Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

Revised Letter

December 6, 2024

Administrator
Grand Village
923 Hale Lake Pointe
Grand Rapids, MN 55744

RE: CCN: 245368
Cycle Start Date: August 29, 2024

Dear Administrator:

This letter was originally sent on December 4, 2024 but the letter didn't have a date on it so this is the same letter with today's date added.

On October 2, 2024, we notified you a remedy was imposed. On September 24, 2024, October 1, 2024 and November 12, 2024 the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 1, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 29, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 2, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 29, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 1, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 10, 2024

Administrator
Grand Village
923 Hale Lake Pointe
Grand Rapids, MN 55744

RE: CCN: 245368
Cycle Start Date: August 29, 2024

Dear Administrator:

On August 29, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Alex Warren, Regional Operations Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Office: 218-302-6186 Mobile: 651-279-5375

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 November 29, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 1, 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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/26/24 to 8/29/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H53687291C (MN00102082) H53686221C (MN00105076) H53687566C (MN00106192) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.	F 553		9/23/24

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

Electronically Signed | 09/17/2024

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.

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F 553	Continued From page 1 (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the opportunity for an admission care conference for 1 of 3 residents (R49) reviewed for care planning. Findings include: R49's admission Minimum Data Set (MDS) assessment dated 8/5/24, identified R49 was cognitively intact. Diagnoses included renal insufficiency, diabetes, and arthritis. Review of R49's electronic medical record (EMR) lacked documentation of a care conference since	F 553	Corrective action: R49 had a care conference on 7/29 and was provided a copy of her care plan. Corrective action as it applies to other residents: All residents have the potential to be affected by this deficient practice. Social Services will be educated on the need to provide a timely, within 14 days after admission care conference which will include a review by and agreement of the residents care plan. Recurrence will be prevented by:	

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F 553	Continued From page 2 admission to the facility. During an interview on 8/26/24 at 7:09 p.m. R49 stated he had not been invited to, or attended any care conference to discuss the plan of care (POC) since admission to the facility on 7/30/24. During an interview on 8/28/24 at 2:29 p.m. registered nurse (RN)-B stated the facility would rarely have an admission care conference. They would build the care plan and just let the resident review it after completion. Staff "usually" never met with the resident until closer to discharge, to discuss the discharge planning. Turn around times on the rehab unit did not allow to meet with each resident at admission to discuss the POC with them. During an interview on 8/29/24 at 10:28 a.m., the social services designee (SSD) stated care conferences would be scheduled by her and social services, nursing, therapies, and other departments would attend them with the resident and family members. The SSD reviewed R49's EMR and confirmed there was no documentation related to a care conference. The SSD also confirmed R49 had not had a care conference since admission. During an interview on 8/29/24 at 10:49 a.m., the director of nursing stated an expectation that all care conferences would be done within 7-12 days of admission, as stated in the policy and the resident admission handbook. Facility Welcome to Grand Village resident handbook last revised 4/11/24 indicated 7-12 days after admission an interdisciplinary team (IDT) meeting called a resident care conference	F 553	Education will be provided to social services on setting up a timely RCC within 14 days after admit, along with review and agreement of residents care plan. An audit will be conducted once a week x 4 weeks to ensure new admission RCC□s are set up, then once a month. Corrective Action will be monitored by DON or designee. The QAPI committee will determine when the audits may be discontinued.	

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F 553	Continued From page 3 would be held to discuss the residents care at the facility. The meeting would include several staff at the facility, the resident, and the resident family. Facility policy Individualized Care Plan last revised 6/24, indicated the IDT would meet with the resident and family related to the POC. The policy lacked documentation of when the care conference should take place.	F 553		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were comprehensively assessed for self-administration of medications for 1 of 1 resident (R2) reviewed and observed for self-administration of medications. Findings include: R2's significant change Minimum Data Set (MDS) dated 7/11/24, identified R2 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. During observation on 8/27/24 at 10:46 a.m., R2 was sitting in her recliner with the nebulizer mask on her face. Nebulizer cup contained a clear solution and nebulizer machine was running with no staff present in room. Nurse walked from the medication cart into R2's room, stated to R2 that	F 554	Corrective action: Corrective action: A Self-administration assessment was conducted on 8/29/2024 on R2. R2 was assessed as being capable of self-administration of nebulizer medication without supervision, her care plan and MAR were updated. Corrective action as it applies to other residents: All residents have the potential to be affected by this deficient practice. An assessment was conducted on residents who use nebulizer treatments for their ability to self-administer. Education will be done with all nursing team members on the SAM (self- administration of medication) policy. Recurrence will be prevented by: All nursing team members will be educated	9/23/24

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F 554	Continued From page 4 the treatment was "all done" and shut the nebulizer machine off. Nurse washed nebulizer mask and cup and left it to air dry. During record review on 8/26/24, the self-administration of medications assessment that was completed on 7/11/24, identified R2 required frequent prompting, cues and reminders, and was not safe to self-administer own medications. Assessment also indicated that R2 did not wish to self-administer any medications. During interview on 8/29/24 at 8:34 a.m., licensed nursing staff (LPN)-A stated there were no residents on this unit that were able to self-administer medications. LPN-A stated if a resident was able to self-administer medications, it would be displayed in the resident's banner in the electronic health record (EHR). LPN-A confirmed that R2 did not have an order to self-administer medications which included nebulizer treatments. LPN-A stated an assessment would need to be completed before a resident was able to self-administer medications. LPN-A stated the assessment was important to ensure that the mask was properly place on resident's face and that the resident was able to keep mask on during treatment as nebulizer could be running with the resident not receiving any solution making the treatment ineffective. During interview on 8/29/24 at 10:17 a.m., registered nurse (RN)-C stated an assessment would need to be completed by the RN prior to a resident being able to self-administer medications. RN-C confirmed R2 did not have an order for self-administration of medications. RN-C stated it was important to complete the	F 554	on the SAM policy, and why they cannot leave nebulizer treatments running without observation for those residents assessed to not be competent to self-administer. SAM audits will be conducted daily x 7 days, then once a week x 4 weeks, and then monthly. Corrective Action will be monitored by DON or designee. The QAPI committee will determine when the audits may be discontinued.	

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F 554	Continued From page 5 assessment to ensure that the resident was cognitively able to use the nebulizer without monitoring and to ensure the resident could remove nebulizer mask from face if resident was experiencing adverse side effects such an increased heart rate with palpitations during nebulizer treatment. During interview on 8/29/24 at 10:38 a.m., director of nursing (DON) stated self-administration of medications assessments are completed by the nurse manager or the MDS nurse. DON stated assessments are completed at time of admission, annually, or with a significant change in status. DON confirmed that nebulizer treatments, when nurse leaves the room, needed to be assessed and a self-administer order would need to be obtained from the provider. It was important for the resident to be assessed for self-administration of medications to ensure that the resident was safe to be left alone with the nebulizer treatment running. The facility Self-Administration of Medications policy, dated 4/23, identified a self-administration of medications assessment would be completed for any resident requesting to administer any medication without the direct supervision of a nurse. Residents who have nebulizer treatments may only self-administer if assessed for self-administration of nebulizer assessment and a physician order is received to self-administer.	F 554		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		9/23/24

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F 684	Continued From page 6 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper wheelchair equipment was used to prevent potential complications for 1 of 1 resident (R55). Findings include: R55's significant change Minimum Data Set (MDS) dated 7/18/24, identified R55 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R55's diagnoses included progressive neurological conditions, degenerative disease of nervous system, non-Alzheimer's Dementia, and unspecified abnormalities of gait and mobility. During observation on 8/26/24 at 1:28 p.m., R55 left the unit with staff to go to activities. Staff assisted R55 with propelling down hallway in his wheelchair that did not have foot pedals. R55 was experiencing difficulty with holding his feet up while staff pushed wheelchair. R55's feet dropped on floor and bounces. R55's foot pedals were laying on top of dresser in room. During observation on 8/29/24 at 9:13 a.m., R55 left the unit with staff to go down to therapy. Staff assisted R55 with propelling down hallway in his wheelchair that did not have foot pedals. R55 was experiencing difficulty with holding his feet up	F 684	Corrective action: Pedals were applied to R55□s wheelchair when identified to not being used per care plan. Corrective action as it applies to other residents: All residents have the potential to be affected by this deficient practice. An audit was done to identify residents who are care planned for the need of w/c pedals when being assisted by staff. Wheelchair pedal bags were ordered and the pedal bags will be placed on the backs of their chairs. All staff education will be provided on the importance of following the care plan, on the use of w/c pedal bag placement for residents who need w/c pedals when being assisted with w/c mobility, and the importance of using pedals for those care planned to use. Audits on w/c pedal bags and use of wheelchair pedals will be conducted once a day for one week, then once a week for four weeks, and then once a month. Corrective Action will be monitored by DON or designee. The QAPI committee will determine when the audits may be discontinued.	

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F 684	Continued From page 7 while staff pushed wheelchair. R55's feet dropped on floor and bounced. R55's foot pedals were laying on top of dresser in room. During record review on 8/28/24, R55's care plan indicated staff were to ensure bilateral foot pedals were on wheelchair when assisting resident to and from destinations due to limited physical mobility related to weakness. During interview on 8/29/24 at 8:36 a.m., licensed practical nurse (LPN)-A stated if R55 was going a long distance or off unit, staff assisted R55 with propelling wheelchair down hallway. LPN-A stated R55 does not have foot pedals for his wheelchair. During interview on 8/29/24 at 8:40 a.m., nursing assistant (NA)-A stated if R55 was going off unit, staff assisted R55 with propelling wheelchair down hallway. NA-A stated R55 does not use foot pedals on his wheelchair. During interview on 8/29/24 at 10:11 a.m., registered nurse manager (RN)-A confirmed R55 was to have foot pedals on his wheelchair when been propelled for longer distances. RN-A stated it was important for foot pedals to be used on wheelchair, so the resident does not fall forward out of wheelchair and/or sustain injuries. During interview on 8/29/24 at 10:31 a.m., director of nursing (DON) stated nursing evaluated whether or not foot pedals needed to be used for the resident and if foot pedals were needed it would be added to the care plan. DON stated that if a resident was not able to hold their legs up that foot pedals should be used. DON stated it was important for foot pedals to be used per care plan to ensure resident safety.	F 684		

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F 684	Continued From page 8 A wheelchair/foot pedal policy was requested but was not provided.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with repositioning to minimize the development of pressure ulcer risk for 1 of 2 residents (R50) reviewed for wound care. Findings include: R50's quarterly Minimum Data Set (MDS) dated 6/26/24, identified R50 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R50's diagnoses included hypertension, renal failure, non-Alzheimer's dementia, anxiety disorder and other symptoms and signs involving the musculoskeletal system. MDS also identified that	F 686	R50 was repositioned at time identified by surveyor. Corrective action as it applies to other residents: All residents have the potential to be affected by this deficient practice. Education will be done with all nursing team members on importance and reasons for repositioning. Recurrence will be prevented by: All nursing team members will be educated on the importance of repositioning and following residents plan of care. Repositioning audits will be completed daily for one week, then once a week for	9/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 9 R50 was at risk for developing pressure ulcers/injuries and is on turning and repositioning program. R50's care plan undated, identified R50 had altered skin integrity related to fragile skin due to closed lumbar fracture and was at risk for the development of pressure ulcers. R50's care plan directed staff to reposition R50 every two hours while in bed and/or wheelchair. During continuous observations on 8/27/24 from 1:12 p.m. to 3:37 p.m. R50 was lying on his back in his bed. At 1:12 p.m., R50 was observed to be lying on his back in bed. At 2:30 p.m., R50 remained in same position in bed. At 2:54 p.m., nurse went into R50's room and obtained vitals but did not reposition R50 and R50 remained in same position in bed. At 3:01 p.m., staff brought in new water pitcher into room and did not reposition R50. At 3:32 p.m., R50 remained in same position in bed. At 3:37 p.m., staff went into R50's room and assisted R50 with repositioning. During interview on 8/27/24 at 3:29 p.m., nursing assistant (NA)-B stated R50 was unable to reposition himself in his bed and needs staff to assist with repositioning. NA-B stated R50 was to receive assistance with repositioning every two hours. During interview on 8/27/24 at 3:40 p.m., licensed practical nurse (LPN)-B stated R50 was to receive assistance with repositioning every two hours when in bed or wheelchair. LPN-B stated R50 was not able to reposition himself in his bed. During interview on 8/29/24 at 8:36 a.m., LPN-A stated R50 had a wound on his spine that was not	F 686	four weeks and then monthly. Corrective Action will be monitored by DON or designee. The QAPI committee will determine when the audits may be discontinued.	

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F 686	Continued From page 10	F 686		

open at this time. LPN-A stated R50 had a protective bandage, placed along his spine, due to him having thin skin. LPN-A stated R50 was to receive assistance with repositioning every two hours as it was important to ensure that R50's skin on back/spine does not break down.

During interview on 8/29/24 at 8:40 a.m., registered nurse clinical manger (RN)-A stated R50 currently does not have any open wounds as the pressure ulcers that he had has resolved. RN-A stated R50 had a preventive protective dressing that was placed on his spine for a bulge that staff has been monitoring closely. RN-A stated R50's skin was very thin and the bulge on his spine was protruding with the area being blanchable. RN-A stated R50 was to receive assistance with repositioning every two hours as it was important due to R50's skin being so vulnerable and his history of pressure ulcers.

During interview on 8/29/24 at 10:35 a.m., the director of nursing (DON) stated the staff were to provide assistance with repositioning in accordance with the care plan. DON stated repositioning a resident was important to prevent skin breakdown.

The facility Positioning the Resident policy dated 6/24, indicated that it was the policy of the facility that staff reposition identified residents to relieve pressure, prevent skin breakdown, pain, and promote proper body alignment.

The facility Individualized Care Plan policy dated 6/24, indicated the facility would develop a comprehensive care plan using the comprehensive assessments, will individualize the plan of care to accurately reflect resident's

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F 686	Continued From page 11 functional capacity and medical, nursing, psychosocial, activity and other identified needs.	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oxygen tubing was changed according to facility policy and failed to ensure nebulizer tubing/cannister was cleaned and allowed to air dry after each use for 1 of 1 resident (R38) reviewed for oxygen therapy. Findings include: R38's admission Minimum Data Set (MDS) dated 8/13/24, identified R38 was cognitively intact and had continuous oxygen therapy since admission to the facility. R38's provider order dated 8/13/24, identified oxygen at 2 liters/minute by nasal cannula (NC) continuously and budesonide inhalation suspension 0.5 milligrams/2 milliters inhaled via nebulizer two times a day. R38's care plan dated 8/7/24, identified R38 needed continuous oxygen therapy and to	F 695	Corrective action: 02 tubing was changed at the time it was identified during survey. An audit was done at the time for all 02 tubing, all other tubing changes were in compliance with the policy. R38□s nebulizer was rinsed and dried per policy at the time it was identified by the surveyor. Corrective action as it applies to other residents-All residents on 02 or with the nebulizer treatments have the potential to be affected by this deficient practice. Education will be done with all nursing team members on the policy of 02 tubing/nasal canula changes and nebulizer cleaning procedure after administration. 02 tubing date stickers were purchased to help with identifying the date tubing is placed. Recurrence will be prevented by: All	9/23/24

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F 695	Continued From page 12 administer oxygen and respiratory medications as per orders. The care plan lacked documentation when to change oxygen tubing and when/how to clean nebulizer tubing/cannister. R38's treatment administration record for 8/24 indicated oxygen tubing and nasal cannula had been changed on 8/11/24, 8/18/24, and 8/25/24. On 8/26/24 at 3:09 p.m., R38 was observed wearing continuous oxygen via NC. The date on the green extension tubing and the NC was 8/18/24. A nebulizer canister and tubing was observed sitting on the bedside table and was also dated 8/18/24. The cannister was noted to be closed and had visible liquid in the cannister along with condensation along the inner walls of the cannister. During interview on 8/26/24 at 3:09 p.m., R38 stated the staff very rarely change the oxygen tubing the way they were supposed to. The staff will never clean out the nebulizer cannister after my treatment. They start out the day by bringing me the vials of nebulizer liquid for all treatments that day and R38 would set up and self-administer the nebulizer treatments when scheduled. The staff never came back to clean the nebulizer cannisters after each use. On 8/27/24 at 1:29 p.m., all the oxygen tubing in R38's room was observed to be dated 8/18/24 along with the nebulizer tubing and cannister. The nebulizer cannister was again noted to have liquid and condensation built up inside the cannister. During interview on 8/27/24 at 1:34 p.m., licensed practical nurse (LPN)-A stated all oxygen tubing and nebulizer tubing/cannisters would be	F 695	nursing team members will be educated on the policy of 02 tubing/nasal canula changes and nebulizer cleaning procedure after administration. Audits will be conducted on 02 tubing and nebulizer treatments daily for one week, then once a week for 4 weeks, then monthly. Corrective Action will be monitored by DON or designee. The QAPI committee will determine when the audits may be discontinued.	

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F 695	Continued From page 13 changed every 7 days based on when the resident was admitted. Documentation of the change would be done in the TAR and the tubing would be labeled with tape and the current date on the tape. LPN-A stated nebulizer cannisters needed to be cleaned after each use and allowed to air dry before the next treatment was given. Cleaning should occur immediately after the medication in the nebulizer was administered. LPN-A entered R38's room and confirmed the date on all oxygen tubing was 8/18/24. Based on that date the tubing should have been changed on 8/25/24. LPN-A also confirmed the nebulizer had not been cleaned out since the last treatment that day which had been at 8:00 a.m. During interview on 8/29/24 at 10:38 a.m. registered nurse (RN)-A stated all oxygen tubing and nebulizer tubing/canisters should be changed every 7 days, on Sunday evening shft. RN-A stated nebulizer cannisters should be cleaned immediately after each use to prevent bacteria growth that can occur in left over moisture in the cannister. During interview on 8/29/24 at 10:48 a.m. the director of nursing (DON) stated an expectation all staff would follow the facility policy related to oxygen tubing changes and nebulizer cleaning schedules. Facility policy Nebulizer Treatment last revised 12/23, identified after each use the nebulizer would have all excess fluid removed from the nebulizer and placed on a paper towel to air dry completely. Nebulizer pieces would be changed weekly, which included tubing. A facility policy for oxygen tubing changes was	F 695		

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F 695	Continued From page 14 requested but not provided.	F 695		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		9/23/24

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F 758	Continued From page 15 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assure the use of PRN (as needed) psychotropic medications (a drug which affects mood/behavior) were limited to 14 days, or had a physician specified, time limited order and failed to monitor orthostatic blood pressures with the use of an antipsychotic medication for 1 of 1 residents (R4) reviewed for hospice. Findings include: R4's quarterly Minimum Data Set (MDS) dated 5/20/24, identified R4 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R4's diagnoses included non-Alzheimer's dementia, anxiety disorder, nutritional deficiency, and chronic pain. R4's physician orders included orders for lorazepam 0.5 milligram (mg) every four hours as needed. This order was initiated on 3/8/24 and was open-ended. Orders also included risperidone (antipsychotic) 0.25 mg by mouth two times daily for obsessive itching/picking related to generalized anxiety disorder.	F 758	Corrective action: R4□s prn psych medication was discontinued at time no order was identified. R 4□s TAR was updated for orthostatic blood pressure. Corrective action as it applies to other residents-All residents on psychotropic medications have the potential to be affected by this deficient practice. Education will be done with all nursing team members on the CMS guidance of psychotropic medications. All prn psychotropic medications will be entered into the MAR with a stop date. An audit was done for monthly orthostatic B/P□s for all residents receiving an antipsychotic. Recurrence will be prevented by: All nursing team members will be educated on the CMS guidance for psychotropic medications. Audits will be done on prn psychotropics and orthostatic b/p□s for those on antipsychotics twice a week for 2 weeks, then weekly for one month, and then monthly. Corrective Action will be	

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F 758	Continued From page 16 R4's medical record was reviewed and lacked any evidence orthostatic blood pressures had been obtained for R4. During interview on 8/28/24 at 1:43 p.m.., registered nurse case manager (RN)-A stated for psychotropic medications monitoring needed to be completed for behaviors. RN-A confirmed that R4's lorazepam was ordered on 3/8/24 and has no end date. RN-A stated R4 did not have any behaviors and probably does not need the lorazepam order at this time. RN-A stated antipsychotic medications are monitored for adverse effects and orthostatic blood pressures are obtained monthly. RN-A confirmed R4 has not had orthostatic blood pressures obtained. DON stated orthostatic blood pressures are important as antipsychotic medications can cause dizziness and cause blood pressure to drop, which could lead them to fall. During interview on 8/29/24 at 10:26 a.m., director of nursing (DON) stated target behaviors and adverse effects are monitored for PRN psychotropic medications. DON stated PRN psychotropics need to be evaluated every 14 days with the provider to ensure medication was still needed with the rationale of why it is needed. It was important to re-evaluate to ensure that resident was not receiving the medication that was not needed and are on the lowest dose possible. During interview on 8/29/24 at 11:40 a.m., consultant pharmacist (CP) stated Lorazepam was to be re-evaluated after 14 days. Provider was expected to document rationale and specify duration of medication. CP stated it was important	F 758	monitored by DON or designee. The QAPI committee will determine when the audits may be discontinued.	

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F 758	Continued From page 17 to re-evaluate medication to make sure the resident was benefiting from it and to ensure the resident was not having any adverse effects from the medication. CP stated any resident on an antipsychotic medication should have orthostatic blood pressures obtained monthly. Pharmacist stated orthostatic blood pressures consist of obtaining a blood pressure when resident is lying, sitting, and then standing within the same timeframe. Pharmacist stated orthostatic blood pressures were important to monitor due to postural hypotension being one of the major side effects, especially in an older person, and would put the resident at a higher risk for falls when taking these medications. The facility Psychopharmacologic Drug Use policy, dated 7/8/2024, identified residents are free from the use of any psychotropic medication for purposes of discipline or convenience and from mediations not required to treat medical symptoms. Psychopharmacologic drugs include antianxiety agents, antidepressants, sedatives, hypnotics, antipsychotics, and "other" drugs that affect behavior. As needed (PRN) orders must include an indication for use. PRN orders for psychotropic drugs are limited to 14 days, except if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. The attending physician or prescribing practitioner directly examines the resident's current condition and progress to determine if the PRN antipsychotic medication is still needed. The facility Blood Pressure - Orthostatic policy,	F 758		

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F 758	Continued From page 18 dated 1/2022, identified orthostatic blood pressures are to be obtained to assess effectiveness of medication, assess potential side effects of medications and to assess risk for falls.	F 758		

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	245368	A. BUILDING **02 - SUB ACUTE** B. WING _____	**08/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/28/2024. At the time of this survey, Grand Village was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 09/17/2024

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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. XXXXXXXX (Building Info) The facility has a capacity of 114 beds and had a census of 65 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 372	Subdivision of Building Spaces - Smoke Barrie	K 372		9/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **02 - SUB ACUTE** B. WING _____	**08/28/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372 SS=F	Continued From page 2 CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 08/28/2024 between 9:00am and 12:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors in the following areas; 1) Corridor door 115 2) By gift shop 119A 3) At entrance to Rivers Wing by 1402 4) At entrance to Lakes Wing by 1408 Tube Room 5) on Norway Link 6) At entrance to Norway Wing 7) At entrance to Cedar Wing	K 372	The identified areas will be corrected by date certain filling the identified penetrations above the fire doors. All smoke barriers were audited and corrected if applicable. The policies regarding fire safety were reviewed and are current. Maintenance staff will be educated on smoke departments and checking fire doors and areas around them. Monthly audits will be completed and after outside contractor's complete work near fire doors. TELS, the preventative maintenance system, has been updated to include monthly audits. These audits will be printed, added to our file, and saved in TELS for secondary access. The QAPI committee will review the results of the audits to determine whether the plan of corrects was effective or if continous monitoring and system changes need to be implemented.	

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K 372	Continued From page 3 8) By Business Office Link Hallway 9) Lodge 1 doors 10) Lodge 2 doors An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 372		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and	K 918		9/30/24

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K 918	Continued From page 4 separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 and 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 08/23/2022, between 0900am and 1200pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing annual generator inspections were not performed from 08/28//2023 to 08/28/2024. On 08/28/2024 between 9:00am and 12:00pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing monthly generator inspections were not performed between 08/28//2023 to 08/28/2024. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 918	Generator load bank testing will be scheduled and completed before date certain. The preventative maintenance tracking system was updated to ensure load bank testing is scheduled by regulation moving forward and will be monitored by the Quality Assurance Performance Improvement Committee. Facility will implement monthly testing, but continue to do annual load bank test. The measures that will be taken to ensure deficiency does not reoccur is a facility review of the emergency generator policy. The person responsible for compliance is the director of environmental services.	
K 920	Electrical Equipment - Power Cords and Extens	K 920		9/30/24

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K 920 SS=D	Continued From page 5 CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include:	K 920	The power strip has been removed from the medication room on Aspen. The maintenance team has audited the facility to ensure compliance in other areas. All staff will be educated on the power cord and extension policy in compliance with NFPA requirements. Audits will be completed bimonthly to ensure compliance. Audits will be reviewed by the safety committee. The director of environmental services or designee is	

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K 920	Continued From page 6 On 08/28/2024 between 9:00am and 12:00pm, it was revealed by observation that there was a refrigerator plugged into a power strip in Aspen medical supply room. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 920	responsible for ensuring compliance.	