. **F322 – SS G** **Notification of changes.** **Grand Village adheres to the requirement as follows;** **A resident who is fed by gastrostomy tube receives**	

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F 322	Continued From page 8 The short term care plan dated 1/5/2014 identified interventions for tube feeding that included: continuous tube feeding at 65 milliliters (ml) per hour, head of bed elevated to 75 degrees, check placement of G-tube prior to administration, respiratory monitoring and notify physician with concerns. On 1/29/2014 at 7:05 a.m. nurse manager (NM)-C was interviewed and stated R1 had a long history of having pain and in an effort to provide comfort she had asked the staff on 1/9/2014 at approximately 3:00 p.m. to place R1 in a Q-foam chair for evaluation. She stated the resident was situated in the chair by staff which positioned the resident in a V shape with head up approximately 45 degrees and thighs at approximately 80 degrees and then the knees bent as if reclining. NM-C stated the Q-Foam chair is often used for comfort measures and she was evaluating R1 for appropriateness of using the chair. NM-C determined the chair was not appropriate for R1 and directed the staff to remove R1 from the chair. NM-C did not verify that staff had removed R1 from the Q-Foam chair. R1 was not able to get out of the Q-foam chair unassisted and no physician order was obtained to use the chair. NM-C stated although the Q-foam chair elevates the resident's head approximately 45 degrees, it cannot be raised higher and she would never recommend running tube feeding while a resident was in the Q-foam chair. The facility's Medical Director was interviewed on 1/29/2014 at 10:08 a.m. and stated the Q-foam chair was often used for comfort however, would cause concern if tube feeding was running while	F 322	**the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.** Complications in tube feeding are not necessarily the result of improper care, but assessment for the potential for complications and care and treatment are provided to prevent complications in tube feeding by the facility. 1. Corrective Action: A. Staff who assisted Resident #1 with nutrition needs were interviewed through established process. B. The DON determined staff involved in the care of Resident # 1 did have previous education in relationship to gastrostomy tube feeding and care in 12/2013 . C. DON determined through interview the RN responsible at the time of implementation of a Q-foam chair chose not to conduct a proper functional	

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F 322	Continued From page 9 a resident was in the chair. The Medical Director stated the position a resident would be in (head and legs elevated) could increase the intra-abdominal pressure of a resident and cause vomiting; increasing the risk for aspiration pneumonitis. Nursing Assistant (NA)-J was interviewed on 1/29/2014 at 2:00 p.m. and stated she had never worked with that type of chair before and had not been trained how to use it. NA-J stated that on 1/9/2014 at approximately 4:30 p.m. she and another NA had used a mechanical lift and placed R1 in the Q-Foam chair. NA-J stated R1 remained in the Q-Foam chair during dinner and the resident consumed half of a pureed meal in addition to the continuous tube feedings at 65 ml per hour. NA-J stated R1 had fallen asleep in the chair so she requested permission from the "Bridge nurse" to allow R1 to remain in it. NA-J stated although the resident could not use the call light for assistance; the resident was assisted several times to reposition throughout the shift because the resident slid down and became "scrunched up" in the chair. NA-J stated R1 stayed in the chair throughout the afternoon shift and she reported to the night shift that R1 was sleeping in the chair. NA-J stated R1 had the tube feeding hooked up and running the whole time R1 was in the Q-foam chair On 2/13/2014 at 10:40 a.m. Licensed Practical Nurse (LPN)-H was interviewed and stated R1 was in the Q-foam chair in his room with the tube feeding running when she started her shift at 2:00 p.m. on 1/9/2014. LPN-H stated R1's head was elevated as it should be when the tube feeding was running and didn't think it mattered that R1's legs were elevated; placing R1 in a V position.	F 322	safety assessment per facility policy and procedure despite education given on 3/4/11, 10/1/12, 2/1/13, 5/2/13 and 5/9/13 or follow specific provider orders for positioning during G-tube nutrition administration for Resident #1 despite education given on 11/22/13 regarding Provider Order Procedure and standards of practice a prudent RN would adhere to as a licensed RN in the State of MN. 2. Corrective Action as it applies to Other Residents: A. The existing clinical procedure and documentation for enteral tube feedings with safety and clinical alerts to manage potential for negative outcomes was reviewed 01/2014. B. The clinical procedure was again shared with facility staff on 01/29/2014 and 05/13/2014. C. The policy and procedure regarding the Functional Assessment was distributed as education in 2/2014. 3. Date of Completion: 5/31/14 4. Reoccurrence will be Prevented by:	

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F 322	Continued From page 10 LPN-H stated she checked for proper placement of the G-tube prior to administering medication to R1 however; did not check for residual tube feeding. NA-K was interviewed on 1/29/2014 at 6:15 a.m., and stated the resident was in the Q-Foam chair with the tube feeding connected at the midnight check on 1/10/2014 and appeared to be normal self. However, at the 2:00 a.m. check appeared weaker and more lethargic. NA-K stated somewhere between the 2:00 a.m. and 4:00 a.m. checks, R1 had vomited and his/her shirt was saturated with tube feeding formula. NA-K stated the nurse and nurse supervisor were notified and R1 was assisted into the bed. The interdisciplinary progress (IDP) notes dated 1/10/2014 at 4:58 a.m. provided information that R1 had a change in condition when staff found R1 at approximately 3:30 a.m. with liquid tube feeding saturating R1's shirt and neck. Licensed practical nurse (LPN)-E documented it appeared R1 had "fluid overload." R1's lung sounds were congested and R1's heart rate (104), respirations (36) and blood pressure (153/90) were all elevated. LPN-E documented the tube feeding was discontinued and the head of the bed was raised to 30 degrees. The note did not mention the use of the Q-foam chair. LPN-E documented registered nurse (RN)-C was notified and would continue to observe R1 and apprise day shift staff of the condition change. LPN-E was interviewed on 2/12/2014 at 2:45 p.m. and established that R1 was in the Q-foam chair; positioned with head up and thighs up and was in a V shape position. LPN-E stated the feeding tube was hooked up properly to R1 and the pump	F 322	A. Staff education on the Eighth Edition of Clinical Skills 05/13/2014, and upon hire, annually, and as needed. a. Review of skilled assessment will be conducted prior to and/or at admission. So the resident is receiving therapy to improve or enhance swallowing skills, as need, and is identified in the comprehensive assessment. b. Dietitian consultation recommendations will be followed. All staff responsibilities for providing enteral feedings will be clearly assigned (i.e., who administers the feeding, formula, amount, feeding intervals, flow rate). c. All staff monitor feeding complications (e.g., diarrhea, gastric distension, aspiration) and administer corrective actions to allay complications (e.g., changing rate of formula administration). Clinical monitoring will include observations for negative consequences of tube use (e.g., agitation, depression, self-extubation, infections, aspiration and restraint use without a medical reason for	

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F 322	Continued From page 11 was working properly as well. LPN-E verified R1 had appeared to have had projectile vomiting with tube feeding saturating the front of the shirt. In addition, LPN-E verified R1's heart rate, respirations and blood pressure were elevated at that time and R1 was not responsive however, she did not realize this was a change for R1 because she did not know R1's baseline. LPN-E confirmed she did not notify the physician and thought the RN Supervisor would do that. On 2/13/2014 at 2:45 p.m. RN-D was interviewed and stated she had been called to R1's room by LPN-E at 3:35 a.m. on 1/10/2014 and found R1 with tube feeding material on the front of R1's shirt and that "the shirt was pretty wet." RN-D verified R1's heart rate, respirations and blood pressure were elevated as well as having congested lung sounds. RN-D stated she did not notify the physician of R1's change in condition because she felt R1 was stable. On 1/10/2014, LPN-I documented that R1 had a significant change on the night shift with an episode of emesis. R1 showed signs of mottling and a change in skin color. LPN-I was interviewed on 4/18/2014 at 1:13 p.m. and stated she called R1's family right away but did not call the physician or emergency response; she assumed the physician had already been notified per facility policy. R1 died shortly after the family was notified. LPN-I recorded R1 had died at 6:55 a.m. on 1/10/2014. The director of nursing was unavailable for interview during the onsite visit. On 1/29/2014 at 9:45 a.m. the facility administrator stated there is no policy related to the use of the Q-foam chair and tube feeding.	F 322	the restraint). Checking for correct tube placement prior to beginning a feeding or administering medications and after episodes of vomiting or suctioning. Checking a resident with a newly inserted gastric tube for gastric residual volume every 2-4 hours until the resident has demonstrated an ability to empty his/her stomach. Proper elevation the resident's head; 30 – 45° degrees unless specific to provider order. Provide the type, rate and volume of the feeding as provider ordered. Using universal precautions and clean technique as per clinical procedures with directions when stopping, starting, flushing, and giving medications through the tube. Using hang time recommendations by the manufacturer to prevent excessive microbial growth; procedures to ensure cleanliness of supplies, e.g. irrigating syringes changed every 24 hours & PRN.	

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			B. Nurse Manager (RN)-C's last day worked at Grand Village was 3/8/14. 5. The Correction will be Monitored by: A. DON, CCC Nurses & QC or designee. B. DON will report summary of condition change to QAPI Committee.	

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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: A complaint investigation was conducted to investigate complaint #H5368024. The following correction orders are issued: When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health,	2 000	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.	

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2 000	Continued From page 1 Division of Compliance Monitoring, Office of Health Facility Complaints; 85 East Seventh Place, Suite 220, St. Paul, Minnesota, 55164-0970.	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement 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	2 265		

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2 265	Continued From page 2 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 record review the facility failed to notify the physician of a change in condition for 1 of 3 residents (R1) who had an increase in heart rate, respirations, blood pressure and congested lung sounds after vomiting tube feeding. R1 died three and half hours after having a change in condition. Findings include: R1's record of admission dated 1/1/2014	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 265	Continued From page 3	2 265		

established R1 had diagnoses that included: craniotomy, intracerebral hemorrhage, hemiparesis, encephalopathy and dysphagia. R1 had difficulty expressing needs, required assist of two and a mechanical lift for transfers, and assist of one to two for all areas of dressing, bathing and grooming. R1 received nutrition via gastric (G)-tube however, could have some foods orally for pleasure if assisted by staff.

The short term care plan dated 1/5/2014 identified interventions for tube feeding that included: continuous tube feeding at 65 milliliters (ml) per hour, head of bed elevated to 75 degrees, check placement of G-tube prior to administration, respiratory monitoring and notify physician with concerns.

The interdisciplinary progress (IDP) notes dated 1/10/2014 at 4:58 a.m. provided information that R1 had a change in condition when staff found R1 with liquid tube feeding saturating R1's shirt and neck. Licensed practical nurse (LPN)-E documented it appeared R1 had "fluid overload." R1's lung sounds were congested and R1's heart rate (104), respirations (36) and blood pressure (153/90) were all elevated. LPN-E documented registered nurse (RN)-D was notified however; did not identify notification of the physician. In addition, there was no further documentation of ongoing monitoring of R1's condition.

LPN-E was interviewed on 2/12/2014 at 2:45 p.m. and established the feeding tube was hooked up properly to R1 and the pump was working properly as well. LPN-E verified R1 had appeared to have had projectile vomit with tube feeding

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2 265	Continued From page 4 saturating the front of his shirt. In addition, LPN-E verified R1's heart rate, respirations and blood pressure were elevated. LPN-E stated R1 was not responsive however, she did not realize this was a change for R1 because she did not know R1's baseline. LPN-E confirmed she did not notify the physician. On 2/13/2014 at 2:45 p.m. RN-D was interviewed and stated she had been called to R1's room by another nurse at 3:35 a.m. on 1/10/2014 and found R1 with tube feeding material on the front of R1's shirt and that "the shirt was pretty wet." RN-D verified R1's heart rate, respirations and blood pressure were elevated as well as having congested lung sounds. RN-D stated she did not notify the physician of R1's change in condition. On 1/10/2014, LPN-I documented that R1 had a significant change on the night shift with an episode of emesis. R1 showed signs of mottling and a change in skin color. LPN-I recorded R1 had died at 6:55 a.m. on 1/10/2014. The facility policy titled Change of Condition dated 10/2012 directed staff to report immediately to the physician; if the resident experiences a significant change in heart rate, respirations, blood pressure from the resident's normal limits and had been monitored for 8-24 hours with no improvement. In addition, the policy directed staff to notify the physician immediately with any significant change in condition as determined by a licensed nurse.	2 265		

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2 265	Continued From page 5 TIME PERIOD FOR CORRECTION: THIRTY (30) DAYS	2 265		
2 510	MN Rule 4658.0300 Subp. 2 Use of Restraints Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure restraints were not used and did not provide the least restrictive device for the shortest amount of time for 1 of 3 residents (R1) when R1 was placed in a Q-foam chair for several hours. R1 could not get out of the chair unassisted. Findings include: R1's record of admission dated 1/1/2014 established R1 had diagnoses that included: craniotomy, intracerebral hemorrhage, hemiparesis, encephalopathy and dysphasia. R1 had difficulty expressing needs, required assist of two and a mechanical lift for transfers, and assist of one to two for all areas of dressing, bathing and grooming. The short term care plan dated 1/5/2014 identified R1 required assist of two staff and the use of a mechanical lift for all transfers. R1 was non-ambulatory and had difficulty with spoken language expression and comprehension.	2 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 04/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

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2 510	Continued From page 6 On 1/29/2014 at 7:05 a.m. nurse manager (NM)-C was interviewed and stated R1 had fallen from bed and would frequently try to get out bed and would yell "help me, help me." NM- C established R1 had a long history of having pain and in an effort to provide comfort; she had asked the staff to place R1 in a Q-foam chair for evaluation. She stated the Q-foam chair is often used for comfort measures and she was evaluating R1 for appropriateness of using the chair. She stated the Q-foam chair placed R1 in a V shape with head and thighs elevated and determined the chair was not appropriate for R1 and directed the staff to remove R1 from the chair. R1 was not able to get out of the Q-foam chair unassisted and no physician order was obtained to use the chair. Nursing Assistant (NA)-J was interviewed on 1/29/2014 at 2:00 p.m. and stated she had never worked with that type of chair before and had not been trained how to use it. NA-J stated R1 was sleeping in the chair and appeared comfortable so she requested permission from the "Bridge nurse" to allow R1 to remain in it. NA-J stated R1 stayed in the chair throughout the afternoon shift and she reported to the night shift that R1 was sleeping in the chair. On 2/13/2014 at 10:40 a.m. LPN-H was interviewed and stated R1 was in the Q-foam chair in his room when she started her shift at 2:00 p.m.. LPN-H stated the chair placed R1 in a V position and he could not get out of the chair. LPN-H did not check for a physician's order or establish monitoring documentation for the use of the device. LPN-E was interviewed on 2/12/2014 at 2:45 p.m.	2 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 04/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 510	Continued From page 7 and established that R1 was in the Q-foam chair positioned with his head up and legs up and was in a V shape position when the night shift started on 1/10/2014. LPN-E stated R1 was assisted to bed by two nursing assistants and a mechanical lift at approximately 3:30 a.m. R1 was restrained in the device for approximately 12 hours. The facility Restraint Policy dated April 2014 established restraints would not be used as a means to control behavior, or maintain a resident with the least amount of effort. When a restraint is used, consultation with appropriate health professionals , such as OT and PT, will occur and be documented. The policy defined a physical restraint as; placing a resident in a chair that prevents rising. In addition, the policy directed that a physician's order would be obtained, staff would receive training for the device, the restraint would be used for the least amount of time, released every two hours and the resident would be repositioned. TIME PERIOD FOR CORRECTION: THIRTY (30) DAYS	2 510		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the	2 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 930	Continued From page 8 appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to provide proper positioning to receive tube feedings for 1 of 2 residents (R1) reviewed for gastric feeding. R1 was positioned in a V shape (head up and legs elevated) that increased intra-abdominal pressure causing R1 to vomit liquid tube feeding resulting in respiratory distress. Findings include: R1's record of admission dated 1/1/2014 established R1 had diagnoses that included: craniotomy, intracerebral hemorrhage, hemiparesis, encephalopathy and dysphagia. R1 had difficulty expressing needs, required assist of two and a mechanical lift for transfers, and assist of one to two for all areas of dressing, bathing and grooming. R1 received nutrition via gastric (G)-tube however, could have some foods orally for pleasure if assisted by staff. The short term care plan dated 1/5/2014 identified interventions for tube feeding that included: continuous tube feeding at 65 milliliters (ml) per hour, head of bed elevated to 75 degrees, check placement of G-tube prior to administration, respiratory monitoring and notify physician with concerns.	2 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	C 04/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 930	Continued From page 9 On 1/29/2014 at 7:05 a.m. nurse manager (NM)-C was interviewed and stated R1 had a long history of having pain and in an effort to provide comfort she had asked the staff to place R1 in a Q-foam chair for evaluation. She stated the Q-foam chair is often used for comfort measures and she was evaluating R1 for appropriateness of using the chair. She stated the Q-foam chair placed R1 in a V shape with head and thighs elevated and determined the chair was not appropriate for R1 and directed the staff to remove R1 from the chair. R1 was not able to get out of the Q-foam chair unassisted and no physician order was obtained to use the chair. NM-C stated although the Q-foam chair elevates the residents' head approximately 45 degrees, it cannot be raised higher and she would never recommend running tube feeding while a resident was in the Q-foam chair. Nursing Assistant (NA)-J was interviewed on 1/29/2014 at 2:00 p.m. and stated she had never worked with that type of chair before and had not been trained how to use it. NA-J stated R1 was sleeping in the chair so she requested permission from the "Bridge nurse" to allow R1 to remain in it. NA-J stated R1 stayed in the chair throughout the afternoon shift and she reported to the night shift that R1 was sleeping in the chair. NA-J stated R1 had the tube feeding hooked up and running the whole time R1 was in the Q-foam chair during her shift. NA-J did not know who had hooked up the tube feeding. On 2/13/2014 at 10:40 a.m. LPN-H was interviewed and stated R1 was in the Q-foam chair in his room with the tube feeding running when she started her shift at 2:00 p.m. on 1/10/2014. LPN-H stated R1's head was elevated	2 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 930	Continued From page 10 as it should be when the tube feeding was running and didn't think it mattered that R1's legs were elevated; placing R1 in a V position. LPN-H stated she checked for proper placement of the G-tube prior to administering medication to R1 however; did not check for residual tube feeding. The interdisciplinary progress (IDP) notes dated 1/10/2014 at 4:58 a.m. provided information that R1 had a change in condition when staff found R1 with liquid tube feeding saturating R1's shirt and neck. Licensed practical nurse (LPN)-E documented it appeared R1 had "fluid overload." R1's lung sounds were congested and R1's heart rate (104), respirations (36) and blood pressure (153/90) were all elevated. LPN-E documented the tube feeding was discontinued and the head of the bed was raised to 30 degrees. The note did not mention the use of the Q-foam chair. LPN-E documented registered nurse (RN)-C was notified however; did not identify notification of the physician. LPN-E was interviewed on 2/12/2014 at 2:45 p.m. and established that R1 was in the Q-foam chair positioned with his head up and legs up and was in a V shape position. LPN-E stated the feeding tube was hooked up properly to R1 and the pump was working properly as well. LPN-E verified R1 had appeared to have had projectile vomit with tube feeding saturating the front of his shirt. In addition, LPN-E verified R1's heart rate, respirations and blood pressure were elevated at that time and R1 was not responsive however, she did not realize this was a change for R1 because she did not know R1's baseline. LPN-E confirmed she did not notify the physician. On 2/13/2014 at 2:45 p.m. RN-D was interviewed	2 930		

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2 930	Continued From page 11 and stated she had been called to R1's room by another nurse at 3:35 a.m. on 1/10/2014 and found R1 with tube feeding material on the front of R1's shirt and that "the shirt was pretty wet." RN-D verified R1's heart rate, respirations and blood pressure were elevated as well as having congested lung sounds. RN-D stated she did not notify the physician of R1's change in condition. On 1/10/2014, LPN-I documented that R1 had a significant change on the night shift with an episode of emesis. R1 showed signs of mottling and a change in skin color. LPN-I recorded R1 had died at 6:55 a.m. on 1/10/2014. The facility's Medical Director was interviewed on 1/29/2014 at 10:08 a.m. and stated the Q-foam chair was often used for comfort however, would cause concern if tube feeding was running while a resident was in the chair. The Medical Director stated the position a resident would be in (head and legs elevated) could increase the intra-abdominal pressure of a resident and cause vomiting; increasing the risk for aspiration pneumonitis. On 1/29/2014 at 9:45 a.m. the facility administrator stated there is no policy related to the use of the Q-foam chair and tube feeding. TIME PERIOD FOR CORRECTION: THIRTY (30) DAYS	2 930		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Post Correction Order Follow-Up/Federal Certification Review Report
PUBLIC DATA

Facility:
Grand Village
923 Hale Lake Pointe
Grand Rapids, MN 55744
Itasca County

Report #: H5368024

Date: June 12, 2014

Date of Visit: June 9, 2014
Time of Visit: 1:20 p.m.

By: Stephanie Richard, R.N.
Special Investigator

Nature of Visit
An unannounced visit was made in order to follow-up three federal deficiencies and three state licensing orders which were issued on May 1, 2014, as the result of an investigation which had been completed on April 21, 2014.

The status of each order is as follow:
1 MN Rule 4658.0085 - Corrected
2 MN Rule 4658.0300 Subp. 2 - Corrected
3 MN Rule 4658.0525 Subp. 7 B. - Corrected

See Attached 2567B for status of federal deficiencies.

xc: Minnesota Department of Health -Licensing & Certification Division

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245368	A. Building B. Wing	6/9/2014

Name of Facility
GRAND VILLAGE

Street Address, City, State, Zip Code
923 HALE LAKE POINTE
GRAND RAPIDS, MN 55744

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0157 Reg. # 483.10(b)(11) LSC	Correction Completed 05/31/2014	ID Prefix F0221 Reg. # 483.13(a) LSC	Correction Completed 05/31/2014	ID Prefix F0322 Reg. # 483.25(g)(2) LSC	Correction Completed 05/31/2014
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By ____ State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By ____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
4/21/2014

____ Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

AH Form Approved
6/12/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00298	A. Building B. Wing	6/9/2014

Name of Facility	Street Address, City, State, Zip Code
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 20265 Reg. # MN Rule 4658.0085 LSC	Correction Completed 05/31/2014	ID Prefix 20510 Reg. # MN Rule 4658.0300 Subp. LSC	Correction Completed 05/31/2014	ID Prefix 20930 Reg. # MN Rule 4658.0525 Subp. LSC	Correction Completed 05/31/2014
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
4/21/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO