



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered  
January 9, 2025

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

RE: CCN: 245495  
Cycle Start Date: December 4, 2024

Dear Administrator:

On January 8, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads '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





*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
December 10, 2024

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

RE: CCN: 245495  
Cycle Start Date: December 4, 2024

Dear Administrator:

On December 4, 2024, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

#### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

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

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

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

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



The Emeralds At Grand Rapids LLC

December 10, 2024

Page 2

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

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

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

## DEPARTMENT CONTACT

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

Annette Winters, Regional Supervisor Federal RR  
Health Regulation Division  
Minnesota Department of Health  
625 Robert Street North  
P.O. Box 64975  
Saint Paul, Minnesota 55164-0975  
Email: [annette.m.winters@state.mn.us](mailto:annette.m.winters@state.mn.us)  
Mobile: (651) 558-7558

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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



occurred sooner than the latest correction date on the ePoC.

## **FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY**

If substantial compliance with the regulations is not verified by March 4, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 4, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

## **INFORMAL DISPUTE RESOLUTION (IDR)**

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

## **INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)**

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:  
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the



The Emeralds At Grand Rapids LLC

December 10, 2024

Page 4

same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Sarah Lane".

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



|                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                         |                                                                                                                          |                            |                                                                 |
|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>245495</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>12/04/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE EMERALDS AT GRAND RAPIDS LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2801 SOUTH HIGHWAY 169</b><br><b>GRAND RAPIDS, MN 55744</b>                  |                            |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                                 |
| F 000                                                                       | INITIAL COMMENTS<br><br>On 12/3/24 through 12/4/24, a standard abbreviated survey was conducted at your facility. Your facility WAS NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed.<br><br>H54951490C (MN00108376) with a deficiency issued at F689.<br><br>H54951494C (MN00108364)<br><br>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.<br><br>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 689<br>SS=D                                                               | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | F 689                                                                   |                                                                                                                          | 12/20/24                   |                                                                 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
  
Electronically Signed

TITLE

(X6) DATE  
  
12/19/2024

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.



|                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                    |
|-----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245495</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/04/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE EMERALDS AT GRAND RAPIDS LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2801 SOUTH HIGHWAY 169</b><br><b>GRAND RAPIDS, MN 55744</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | (X5)<br>COMPLETION<br>DATE                                         |
| F 689                                                                       | <p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interviews, and documentation review the facility failed to properly provide maintenance to maintain bed wheel locks to prevent bed from moving during transfers for 1 of 3 residents (R2) resident reviewed for falls.</p> <p>Findings include:</p> <p>User-Service Manual for Joern's Bed Frames Easy-Care Bed dated 2020, identified to keep bed from rolling in the lowest position, press down on the locking lever to lock casters. The standard caster set comes with two locking casters placed at opposing corners of bed. Possible injury: before leaving the bed unattended, check that the lock feature was in locked position. Never leave an unlocked bed unattended. The Easy-Care Bed contained various parts that wear from normal use.</p> <p>R2's Fall Review Evaluation dated 10/2/24, identified at risk for falls. R2's displayed agitated behavior (verbally/physically abusive, socially inappropriate such as screams, disrobes, and self-abusive), unable to walk even when assisted by staff, and required hands-on assistance to move from place to place.</p> <p>R2's diagnoses document dated 10/11/24, identified hepatic encephalopathy (a brain disorder caused by severe liver disease and toxin buildup in the blood causing a change in mental status), urea cycle metabolism disorder (a genetic condition that causes ammonia to build up in the body, toxic, and symptoms of this condition target your brain and organ function, and alcohol/psychoactive (mind altering drug that</p> | F 689                                                                      | <p>Immediate Corrective Action:<br/>R2 bed breaks replaced on 12/4/24.</p> <p>Corrective Action as it applies to others :<br/>All resident beds were audited on 11/18/24 for functioning bed breaks. Any identified beds that had failed breaks were replaced and fixed.</p> <p>Maintenance Director and Maintenance Assistant will be educated on maintaining bed wheel locks to prevent resident beds from moving.</p> <p>Reoccurrence will be prevented by:<br/>Resident beds will be audited for functioning bed breaks monthly x3 months.</p> <p>Audit results will be reported to QAPI committee for further recommendations.</p> <p>Corrections will be monitored by"<br/>Maintenance Director or Designee.</p> |  |                                                                    |



|                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                          |  |                                                                    |
|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245495</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/04/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE EMERALDS AT GRAND RAPIDS LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2801 SOUTH HIGHWAY 169</b><br><b>GRAND RAPIDS, MN 55744</b>                  |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                         |
| F 689                                                                       | <p>Continued From page 2</p> <p>affects the function of the brain) substance abuse, and cirrhosis of the liver (liver is scarred, permanently damaged, and prevents the liver from working normally and can become life threatening).</p> <p>R2's quarterly Minimum Data Set dated 10/29/24, identified intact cognition, unclear speech with slurred or mumbled words and no behaviors. R2 had impairment of upper and lower extremity on one side and used a wheelchair for mobility. R2 was dependent upon staff for oral hygiene, toileting hygiene, shower/bath, putting on /taking off lower body clothing and footwear, sit to stand, and all transfers. R2 required substantial to maximal assistance with roll left and right, sit to lying, and lying to sit. R2 had no falls since admission to facility from 9/26/24 to 10/29/24.</p> <p>R2's incident review dated 11/16/24 at 8:04 p.m. identified nature of incident: lowered to the floor. Staff prepared R2 to be transferred from her bed to the toilet. Staff member had R2's legs placed on resident [sic], positioned her to start standing up, and R2's bottom slid off the bed. NA when [sic] to catch resident and both parties fell on the floor. Resident has ataxia (lack of muscle coordination) in her left leg. R2 was downgraded to Hoyer lift times (x) two staff until therapy could assess resident for transfers. VA report filed.</p> <p>R2's progress note on 11/16/24 at 4:21 p.m. nurse notified of a resident fall during the morning. No bruising/injury observed on this shift. Resident stated she had a fall this morning during a transfer, hit head and complained of headache. Head to toe assessment completed, notified family and director of nursing (DON). Resident sent to hospital to be evaluated.</p> | F 689                                                                      |                                                                                                                          |  |                                                                    |



|                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                          |  |                                                                    |
|-----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245495</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/04/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE EMERALDS AT GRAND RAPIDS LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2801 SOUTH HIGHWAY 169</b><br><b>GRAND RAPIDS, MN 55744</b>                  |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                         |
| F 689                                                                       | <p>Continued From page 3</p> <p>R2's progress note on 11/16/24 at 5:02 p.m. correction to type of lift device used during transfer was an easy stand not a Hoyer lift.</p> <p>R1's emergency department (ED) visit dated 11/16/24, from 4:13 p.m. to 7:00 p.m. identified presented via emergency medical services (EMS) from a local nursing home for an evaluation of a posterior headache status post fall. No blood thinners and past medical history significant for remote cerebral vascular accident (stroke) and pontine hemorrhage. Physical assessment identified R2 was alert, oriented to person, place, time, and no pain or distress. According to nursing home R2 fell out of the Hoyer lift. Cross-sectional imaging of R2's head and cervical spine was unremarkable for evidence of emergent etiology or intracranial catastrophe. At this point R2 could be safely discharged to her previous living arrangement with close follow-up.</p> <p>Review of an interview completed on 11/17/24 at 10:20 a.m. by DON and administrator for facility investigation of R2's fall with nursing assistant (NA)-A identified: NA-A brought the EZ stand lift machine into R2's room and placed machine up to next to her bed. NA-A sat R2 up on edge of bed, lowered the bed, placed leg lock (strap around lower legs) and fixed legs in the machine. NA-A placed sling behind her and the bed slide out a few inches. R2 kicked her legs out, her bottom slid off the bed, and was caught by NA-A. NA-A identified brakes on R2's bed wheels did not stay locked. NA-A thought they seemed like they were locked then slide off. NA-A had told many people about bed sliding and was unsure as to how to put into the tele (communication system) and seemed like no one knew how to.</p> | F 689                                                                      |                                                                                                                          |  |                                                                    |



|                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |                                                                                                                          |  |                                                                    |
|-----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245495</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/04/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE EMERALDS AT GRAND RAPIDS LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2801 SOUTH HIGHWAY 169</b><br><b>GRAND RAPIDS, MN 55744</b>                  |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                         |
| F 689                                                                       | <p>Continued From page 4</p> <p>R2's progress note on 11/18/24 at 2:28 p.m. physical therapy (PT) confirmed R2 was to use a Hoyer lift and up dated care plan.</p> <p>R2's progress note on 11/18/24 at 12:00 a.m. follow up visit with provider identified R2 endorsed tenderness to the back of her head from her fall. Discussed and verified her fall from over the weekend placed orders for PT/OT to evaluate and treat to ensure the patient is properly able to use the lift.</p> <p>Review of Bed Inspection Excel Spreadsheet dated 11/18/24, identified a total of 89 beds were inspected by the maintenance assistant (MA). There were 86 beds identified passed the inspection and three beds that failed (104-2, 209-1, 210-2). R2's bed was documented as passed the inspection on the excel spreadsheet.</p> <p>R2's care plan dated 11/21/24, identified R2 was at risk for falls due to pontine intracranial hemorrhage (when an artery became blocked by a blood clot and then bursts in the largest component of the brain (pons) causing slurred speech, facial drooping, and weakness on one side of the body). Staff were instructed to have placed R2's bed in low position and fall matt when in bed, follow PT and occupational therapy (OT) instructions for mobility function, and monitor and document on safety. R2 had an alteration in communication and staff were instructed to speak clearly, distinctly, repeat conversation as needed, allow R2 adequate time to communicate her needs, and ask simple questions. R2 had an alteration in mobility and instructed staff to follow PT instructions, transfer via Hoyer lift, and assist with movement in and out of bed.</p> | F 689                                                                      |                                                                                                                          |  |                                                                    |



|                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                          |  |                                                                    |
|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245495</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/04/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE EMERALDS AT GRAND RAPIDS LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2801 SOUTH HIGHWAY 169</b><br><b>GRAND RAPIDS, MN 55744</b>                  |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                         |
| F 689                                                                       | <p>Continued From page 5</p> <p>R2's incident review dated 11/22/24 at 9:12 a.m. identified nature of incident: fall from bed on 11/21/24 at 2:15 p.m. R2 was found sitting on the ground next to her bed leaning on the back of her bed. R2 stated she had slipped. Invoice dated 11/25/24, from an industrial products supply company identified an order placed for 11 bed casters and a ship date of 11/25/24.</p> <p>During an Interview/observation on 12/4/24 at 9:55 a.m. NA-A stated R2's bed was located over by the window on 11/16/24, wheels on her bed did not stay locked, and thought the bed was pushed all the way over to the wall prior to the transfer. NA-A stated R2 had random uncontrollable jerking movements and staff needed to stay near her when she sat up on side of her bed to transfer. NA-A stated she had positioned the EZ stand lift in front of R2 while she sat on edge of bed, then placed her left hand on the lift bar but was unable to hang onto it. NA-A stated R2 hung onto EZ stand bar with her right hand. NA-A stated while she placed the lift sling around R1's lower legs, she kicked out her left leg/foot and the entire bed slide out about two or three inches. NA-A stated R2 started to slide down the side of the bed. NA-A stated R2's legs were in a squatting position, grabbed the pants waistband, and pulled her up onto the side of the bed. NA-A stated and demonstrated at the same time how she locked the brakes on R2's bed wheels located at the lower end of the bed on each side. NA-A pushed the bed, and it moved at least two inches away from her. NA-A stated the bed was not safe like this and she had told other staff about the brakes would not hold.</p> <p>During an interview on 12/4/24 at 3:38 p.m. NA-B</p> | F 689                                                                      |                                                                                                                          |  |                                                                    |



|                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                          |  |                                                                    |
|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245495</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/04/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE EMERALDS AT GRAND RAPIDS LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2801 SOUTH HIGHWAY 169</b><br><b>GRAND RAPIDS, MN 55744</b>                  |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                         |
| F 689                                                                       | <p>Continued From page 6</p> <p>stated staff are expected to have notified maintenance if the bed wheel brakes do not lock properly to hold the bed. NA-B stated there were two ways to notify maintenance: get on channel 7 on the walkie or send a work order through a tele communication system. NA-B stated there was a period not too long ago some beds in the facility had problems with the wheels locking but thought maintenance had already replaced them.</p> <p>During an Interview on 12/4/24 at 3:45 p.m. with MA stated he had worked at facility for one year now. MA stated staff would be expected to either complete a work order or use a walkie to alert maintenance there was a concern about a resident's bed. MA stated many of the resident beds in the facility were old, unable to get parts for some of them anymore, and functional but insufficient due to being outdated. MA stated maintenance stayed on top of the requirements to assure the beds were safe and functional but because they were so old had more breakdowns. MA stated checks/audits were completed constantly on resident beds and included: wheels, brakes, control hand controllers, handrails, wear and tear, and mattresses to provide upkeep. MA stated the older beds had one wheel at each end of the bed with single casters (a single wheel mounted to the bottom of a larger object with a purpose to make an object move easier). MA stated the most updated bed had two wheel per leg and would have been better because the type of lock on it, the bed should not move side to side after the wheel was locked. MA stated the locks on the newer beds would be flipped in place and hold a more secure and safer position.</p> <p>During an Interview/observation on 12/4/24 at 3:55 p.m. with maintenance director (MD) stated</p> | F 689                                                                      |                                                                                                                          |  |                                                                    |



|                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                          |  |                                                                    |
|-----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245495</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/04/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE EMERALDS AT GRAND RAPIDS LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2801 SOUTH HIGHWAY 169</b><br><b>GRAND RAPIDS, MN 55744</b>                  |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                         |
| F 689                                                                       | Continued From page 7<br><br>had worked as director for about one year now and there was not a preventative task to periodically complete bed/part inspections. MD stated the self-schedule bed inspections were completed at least quarterly and just started documenting the inspections on an excel spread sheet. MD stated there were multiple styles of beds through the facility. Stated after R2's fall on 11/16/24, the administrator requested a break check on all facility beds. MD stated the inspection was started on 11/17/24 and it was noted three of the older bed required break replacement. MD stated the parts were ordered and came in last week. MD stated MA was installing the new breaks on those beds today. MD stated R2's breaks passed the test, not an issue with her breaks, and therefore were not replaced. At 4:05 p.m. MD and surveyor arrived at R2's room. R2 laid on her back in the bed awake. MD got down on the floor on his knees and verified R2's bed had one wheel on each bed leg located at each end of the bed. MD pushed on the end of the bed, and it moved approximately three to four inches. MD turned the mental teeter totter brake to one side to stop wheel from moving on both of the lower bed wheels, and pushed the bed it moved again approximately three to four inches. MD stated R2's bed breaks were not working and doing absolutely nothing to stop the bed from moving. MD stated R2's bed could had slid away during a transfer and caused an accident. At 4:10 p.m. MD reviewed the excel inspection spread sheet dated 11/18/24 and identified R2's bed inspection was checked off as completed and indicated passed inspection. MD stated was very surprised that R2's breaks did not work/pass today, but that style of wheel brake had a history of premature failure. MD stated the older bed life span was less | F 689                                                                      |                                                                                                                          |  |                                                                    |



|                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                          |  |                                                                    |
|-----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245495</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/04/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE EMERALDS AT GRAND RAPIDS LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2801 SOUTH HIGHWAY 169</b><br><b>GRAND RAPIDS, MN 55744</b>                  |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                         |
| F 689                                                                       | <p>Continued From page 8</p> <p>than those of a new bed brake and depended on whether the bed had been moved with brakes on, would most likely wear them down quicker, and destroyed them by eating them up.</p> <p>During a follow up interview/observation on 12/4/24 at 4:20 p.m. R2 laid on her back in bed. MA stated he had completed the inspection on R2's bed, wheels, brakes, signed it off on the excel spread sheet with no replacements needed. MA turned the metal teeter totter brake on both bottom wheels, gave the bed a push. R2's bed rolled, and MA stated the brakes on the lower left end did not close tight, was not working properly, would be considered a safety issue, and needed to be replaced. MA stated the left lower wheel rubber was intact but worn down and the use expectancy of that wheel was close to the end. MA stated when the brake failed was based on use, wear and tear but was required to be within the standards. MA stated front left side wheel looked good but did not have a teeter totter brake on it at all, front right side wheel brake looked ok, the lower right side of bed wheel brake was on and appeared newly replaced. MA stated all four wheels were required to be locked to make sure bed does not move. MA stated unsure why the front left wheel did not have a brake on it. MA tested and retested the left lower wheel lock and stated it would not lock when he pushed the bed and it moved. MA stated the wheel failed to lock and could increase the risk for falls and was critical to assure the hardware was up to date and functional. MA stated the design on the wheel brake was insufficient, unable to do what it was designed to do over a period and wore out fast. MA stated older beds required more repairs.</p> <p>During an interview on 12/4/24 at 4:40 p.m.</p> | F 689                                                                      |                                                                                                                          |  |                                                                    |



|                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            |                                                                                                                          |  |                                                                    |
|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245495</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/04/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE EMERALDS AT GRAND RAPIDS LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2801 SOUTH HIGHWAY 169</b><br><b>GRAND RAPIDS, MN 55744</b>                  |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                         |
| F 689                                                                       | Continued From page 9<br>administrator stated during the facility<br>investigation of R2's fall on 11/16/24 there could<br>have been a possible issue with her bed<br>wheels/brakes. Administrator stated maintenance<br>was contacted and asked to inspect all resident<br>beds to assure the brakes on the bed wheels<br>were in working order. Administrator stated she<br>understood R2's bed had passed the inspection<br>and was not aware of any other issues. | F 689                                                                      |                                                                                                                          |  |                                                                    |





*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

December 10, 2024

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

Re: Event ID: QT7311

Dear Administrator:

The above facility survey was completed on December 4, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads '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



Minnesota Department of Health

|                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         |                                                                                                                          |                                                                    |
|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>00299</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/04/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE EMERALDS AT GRAND RAPIDS LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2801 SOUTH HIGHWAY 169</b><br><b>GRAND RAPIDS, MN 55744</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| 2 000                                                                       | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS:<br/>On 12/3/24 through 12/4/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.</p> <p>The following complaints were reviewed:</p> | 2 000                                                                                                   |                                                                                                                          |                                                                    |

|                                                                       |       |           |
|-----------------------------------------------------------------------|-------|-----------|
| Minnesota Department of Health                                        |       |           |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| Electronically Signed                                                 |       | 12/19/24  |



Minnesota Department of Health

|                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                           |                                                                                                                          |  |                                                                    |
|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>00299</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/04/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE EMERALDS AT GRAND RAPIDS LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2801 SOUTH HIGHWAY 169</b><br><b>GRAND RAPIDS, MN 55744</b>                  |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| 2 000                                                                       | Continued From page 1<br><br>H54951490C (MN00108376)<br><br>H54951494C (MN00108364)<br><br>NO licensing orders were issued.<br><br>Minnesota Department of Health is documenting<br>the State Licensing Correction Orders using<br>Federal software. The facility is enrolled in ePOC<br>and therefore a signature is not required at the<br>bottom of the first page of state form.<br><br>Although no plan of correction is required, it is<br>required that the facility acknowledge receipt of<br>the electronic documents. | 2 000                                                                     |                                                                                                                          |  |                                                                    |