DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 8, 2022

Administrator
The Emeralds At Grand Rapids A
2815 Highway 169 South
Grand Rapids, MN 55744

RE: Project Number(s) SL30227015

Dear Administrator:

On August 1, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the March 17, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 14, 2022

Administrator
The Emeralds At Grand Rapids A
2815 Highway 169 South
Grand Rapids, MN 55744

RE: Project Number(s) SL30227015

Dear Administrator:

On May 27, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on March 17, 2022. The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the March 17, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on March 17, 2022, found not corrected at the time of the May 27, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0550-Resident Grievances; Reporting Maltreatment-144g.41 Subd. 7b = $500.00
1290-Background Studies Required-144g.60 Subdivision 1 = $3,000.00
2040-Fire Protection And Physical Environment-144g.81 Subdivision 1 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on May 27, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $4,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Also, at the time of this follow-up evaluation completed on May 27, 2022, we identified the following violation(s):

1910-Disposition Of Medications-144g.71 Subd. 22

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30227	A. BUILDING: _____ B. WING _____	R 05/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS A	2815 HIGHWAY 169 SOUTH GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project #SL30227015-1 On May 25, 2022, through May 27, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on March 17, 2022. At the time of the survey, there were 42 active residents: 32 receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued. An immediate correction order was identified on May 27, 2022, issued for SL30227015-1, tag identification 1290. On May 26, 2022, the immediacy of correction order 1290 was removed, however non-compliance remained at a level 3 scope of widespread (l).	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to post in a conspicuous place, information about the facility's grievance procedure with the required content. This had the potential to affect the licensee's 42 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting of the grievance procedure to include the name, telephone number and e-mail contact information for the	{0 550}		

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{0 550}	Continued From page 2 individuals who are responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. On May 25, 2022, at approximately 2:30 p.m., housing director (HD)-C verified the bulletin board located in the main common area was where required items were posted; however, verified the grievance procedure was not posted. The licensee's Complaints policy, undated, did not address complaint/grievance posting requirements. No further information was provided.	{0 550}		
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives,	{0 730}		

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{0 730}	Continued From page 3	{0 730}		

guardianships, powers of attorney, or conservatorships;
(7) the facility's current and previous assessments and service plans;
(8) all records of communications pertinent to the resident's services;
(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;
(10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;
(11) documentation that services have been provided as identified in the service plan;
(12) documentation that the resident has received and reviewed the assisted living bill of rights;
(13) documentation of complaints received and any resolution;
(14) a discharge summary, including service termination notice and related documentation, when applicable; and
(15) other documentation required under this chapter and relevant to the resident's services or status.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure a resident record included a discharge summary for one of one discharged resident (R12) with record reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to

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{0 730}	Continued From page 4 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R12's diagnoses included ulcerative pancolitis (inflammation and ulceration of the colon and rectum causing pain and diarrhea), major depressive disorder and anxiety. R12 was admitted for services on March 29, 2019, and began receiving assisted living services on August 1, 2021. R12 was discharged to the hospital on April 27, 2022, and later passed away. R12's record included document titled The Emeralds at Grand Rapids, dated August 25, 2020, intended as the service plan, which indicated R12 received services including behavior support, cueing, medication set-up and administration, meals, laundry, housekeeping and daily well-being checks. R12's record included a Discharge Summary, dated May 5, 2022, which lacked the following information: -a summary of the resident's stay that included diagnoses, course of illnesses, allergies, treatments and therapies, and pertinent lab, radiology and consultation results; -a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral and functional status; and	{0 730}		

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{0 730}	Continued From page 5 -a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications. On May 25, 2022, at approximately 4:58 p.m., licensed assisted living director (LALD)-B confirmed the discharge summary lacked the above information. No further information was provided.	{0 730}		
{01290} SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure background studies were conducted prior to staff providing services, for two of ten employees (unlicensed personnel (ULP)-E, housing director (HD)-C) with records reviewed.	{01290}	On May 26, 2022, the immediacy of correction order 1290 was removed, however non-compliance remained at a level 3 scope of widespread.	

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{01290}	Continued From page 6 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-E ULP-E had a hire date of January 6, 2007, and began providing assisted living with dementia care services to the licensee's residents on August 1, 2021. ULP-E's employee record included an "ADP" Background Screening Results form, dated December 8, 2016, submitted by a company that previously owned the facility location; however, the document was a non-approved, non-Department of Human Services (DHS) NETStudy 2.0 background study. ULP-E's record lacked evidence the licensee submitted a background study for ULP-E under the current licensure. On May 26, 2022, at approximately 11:12 a.m., licensed assisted living director (LALD)-B verified ULP-E's record lacked a background study clearance. On May 26, 2022, at approximately 11:14 a.m., the surveyor observed the posted staffing schedule for this date. ULP-E's name was listed and noted she was working from 6:00 a.m. to 2:00 p.m.	{01290}		

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{01290}	Continued From page 7	{01290}		

During an interview on May 26, 2022, at approximately 1:57 p.m., ULP-E stated she provided care to the residents in the facility. ULP-E stated her additional responsibilities included ensuring medications were received from the pharmacy and were accurate in the medication cart, scheduling resident appointments and transportation and staffing for the licensee. ULP-E stated she did not recall completing a background study since beginning her employment in 2007.

HD-C
HD-C had a hire date of March 22, 2011, and began providing assisted living with dementia care services to the licensee's residents on August 1, 2021.

HD-C's employee record contained a background study submitted by a company that previously owned the facility location, dated February 3, 2017. HD-C's employee record lacked evidence the licensee submitted a background study for HD-C under the current licensure.

On May 26, 2022, at approximately 10:00 a.m., HD-C stated the current owner of the facility took over in 2019, and staff working at that time were not expected to complete a new background study.

On May 26, 2022, at approximately 2:45 p.m., LALD-B stated they audited all employee records after the initial survey in March 2022; however, thought ULP-E and HD-C's records were acceptable.

The licensee's Background Study Policy, last revised December 2016, indicated upon hire or facility transfer, the employee would complete a

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{01290}	Continued From page 8 facility background study form and the Human Resources Director would submit an online Background Study Request. Also included, the employee may not begin working until the results of the request are received and indicate the applicant is not disqualified. A copy of the initial DHS Background Study results shall be accepted as compliant with background study requirements. This copy must be maintained in the employee file. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	{01290}		
{01540} SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01540}		

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{01540}	Continued From page 9 Based on interview and record review, the licensee failed to ensure two of four employees (unlicensed personnel (ULP)-L, ULP-H) received the required amount of dementia care training in the required time frame with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee had a current assisted living facility with dementia care license. ULP-L ULP-L had a hire date of April 6, 2022, to provide direct care services to the licensee's residents. ULP-L's employee record identified 4.0 hours of training for dementia care completed January 4, 2022, while ULP-L was employed in the adjacent long term care facility. ULP-L's employee record lacked evidence ULP-L had completed the required eight (8) hours of dementia training on the specific dementia care topics within 80 working hours of ULP-L's hire date, noted as May 1, 2022. ULP-H ULP-H had a hire date of June 22, 2021, to provide direct care services to the licensee's residents.	{01540}		

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{01540}	Continued From page 10 ULP-H's record identified 7.5 hours of training for dementia completed on May 8, 2022. ULP-H's employee record lacked evidence ULP-H had completed the required eight (8) hours of training on the specific dementia care topics within 80 working hours of ULP-H's hire date, noted as July 13, 2021. On May 27, 2022, at approximately 1:38 p.m., housing director (HD)-C verified the above hours and stated the licensee failed to assign the correct classes in Healthcare Academy (educational program) to ULP-L when she transferred to the assisted living facility. In addition, HD-C verified ULP-H lacked hours during the initial survey, and although she completed another class, she still lacked the required hours. The licensee's Training Requirement for Assisted Living with Dementia Care policy, undated, indicated direct care staff would complete a minimum of eight hours of initial training on dementia care topics within 160 working hours of the employment start date. Licensee's policy did not contain information pertaining to requirements for an assisted living with dementia care license. No further information was provided.	{01540}		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a	01910		

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THE EMERALDS AT GRAND RAPIDS A	2815 HIGHWAY 169 SOUTH GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 11 resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R12) upon discharge, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R12's record lacked documentation of medication disposition upon R12's discharge from the facility.	01910		

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01910	Continued From page 12 R12's diagnoses included ulcerative pancolitis (inflammation and ulceration of the colon and rectum causing pain and diarrhea), major depressive disorder and anxiety. R12 was admitted for services on March 29, 2019, and began receiving assisted living services on August 1, 2021. R12 was discharged to the hospital on April 27, 2022, and later passed away. R12's record included document titled The Emeralds at Grand Rapids, dated August 25, 2020, intended as the service plan, which indicated R12 received services including behavior support, cueing, medication set-up and administration, meals, laundry, housekeeping and daily well-being checks. R12's signed physician's orders, dated March 31, 2022, indicated R12's medications included gout medication, antihypertensives (lower blood pressure), pain reliever, eye drops, antidepressants and supplements. R12's discharge summary, dated May 5, 2022, indicated R12 received assistance with activities of daily living and medication management, and indicated "medications sent back to TW [Thrifty White] as new cycle had been delivered the day resident admitted to hospital." R12's record lacked evidence of documentation of R12's disposition of medications to include name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On May 26, 2022, at approximately 4:45 p.m.,	01910		

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01910	Continued From page 13 housing director (HD)-C stated the pharmacy had delivered medications on the day R12 was discharged and they were handed back to the pharmacy representative, so no disposition of medications was completed; however, HD-C confirmed R12 had other medications in the facility when she was discharged and verified R12's record lacked documentation of the disposition of those medications upon discharge. The licensee's Medication Disposal policy, dated August 1, 2021, indicated upon discharge, the licensee must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided.	01910		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by:	{02040}		

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{02040}	Continued From page 14 Based on document review, the licensee failed to provide a hazard vulnerability or safety risk assessment that included hazards identified on and around the property. Mitigation of property hazards to protect residents from harm was not included. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 27, 2022, at 4:00 p.m., the licensed assisted living director (LALD)-B emailed documents for review. Documents were reviewed by survey staff on June 6, 2022, between 8:00 a.m. and 9:00 a.m. The Hazard Vulnerability Analysis document identified natural, technological, and human hazards, but did not include hazards or safety risks identified on and around the property. No further information was provided.	{02040}		
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and	{03090}		

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{03090}	Continued From page 15 maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents, staff and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 25, 2022, at approximately 1:20 p.m., upon entrance to the facility, the surveyor observed no electronic monitoring notice posted on entry or in the facility with the statutory required language. On May 25, 2022, at approximately 2:30 p.m., housing director (HD)-C verified the above. No further information was provided.	{03090}		

Electronically Delivered

April 20, 2022

Administrator
The Emeralds At Grand Rapids A
2815 Highway 169 South
Grand Rapids, MN 55744

RE: Project Number(s) SL30227015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 17, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal. **OR** Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general Free from Maltreatment reconsideration

reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jessica Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-508-2791 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders have been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30227015 On March 15, 2022, through March 17, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders were issued. At the time of the survey, there were thirty-eight (38) residents receiving services under the Assisted Living with Dementia license. An immediate correction order was identified on March 16, 2022, issued for SL30227015, tag identification 2310. On March 17, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a widespread scope and level three.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 250	Continued From page 1	0 250		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250		

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0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 15,	0 250		

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0 250	Continued From page 3 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-C stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building (s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which	0 250		

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0 250	Continued From page 4	0 250		

may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices.

- I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license.

- I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.

- I have examined this application and all

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0 250	Continued From page 5 attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by owner/agent (OA)-J on May 26, 2021. The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - orientation to and implementation of the assisted living bill of rights; - reminders for medications, treatments, or exercises, if provided;	0 250		

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0 250	Continued From page 6 - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; and - supervision of unlicensed personnel performing delegated tasks. On March 17, 2022, at 12:37 p.m., LALD-C confirmed the licensee provided contracted assisted living services as noted above, but failed to develop and implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0250, 0430, 0450, 0470, 0550, 0630, 0640, 0650, 0660, 0680, 0730, 0780, 0800, 0810, 0900, 1290, 1440, 1470, 1540, 1620, 1650, 1730, 1880, 1940, 2040, 2110, 2170, 2310 and 3090, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted	0 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30227	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS A	2815 HIGHWAY 169 SOUTH GRAND RAPIDS, MN 55744

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0 430	Continued From page 7 under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) to six of six residents (R1, R2, R3, R7, R8, R9) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1 R1 admitted for service on April 21, 2018, under the comprehensive home care license and began receiving assisted living services on August 1, 2021.	0 430		

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0 430	Continued From page 8 R1's Service Plan dated August 24, 2020, indicated R1 received assistance with weight monitoring, reassurance checks, housekeeping, laundry and medication administration. R1's record lacked a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. R2 R2 admitted for services on October 30, 2015, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R2's Service Plan dated August 21, 2020, indicated R2 received services for personal cares, bathing, behavior support, reassurance checks, housekeeping, laundry and medication management. R2's record lacked a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide.	0 430		

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0 430	Continued From page 9 R3 R3 admitted for services on March 29, 2021, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R3's Service Plan dated April 16, 2021, indicated R3 received services for toileting assist, dressing, grooming, bathing, housekeeping, laundry and medication administration. R3's record lacked a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. R7 R7 admitted for services on October 1, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R7's Service Plan dated August 25, 2020, indicated R7 received services for dressing, grooming, behavior support, reassurance checks, housekeeping and laundry. R7's record lacked a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and	0 430		

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0 430	Continued From page 10 - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. R8 R8 admitted for services on February 1, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R8's Service Plan dated August 25, 2020, indicated R8 received services for reassurance checks, housekeeping and laundry. R8's record lacked a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. R9 R9 admitted and began receiving assisted living services on August 1, 2021. R9's record lacked a service plan. A Services Received report dated February 2022 indicated R9 received services for ambulation/walking assist, housekeeping and laundry. R9's record lacked a uniform checklist disclosure of services to include:	0 430		

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0 430	Continued From page 11 - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. On March 16, 2022, at approximately 7:59 a.m., licensed assisted living director designee (LALDD)-C stated R1, R2, R3, R7, R8, R9 and all other residents receiving services under the licensee's Assisted Living with Dementia Care License had not received the uniform checklist disclosure. The licensee lacked a policy regarding the UDALSA. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and	0 450		

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0 450	Continued From page 12 evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident and a written acknowledgement received for four of six residents (R1, R2, R8, R9) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1 admitted for services on April 21, 2018, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R1's record lacked evidence R1 had received the Assisted Living Bill of Rights. R2 R2 admitted for services on October 30, 2015, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R2's record lacked evidence R2 had received the	0 450		

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0 450	Continued From page 13 Assisted Living Bill of Rights. R8 R8 admitted for services on February 1, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R8's record lacked evidence R8 had received the Assisted Living Bill of Rights. R9 R9 admitted and began receiving assisted living services on August 1, 2021. R9's record lacked evidence R9 had received the Assisted Living Bill of Rights. On March 17, 2022, at approximately 11:23 a.m., licensed assisted living director designee (LALDD)-C confirmed R1, R2, R8 and R9 had not received the Assisted Living Bill of Rights. The licensee's Minnesota Home Care Bill of Rights for Assisted Living Residents of Licensed Only Home Care Providers policy, undated, was a printed version of the home care bill of rights with licensee's corporate logo and did not address the requirement of providing residents a written copy or the licensee attaining a written acknowledgement of receipt. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 14 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a staffing plan was developed. This had the potential to affect all thirty-eight (38) residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 470		

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0 470	Continued From page 15 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia license. The facility was licensed for a capacity of fifty-one (51) residents and had a current census of thirty-eight (38) residents. The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. During the entrance conference on March 15, 2022, at approximately 11:00 a.m., a copy of the facility's staffing plan was requested from licensed assisted living director (LALD)-B. On March 15, 2022, at approximately 12:30 p.m., LALD-B provided a copy of the biweekly staffing schedule posted in the nursing office. LALD-B stated the staffing schedule could be changed based on the census number of the facility and/or the acuity of the residents. LALD-B confirmed the registered nurse had not developed a written staffing plan which included the above noted	0 470		

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0 470	Continued From page 16 required content. A staffing plan policy was requested but not received. No further information was provided. TIME PERIOD OF CORRECTION: Twenty-One (21) days	0 470		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to post in a conspicuous place, information about the facility's grievance procedure with the required content. This had the potential to affect the licensee's thirty-eight (38) residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 550		

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0 550	Continued From page 17 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting of the grievance procedure to include the name, telephone number and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. On March 15, 2022, at approximately 11:30 a.m., licensed assisted living director designee (LALDD)-C verified the main entrance was used by staff, residents, and visitors to the facility. The surveyor observed a bulletin board located in the main entrance area was noted to lack the required posting of the grievance procedure. On March 15, 2022, at approximately 11:35 a.m., LALDD-C verified the grievance procedure was not posted as required. The licensee's Complaints policy, undated, did not address complaint/grievance posting requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		

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0 630	Continued From page 18	0 630		
0 630 SS=F	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individual abuse prevention plan with the required content for six of six residents (R1, R2, R3, R7, R8, R9) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included hypertension, atrial fibrillation, pain and long term use of anticoagulants.	0 630		

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0 630	Continued From page 19 R1's Service Plan dated August 24, 2020, indicated R1 received assistance with weight monitoring, reassurance checks, housekeeping, laundry and medication administration. On March 16, 2022, at approximately 7:12 a.m., the surveyor observed unlicensed personnel (ULP)-H administer R1's morning medications. R1's Vulnerability Assessment/Abuse Prevention Plan dated February 11, 2021, identified areas of vulnerability with anxiety; history of falls; disoriented to date and time and memory difficulties due to dementia. R1's individual abuse prevention plan did not include a review of R1's risk of abusing other vulnerable adults, susceptibility to be abused by another individual, including other vulnerable adults or statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R2 R2's diagnoses included hypertension, chronic obstructive pulmonary disease, major depressive disorder and emphysema. R2's Service Plan dated August 21, 2020, indicated R2 received services for morning and evening personal cares, bathing, behavior support, reassurance checks, housekeeping, laundry and medication management. On March 16, 2022, at approximately 7:32 a.m., the surveyor observed ULP-D administer R2's morning medications. R2's Vulnerability Assessment/Abuse Prevention Plan dated April 23, 2019, identified areas of vulnerability with chronic pain; impaired mobility;	0 630		

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0 630	Continued From page 20 at risk for falls, impaired gait and continuous use of oxygen supplement. R2's individual abuse prevention plan did not include a review of R2's risk of abusing other vulnerable adults, susceptibility to be abused by another individual, including other vulnerable adults or statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R3 R3's diagnoses included dementia, diabetes mellitus, hypertension and long-term use of opiate analgesics. R3's Service Plan dated April 16, 2021, indicated R3 received services for toileting assist, dressing, grooming, bathing, housekeeping, laundry and medication administration. On March 16, 2022, at approximately 8:53 a.m., the surveyor observed ULP-H administer R3's morning medications. R3's Vulnerability Assessment/Abuse Prevention Plan dated December 1, 2021, identified areas of vulnerability with disorientation to time, place and person; impaired mobility; at risk for falls and visual difficulties. R3's individual abuse prevention plan did not include a review of R3's risk of abusing other vulnerable adults, susceptibility to be abused by another individual, including other vulnerable adults or statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R7 R7's diagnoses included bipolar disorder and arthritis.	0 630		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS A	2815 HIGHWAY 169 SOUTH GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 630	Continued From page 21 R7's Service Plan dated August 25, 2020, indicated R7 received services for dressing, grooming, behavior support, reassurance checks, housekeeping and laundry. On March 17, 2022, at approximately 11:12 a.m., the surveyor interviewed R7 to confirm services documented as provided were received daily. R7 confirmed the above noted services were provided by ULP's. R7's Vulnerability Assessment/Abuse Prevention Plan dated October 31, 2019, identified areas of vulnerability with forgetfulness; anxiety; chronic pain; some limited vision and inability to follow directions consistently. R7's individual abuse prevention plan did not include a review of R7's risk of abusing other vulnerable adults, susceptibility to be abused by another individual, including other vulnerable adults or statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R8 R8's diagnoses included hypertension, hiatal hernia, chronic kidney disease, bladder disorder and balance problems. R8's Service Plan dated August 25, 2020, indicated R8 received services for reassurance checks, housekeeping and laundry. On March 17, 2022, at approximately 10:41 a.m., the surveyor interviewed R8 to confirm services documented as provided were received daily. R8 confirmed the above noted services were provided by ULP's.	0 630		

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0 630	Continued From page 22 R8's Vulnerability Assessment/Abuse Prevention Plan dated December 1, 2021, identified areas of vulnerability with balance issues; at risk for falls; history of falls; low vision in left eye and chronic pain. R8's individual abuse prevention plan did not include a review of R8's risk of abusing other vulnerable adults, susceptibility to be abused by another individual, including other vulnerable adults or statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R9 R9's diagnoses included Parkinson's disease. R9's record lacked a service plan. A Services Received report dated February 2022 indicated R9 received services for ambulation/walking assist, housekeeping and laundry. On March 17, 2022, at approximately 11:03 a.m., the surveyor interviewed R9 to confirm services documented as provided were received daily. R9 confirmed the above noted services were provided by ULP's. R9's record lacked an Individual Abuse Prevention Plan. On March 17, 2022, at 12:11 p.m., licensed assisted living director designee (LALDD)-C confirmed R1, R2, R3, R7 and R8's Individual Abuse Prevention Plan did not address the above noted areas of risk. Additionally, LALDD-C confirmed R9 lacked an Individual Abuse Prevention Plan. A policy pertaining to Individual Abuse Prevention plans was requested, but not received.	0 630		

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0 630	Continued From page 23 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information to include: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; and (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 640		

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0 640	Continued From page 24 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting of the 911 emergency number in common areas and near telephones provided by the assisted living and the information for reporting suspected maltreatment to MAARC. On March 15, 2022, at approximately 11:30 a.m., the surveyor toured the facility with licensed assisted living director designee (LALDD)-C and observed the common areas lacked the required posting for the 911 emergency number and the reporting number for MAARC. On March 15, 2022, at approximately 11:43 a.m., LALDD-C confirmed the 911 emergency number was not posted on or near the telephone located within the main entry area and the contact information or reporting number for MAARC was not posted in a conspicuous manner. A policy regarding posting of 911 and reporting suspected maltreatment to MAARC was requested, but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=E	144G.42 Subd. 8 Employee records	0 650		

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0 650	Continued From page 25 (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for two of three employees (unlicensed personnel (ULP)-D, ULP-G) with records reviewed.	0 650		

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0 650	Continued From page 26 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-D ULP-D had a start date of February 17, 2010, and began providing assisted living services on August 1, 2021. ULP-D's employee record included two previous background checks conducted by two previous owners of the facility on February 17, 2010 and December 15, 2016. ULP-D's employee record lacked the following: - a current background study completed by licensee; and - documentation of annual performance reviews that identify areas of improvement needed and training needs. ULP-G ULP-G had a start date of November 9, 2021. ULP-G's employee's record lacked evidence of the following: - a current job description. On March 16, 2022, at approximately 3:50 p.m., licensed assisted living director designee (LALDD)-C verified the above contents were	0 650		

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0 650	Continued From page 27 missing from the employee records. The licensee's Personnel Files/Employee Records policy, dated November 2019 indicated employee records for each employee would include: -current signed job description, which includes qualifications, responsibilities, and identification of supervisors, if any; -documentation of annual performance reviews that identify areas of improvement needed and training needs; and -documentation of a completed background study. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	0 660		

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0 660	Continued From page 28 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screenings for health history, symptoms, and active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for three of three employees (unlicensed personnel (ULP)-D, ULP-G and ULP-H) with employee records reviewed. This had the potential to affect all thirty-eight (38) residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility's TB risk assessment, last updated January 10, 2022, determined the setting to be a low risk level. The licensee's employee records lacked evidence of a completed health history and symptom screening, including completion of a two-step TST or other evidence of TB screening, such as a blood test. ULP-D	0 660		

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0 660	Continued From page 29 ULP-D had a hire date of February 17, 2010, to provide direct care to licensee's residents. ULP-D's employee record lacked the following as required: - documentation of a completed health history and symptom screening; and - completion of a two-step TST or other evidence of TB screening such as a blood test. ULP-G ULP-G had a hire date of November 9, 2021, to provide direct care to licensee's residents. ULP-G's employee record lacked the following as required: - completion of a two-step TST or other evidence of TB screening such as a blood test. ULP-H ULP-H had a hire date of June 22, 2021, to provide direct care to licensee's residents. ULP-H's employee record lacked the following as required: - documentation of a completed health history and symptom screening; and - completion of a two-step TST or other evidence of TB screening such as a blood test. On March 16, 2022, at approximately 12:21 p.m., licensed assisted living director designee (LALDD)-C confirmed ULP-D, ULP-G and ULP-H did not complete the required TB history and symptom screening, a two-step TST, or a blood test as required. The licensee's Tuberculosis and Staff Screening policy dated January 2020, indicated all home care staff whose essential job functions require work within the same air space of residents would be screened and tested for TB. Additionally, the policy indicated licensee would have an ongoing	0 660		

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0 660	Continued From page 30 program for screening. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients and a baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to	0 680		

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0 680	Continued From page 31 all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to prominently post an emergency disaster plan, emergency exit diagrams and failed to provide residents with exit diagrams. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 15, 2022, at approximately 11:10 a.m., the surveyor asked to review the licensee's emergency preparedness plan and Appendix Z. During tour of the facility on March 15, 2022, at	0 680		

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0 680	Continued From page 32 approximately 11:30 a.m., the surveyor observed no signage or information posted regarding the licensee's emergency plan or emergency exit diagrams at the facility entrance, hallways, hallway exit doors or in the main living areas. On March 16, 2022, at approximately 3:47 p.m., licensed assisted living director designee (LALDD)-C confirmed the licensee lacked the following items as part of licensee's customized emergency preparedness plan: - post an emergency disaster plan prominently; - provide building emergency exit diagrams to all residents; and - post emergency exit diagrams on each floor. The licensee's Emergency Preparedness policy, undated, did not address posting requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing	0 730		

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0 730	Continued From page 33 medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a resident record included a discharge summary for one of one discharged resident (R6) with record reviewed.	0 730		

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0 730	Continued From page 34 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R6's diagnosis included Alzheimer's disease. R6 admitted for services on April 21, 2018, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R6 was discharged on March 8, 2022. R6's record lacked evidence a discharge summary was completed. On March 17, 2022, at approximately 12:17 p.m., licensed assisted living director designee (LALDD)-C confirmed a discharge summary had not been completed for R6. A discharge summary policy was requested, but not received. No further information provided. TIME PERIOD OF CORRECTION: Twenty-One (21 days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS A	2815 HIGHWAY 169 SOUTH GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 35 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 780		

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0 780	Continued From page 36 On March 15, 2022, between 1:00 p.m. and 2:15 p.m., survey staff toured the facility with the licensed assisted living director designee (LALDD)-C and the environmental services director (ESD)-F. During the facility tour, survey staff observed that smoke alarms were not installed in resident sleeping rooms. The LALDD-C confirmed during the tour that smoke alarms were not provided in resident sleeping rooms. Survey staff discussed with the LALDD-C that newly installed smoke alarms must be interconnected within dwelling units so that the actuation of one alarm causes all alarms in the dwelling unit to operate. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly	0 800		

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0 800	Continued From page 37 affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 15, 2022, between 1:00 p.m. and 2:15 p.m., survey staff toured the facility with the licensed assisted living director designee (LALDD)-C and the environmental services director (ESD)-F. During the facility tour, survey staff observed the following: 1. Several emergency exits were obstructed with snow. The snow also prevented these exit doors from opening outward. The LALDD-C confirmed that these emergency exits were blocked and required maintenance. TIME PERIOD FOR CORRECTION: Seven (7) days 2. The ceiling was water damaged in the hallway and in an adjacent room identified with a sign marked "Private". The ESD-F explained that the ceiling had been damaged by water due to an ice dam on the roof and that the ceiling required repair. TIME PERIOD FOR CORRECTION: Two (2) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 38 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide the required plans, training, and drills for fire safety and evacuation. This had the potential to directly affect all	0 810		

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0 810	Continued From page 39 residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 15, 2022, between 2:45 p.m. and 3:45 p.m., documents were provided for review by the licensed assisted living director (LALD)-B. Documents were reviewed by survey staff on March 15, 2022, between 2:45 p.m and 4:00 p.m. 1. The facility map included with the documentation was for the skilled nursing facility. The plans failed to include the location and number of resident rooms at the assisted living facility location. 2. The document titled Fire Emergency Code Red did not include a plan with accurate instructions on fire protection procedures for this location. a. elevators and stairwell doors were referenced, which were not identified in the plans; b. the document states that the sprinkler system will control the fire, but the plan does not identify where sprinklers are installed. 3. Meeting notes dated 10-14-2021 were provided for review. These notes contained information on fire safety and evacuation topics that were discussed during this meeting. Documentation of staff training upon hire and at least twice per year thereafter for fire safety and evacuation was requested but not provided. 4. The licensee failed to provide annual training for residents that included proper actions to take in the event of a fire to include movement,	0 810		

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0 810	Continued From page 40 evacuation, or relocation. Documentation of resident training was requested but not provided. 5. Documentation of an evacuation drill dated 10/2021 was provided. No additional drill logs or a drill schedule were provided. On March 15, 2022, between 4:00 p.m. and 4:15 p.m., the LALD-B confirmed during the interview that the licensee failed to provide the required content within the fire safety and evacuation plans. They also confirmed that the training for staff and residents was not met. The LALD-B stated that the licensee had not completed an evacuation drill since October of 2021 and confirmed that the evacuation drill frequency was not met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to	0 900		

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0 900	Continued From page 41 the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and execute a written contract with the required content for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 900		

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0 900	Continued From page 42 The findings include: R1 R1's diagnoses included hypertension, chronic atrial fibrillation and long-term use of anticoagulants. R1's service plan dated August 24, 2020, indicated R1 received services to include, weight monitoring, reassurance checks, housekeeping, laundry and medication administration. R1's records lacked a written contract to include all of the terms concerning the provisions of the following as required: (1) housing (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. In addition, R1's records lacked evidence that the contract had been fully executed as the facility must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. R2 R2's diagnoses included chronic obstructive pulmonary disease (COPD), emphysema, hypertension and major depressive disorder. R2's service plan dated August 21, 2020, indicated R2 received services to include, oxygen monitoring, morning and evening personal cares, behavior support, housekeeping, laundry and	0 900		

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0 900	Continued From page 43 medication management. R2's records lacked a written contract to include all of the terms concerning the provisions of the following as required: (1) housing (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. In addition, R1's records lacked evidence that the contract had been fully executed as the facility must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. R3 R3's diagnoses included dementia, Type II diabetes mellitus, hypertension and major depressive disorder. R3's service plan dated April 16, 2021, indicated R3 received services to include, dressing, grooming, toileting assist, bathing, transfer assist, escorts, housekeeping, laundry and medication management. R3's records lacked a written contract to include all of the terms concerning the provisions of the following as required: (1) housing (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable.	0 900		

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0 900	Continued From page 44 In addition, R1's records lacked evidence that the contract had been fully executed as the facility must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. On March 16, 2022, at approximately 7:59 a.m., licensed assisted living director designee (LALDD)-C confirmed a written assisted living contract had not been developed or executed for R1, R2, R3 or licensee's other current residents as required. Additionally, LALDD-C stated "the consultant said it wasn't right yet". A policy pertaining to licensee's assisted living contracts was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under	01290		

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01290	Continued From page 45 section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a background study was submitted and received for one of one employee (unlicensed personnel (ULP)-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D had a start date of February 17, 2010, and began providing assisted living services on August 1, 2021. On March 16, 2022, at 7:32 a.m., the surveyor observed ULP-D administer R2's morning medications. ULP-D's employee record contained a background study submitted by a company that previously owned the facility location, dated February 18, 2010. ULP-D's employee record lacked evidence the licensee submitted a	01290		

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01290	Continued From page 46 background study for ULP-D under the current license. On March 16, 2022, at approximately 4:37 p.m., licensed assisted living director designee (LALDD)-C confirmed the licensee had not submitted a background study for ULP-D under the current assisted living license. The licensee's Personnel Files/Employee Records policy dated November 2019, indicated every employee of licensee's employee file would contain verification of a background study. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30	01440		

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01440	Continued From page 47	01440		

calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff carrying out a delegated task within 30 days of providing nursing services for three of three employees (unlicensed personnel (ULP)-D, ULP-H, ULP-G) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

ULP-D
On March 16, 2022, at approximately 7:32 a.m., the surveyor observed ULP-D administer R2's morning medications.

ULP-D had a start date of February 17, 2010, and began providing assisted living services on August 1, 2021.

ULP-D's employee record lacked documentation the RN supervised ULP-D performing the delegated tasks within 30 days of hire or any as

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01440	Continued From page 48 needed supervision of performance thereafter. ULP-H On March 16, 2022, at approximately 8:53 a.m., the surveyor observed ULP-H administer R3's morning medications. ULP-H had a hire date of June 22, 2021, to provide direct care services to licensee's residents. ULP-H's employee record lacked documentation the RN supervised ULP-G performing the delegated tasks within 30 days of hire. ULP-G On March 15, 2022, at approximately 12:48 p.m., the surveyor observed ULP-G administer R3's as needed (PRN) medication. ULP-G had a hire date of November 9, 2021, to provide direct care services to licensee's residents. ULP-G's employee record lacked documentation the RN supervised ULP-G performing the delegated tasks within 30 days of hire. On March 16, 2022, at approximately 4:46 p.m., licensed assisted living director designee (LALDD)-C confirmed the RN did not complete a 30-day supervisory for ULP-D, ULP-H or ULP-G. Licensee's Supervision of ULP policy, dated December 2019, indicated ULP's must be supervised by an RN within 30 days after the date on which the ULP begins working for the home care provider. Supervision would include observation of the staff administering medications or treatments.	01440		

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01440	Continued From page 49 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and	01470		

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01470	Continued From page 50 (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to 144G licensing requirements for three of three employees (unlicensed personnel (ULP)-G, ULP-D and ULP-H) with employee records reviewed. This had potential to affect all thirty-eight (38) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01470		

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01470	Continued From page 51 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on March 15, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-B and licensed assisted living director designee (LALDD)-C stated they understood assisted living licensure regulation and requirements. ULP-G ULP-G had a hire date of November 9, 2021, to provide direct care services to the licensee's residents. ULP-G's employee record lacked documentation of the following required orientation: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULP-D ULP-D was hired on February 17, 2010, to provide direct care services to the licensee's residents. ULP-D's employee record lacked documentation of the following required orientation: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and	01470		

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01470	Continued From page 52 - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULP-H ULP-H had a hire date of June 22, 2021, to provide direct care services to licensee's residents. ULP-H's employee record lacked documentation of the following required orientation: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On March 17, 2022, at approximately 11:26 a.m., LALDD-C confirmed ULP-G, ULP-D and ULP-H did not receive the required assisted living licensure orientation. Licensee's Orientation of Home Care Staff policy dated November 2019, indicated all staff providing and supervising direct services must complete an orientation to assisted living requirements and regulations before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working	01540		

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01540	Continued From page 53 hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of three employees (unlicensed personnel (ULP)-D, ULP-H) received the required amount of dementia care training in the required time frame with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee had a current assisted living facility with dementia care license. ULP-D ULP-D was hired on February 17, 2010, to	01540		

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01540	Continued From page 54 provide direct care services to licensee's residents. ULP-D's employee record contained no evidence ULP-D had completed initial or on-going dementia training. ULP-D's employee record lacked evidence ULP-D had completed the required eight (8) hours of training on the specific dementia care topics within 80 working hours of ULP-D's hire date. ULP-H ULP-H had a hire date of June 22, 2021, to provide direct care services to licensee's residents. ULP-H's record identified 6 hours of training for dementia completed on June 22, 2021. ULP-H's employee record lacked evidence ULP-H had completed the required eight (8) hours of training on the specific dementia care topics within 80 working hours of ULP-H's hire date. On March 17, 2022, at approximately 12:30 p.m., licensed assisted living director designee (LALDD)-C confirmed ULP-D and ULP-H lacked the required dementia training. The licensee's Training Requirement for Assisted Living with Dementia Care policy, undated, indicated direct care staff would complete a minimum of eight hours of initial training on dementia care topics within 160 working hours of the employment start date. Licensee's policy did not contain information pertaining to requirements for an assisted living with dementia care license.	01540		

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01540	Continued From page 55 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing	01620		

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01620	Continued From page 56	01620		

resident reassessments and did not exceed 90 days for three of three residents (R3, R2, R1) as required with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

R3
R3's Service Plan dated April 16, 2021, indicated R3 received services for toileting assist, dressing, grooming, bathing, housekeeping, laundry and medication administration.

On March 15, 2022, at approximately 12:48 p.m., the surveyor observed unlicensed personnel (ULP)-G administer R3 an as needed (PRN) medication.

R3's record indicated the RN completed a reassessment on December 1, 2021, and March 14, 2022, which indicated 103 days passed between assessments.

R2
R2's service plan dated August 21, 2020, indicated R2 received services to include, oxygen monitoring, morning and evening personal cares, behavior support, housekeeping, laundry and medication management.

On March 16, 2022, at approximately 7:32 a.m., the surveyor observed ULP-D administer R2's

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01620	Continued From page 57 scheduled morning medications. R2's record indicated the RN completed a reassessment on August 24, 2021, and on December 2, 2021, which indicated 100 days passed between assessments. No additional reassessments were completed after December 2, 2021. R1 R1's service plan dated August 24, 2020, indicated R1 received services to include; weight monitoring, reassurance checks, housekeeping, laundry and medication administration. On March 17, 2022, at approximately 8:23 a.m., the surveyor observed ULP-I administer R1's scheduled morning medications. R1's record indicated the RN completed a reassessment on May 12, 2021, and an assisted living assessment on February 15, 2022, which indicated 276 days passed between assessments. On March 17, 2022, at approximately 9:25 a.m., registered nurse (RN)-A confirmed R3, R2 and R1's ongoing reassessments were not completed at least every 90 days. The licensee's Assessments - Schedule policy revised July 29, 2021, indicated the RN would conduct assessments, monitoring and reassessments consistent with Assisted Living regulation and the individual needs of each assisted living resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	01620		

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01620	Continued From page 58 days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included all required content for three of	01650		

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01650	Continued From page 59 three residents (R3, R2, R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 R3's Service Plan dated April 16, 2021, indicated R3 received services for toileting assist, dressing, grooming, bathing, housekeeping, laundry and medication administration. On March 15, 2022, at approximately 12:48 p.m., the surveyor observed unlicensed personnel (ULP)-G administer R3 as needed (PRN) medication. R3's service plan lacked the following required content: - the schedule and methods of monitoring staff providing services. R2 R2's diagnoses included hypertension, chronic obstructive pulmonary disease, major depressive disorder and emphysema. R2's service plan dated August 21, 2020, indicated R2 received services to include, oxygen monitoring, morning and evening personal cares, behavior support, housekeeping, laundry and medication management.	01650		

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01650	Continued From page 60 On March 16, 2022, at approximately 7:32 a.m., the surveyor observed ULP-D administer R2's scheduled morning medications. R2's service plan lacked the following required content: - the schedule and methods of monitoring staff providing services. R1 R1's diagnoses included hypertension, atrial fibrillation, pain and long term use of anticoagulants. R1's service plan dated August 24, 2020, indicated R1 received services to include, weight monitoring, reassurance checks, housekeeping, laundry and medication administration. On March 17, 2022, at approximately 8:23 a.m., the surveyor observed ULP-I administer R1's scheduled morning medications. R1's service plan lacked the following required content: - the schedule and methods of monitoring staff providing services. On March 17, 2022, at approximately 9:40 a.m., registered nurse (RN)-A confirmed R3, R2 and R1's service plan did not include a schedule or method for monitoring staff providing services. Additionally, RN-A stated the service plan is a template used for all residents. The licensee's Service Plan policy dated November 2019, indicated the service plan must include the frequency of sessions of supervision by staff and the type of personnel who would	01650		

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01650	Continued From page 61 supervise staff. The policy did not address the method of monitoring staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and	01730		

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01730	Continued From page 62 (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 15, 2022, at approximately 11:00 a.m., licensed assisted living director designee (LALDD)-C and licensed assisted living director (LALD)-B stated the licensee provided medication management services for the licensee's residents.	01730		

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01730	Continued From page 63 R1 R1's diagnoses included hypertension, atrial fibrillation, pain and long term use of anticoagulants. R1's service plan dated August 24, 2020, indicated R1 received medication management services two (2) times daily. R1's electronic medication administration record (EMAR) dated February 2022, included the following medications: a mild pain reliever, a blood pressure reducer, a vitamin supplement, a medication to stabilize the heart rate, two antipsychotic mood stabilizers and one blood thinner. On March 17, 2022, at approximately 8:23 a.m., the surveyor observed ULP-I administer R1's scheduled morning medications. R1's medication management plan lacked the following: - a statement describing the medication management services that would be provided; - documentation of specific resident instructions relating to the administration of medications; - identification of medication management tasks that may be delegated to ULP; - procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services; - any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions; and	01730		

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THE EMERALDS AT GRAND RAPIDS A	2815 HIGHWAY 169 SOUTH GRAND RAPIDS, MN 55744

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01730	Continued From page 64 - completion of medication reconciliation. R2 R2's diagnoses included hypertension, chronic obstructive pulmonary disease, major depressive disorder and emphysema. R2's Service Plan dated August 21, 2020, indicated R2 received medication management services four (4) times daily. R2's electronic medication administration record (EMAR) dated December 2021, included the following medications: two narcotic pain relievers, two anxiety reducers, one thyroid medication, two inhalers, two antidepressants, one diuretic, one eye drop for dry eyes, two blood pressure reducers, two skin ointments, one stomach acid reducer, one stool softener and one medication used to treat constipation. On March 16, 2022, at approximately 7:32 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's morning medications. R2's medication management plan lacked the following: - a statement describing the medication management services that would be provided; - documentation of specific resident instructions relating to the administration of medications; - identification of medication management tasks that may be delegated to ULP; - procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services; - any resident-specific requirements relating to documenting medication administration, verification that all medications are administered	01730		

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01730	Continued From page 65	01730		

as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions; and
- completion of medication reconciliation.

R3
R3's diagnoses included dementia, diabetes mellitus, hypertension and long term use of opiate analgesics.

R3's Service Plan dated April 16, 2021, indicated R3 received services for medication administration three (3) times daily.

R3's electronic medication administration record (EMAR) dated December 2021, included the following medications: one mild pain reducer, one antidiarrheal, three blood pressure reducers, one insulin, one mood stabilizer, one vitamin supplement, one diuretic, one nerve pain reducer, one stomach acid reducer and one mouth rinse.

On March 16, 2022, at approximately 8:53 a.m., the surveyor observed ULP-H administer R3's morning medications.

R3's medication management plan lacked the following:
- a statement describing the medication management services that would be provided;
- documentation of specific resident instructions relating to the administration of medications;
- identification of medication management tasks that may be delegated to ULP;
- procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services;
- any resident-specific requirements relating to documenting medication administration,

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01730	Continued From page 66 verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions; and - completion of medication reconciliation. On March 17, 2022, at approximately 9:48 a.m., registered nurse (RN)-A confirmed R1, R2 and R3's individualized medication management plans did not include all the required content. RN-A stated she [RN-A] had not been trained on the electronic system used by licensee and was the reason that resident records would be missing items as noted above. The licensee's Development of the Individualized Medication, Treatment and Therapy Management Plan and Individualized Medication and Treatment Record dated November 2019, indicated the RN would develop an individualized medication treatment and therapy plan for each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prescription	01880		

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01880	Continued From page 67 medications were stored according to the manufacturer's directions. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 15, 2022, at approximately 12:19 p.m., in the presence of registered nurse (RN)-A and licensed assisted living director designee (LALDD)-C, the surveyor observed the locked medication refrigerator in the nurse's office. The Refrigerator Temperature Log posted on the door of the medication refrigerator, dated January 1, 2022, to March 2022, indicated refrigerator temperatures were not recorded 19 of the 74 days of opportunity. The medication refrigerator contained an insulin pen belonging to R3 as follows: - one unopened Basaglar Kwikpen 100 units (u)/milliliter (ml) On March 15, 2022, at approximately 12:25 p.m., RN-A confirmed the refrigerator temperature was 41 degrees fahrenheit and resident insulins are kept in the medication refrigerator. Additionally, RN-A confirmed 19 of 74 days of opportunity for temperature monitoring were not completed. RN-A stated, "I've never looked at it to be honest."	01880		

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01880	Continued From page 68 The manufacturer's instructions for Basaglar insulin pens dated December 2015, indicated unopened pens should be stored in the refrigerator at 36 to 46 degrees F. A policy pertaining to storage of medications was requested, but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy	01940		

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01940	Continued From page 69 received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individual treatment management plan to include all required content for two of three residents (R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's diagnoses included hypertension, chronic obstructive pulmonary disease, major depressive disorder and emphysema. R2's service plan dated August 21, 2020, indicated R2 received services to include oxygen monitoring. R2's physician orders with a print date of March 15, 2022, included supplemental oxygen, 3 - 4	01940		

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01940	Continued From page 70 liters per minute (LPM) continuous via nasal cannula. On March 16, 2022, at approximately 7:32 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's scheduled morning medications and verify oxygen concentrator was set at 3 LPM. R2's Treatment/Therapy Management Plan lacked the following content: - identification of the treatment or therapy that will be delegated to unlicensed personnel; - procedures for notifying a nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services; and - any resident-specific requirements relating to documenting of treatment and therapy received' verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R3 R3's diagnoses included dementia, diabetes mellitus, hypertension and long term use of opiate analgesics. R3's Service Plan dated April 16, 2021, indicated R3 received services for compression stockings (TEDs). R3's physician orders with a print date of March 16, 2022, included TEDs twice daily, apply in the morning, remove in the evening to treat edema. On March 16, 2022, at approximately 8:53 a.m., the surveyor observed ULP-H administer R3's morning medications and observed compression	01940		

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01940	Continued From page 71 stockings were on R3 at the time of visit. ULP-H confirmed R3's TEDs had been put on earlier in the morning by ULP-H. R3's Treatment/Therapy Management Plan lacked the following content: - identification of the treatment or therapy that will be delegated to unlicensed personnel; - procedures for notifying a nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services; and - any resident-specific requirements relating to documenting of treatment and therapy received' verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On March 17, 2022, at approximately 9:50 a.m., registered nurse (RN)-A confirmed R2 and R3's record lacked a complete and accurate individualized treatment and therapy plan. The licensee's Development of the Individualized Medication, Treatment and Therapy Management Plan and Individualized Medication and Treatment Record dated November 2019, indicated the RN would develop an individualized treatment and therapy plan for each resident based on the needs and services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment	02040		

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02040	Continued From page 72 An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment that included hazards identified on and around the property. Mitigation of property hazards to protect residents from harm was not included. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 15, 2022, between 2:45 p.m. and 3:45 p.m., documents were provided for review by the licensed assisted living director (LALD)-B. Documents were reviewed by survey staff on March 15, 2022, between 2:45 p.m. and 4:00 p.m. A hazard vulnerability assessment was included within the Emergency Preparedness	02040		

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02040	Continued From page 73 binder dated 10/18/2021. The Hazard Vulnerability Assessment did not include hazards or safety risks identified on and around the assisted living property. Mitigation of property hazards to protect residents from harm was not included. On March 15, 2022, between 4:00 p.m. and 4:15 p.m., the LALD-B confirmed during the exit interview that the licensee failed to include safety risks or hazards identified on and around the property in the assessment. They also confirmed that mitigation of property hazards to protect residents from harm was not included. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;	02110		

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02110	Continued From page 74 (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care. This had the potential to affect all residents in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	02110		

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02110	Continued From page 75 The licensee was licensed as an Assisted Living with Dementia Care facility. Review of the licensee's policies on March 17, 2022, indicated the licensee lacked the following required policies and procedures: - philosophy of how services are provided based upon the assisted living facility license's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; - description of life enrichment programs and how activities are implemented; - descriptions of family support program and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On March 17, 2022, at approximately 11:32 a.m., the licensed assisted living director designee (LALDD)-C verified the above noted policies had not been provided to the surveyor upon request and licensed assisted living director (LALD)-A stated the corporate consultant was working on providing the requested policies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

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02170	Continued From page 76	02170		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities.	02170		

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02170	Continued From page 77 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have an evaluation for an activity plan for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had a current assisted living with dementia care license. R1 R1's diagnoses included hypertension, atrial fibrillation, pain and long term use of anticoagulants. R1's RN Assessment, dated February 15, 2022, indicated R1 was independent with mobility with the use of an assistive device, needed supervision with finances, needed hands-on assist of one with shopping and was dependent on staff for housekeeping, laundry, appointments and transportation. R1's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - current abilities and skills;	02170		

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THE EMERALDS AT GRAND RAPIDS A	2815 HIGHWAY 169 SOUTH GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02170	Continued From page 78 - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R1's record lacked the development of an individualized activity plan. R2 R2's diagnoses included hypertension, chronic obstructive pulmonary disease, major depressive disorder and emphysema. R2's RN Assessment, dated August 24, 2021, indicated R2 required assistive devices, wheelchair, walker and lift chair to aide in mobility. R2 was noted to have sensory loss due to macular degeneration, required assistance with dressing, grooming, toileting and bathing. R2 required assistance with finances, shopping, housekeeping, laundry and meal preparation. R2's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R2's record lacked the development of an individualized activity plan. R3	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30227	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS A	2815 HIGHWAY 169 SOUTH GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02170	Continued From page 79 R3's diagnoses included dementia, diabetes mellitus, hypertension and long term use of opiate analgesics. R3's RN Assessment, dated December 1, 2021, indicated R3 required assistive devices, wheelchair and walker to aide with mobility. R3 was noted to have sensory loss due to macular degeneration, required hands-on assistance with dressing, toileting, bathing and hair care. R3 required assistance with telephones, finances, shopping, housekeeping, laundry, meal preparation and transportation. R3's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R3's record lacked the development of an individualized activity plan. On March 17, 2022, at approximately 9:23 a.m., registered nurse (RN)-A confirmed an activity assessment was not completed for R1, R2, R3 or for the other current residents residing at the facility. RN-A stated, "I didn't know I needed to do that." A policy regarding assessment for activities and development of individual resident activity plans under the dementia care license was requested, but not provided.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30227	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS A	2815 HIGHWAY 169 SOUTH GRAND RAPIDS, MN 55744

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02170	Continued From page 80 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for five of five residents (R1, R2, R3, R4, R5) with bedrails. This resulted in an immediate correction order on March 16, 2022, at approximately 12:58 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 On March 16, 2022, at approximately 6:59 a.m.,	02310	On March 17, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope and level of I.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30227	A. BUILDING: _____ B. WING _____	03/17/2022

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02310	Continued From page 81 the surveyor observed a bedrail on the right side near the foot of the bed. The bedrail was secured with a strap around the frame and box spring. R1's diagnoses included hypertension, pain, chronic atrial fibrillation and long-term use of anticoagulants. R1's service agreement dated April 21, 2018, indicated R1 received the following services: assurance checks daily, vital signs monthly, housekeeping, laundry and medication management. On March 16, 2022, at approximately 10:12 a.m., licensed assisted living director designee (LALDD)-C stated the bedrail was to assist with mobility and was secured to the bed. LALDD-C measured the bedrail with the surveyor present. The outside diameter of the bedrail measured 19 inches wide by 34 inches tall. The inside rail measured 15 inches wide by 30 inches tall. The bedrail measurements did not comply with FDA guidelines for bedrails. On June 17, 2019, a registered nurse (RN) conducted a side rail assessment, however, the assessment did not include documentation of a review of risks and benefits for the resident's use of bedrails and did not include a measurement of the bedrails. R2 On March 16, 2022, at approximately 7:32 a.m., the surveyor observed bedrails raised on the right and left side of the resident's bed. The bedrails were secured to the hospital bed frame. R2's diagnoses included pulmonary emphysema, chronic obstructive pulmonary disease,	02310		

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02310	Continued From page 82 hypertension and major depressive disorder. R2's service agreement dated August 21, 2020, indicated the resident received the following services: assistance with morning cares, behavior support, housekeeping, oxygen monitoring, toileting, transfer assist and medication management services. On March 16, 2022, at approximately 10:17 a.m., LALDD-C stated the bedrail was to assist with mobility and both raised bedrails were secured to the bed. LALDD-C measured the bedrail with the surveyor present. The bedrail measured 31.5 inches wide by 22.5 inches tall. The gap between the rails was 3 inches, which was in compliance with FDA guidelines for bedrails. On April 23, 2019, a RN conducted a side rail assessment, however, the assessment did not include documentation of a review of risks and benefits for the resident's use of siderails and did not include a measurement of the bedrails. R3 On March 16, 2022, at approximately 8:23 a.m., the surveyor observed a bedrail on the left side near the head of the resident's bed. The bedrail was an open loop style secured between the mattress and box spring with extension bars and a strap wrapped around the box spring. R3's diagnoses included dementia, type 2 diabetes and osteoarthritis. R3's service agreement dated April 16, 2021, indicated the resident received the following services: dressing, grooming, toileting assistance, bathing assist, housekeeping, laundry and medication management.	02310		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT GRAND RAPIDS A	2815 HIGHWAY 169 SOUTH GRAND RAPIDS, MN 55744

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02310	Continued From page 83 On March 16, 2022, at approximately 10:24 a.m., LALDD-C stated the bedrail was to assist R3 with mobility around the bed and sitting on the bed. LALDD-C measured the bed rail with the surveyor present. The hoop style bed rail measured 14.5 inches wide by 35 inches tall. The gap between the diameter was 14.5 inches and was not in compliance with FDA guidelines for bedrails. LALDD-C confirmed an assessment for the bedrail had not been completed. R4 On March 16, 2022, at approximately 8:53 a.m., the surveyor observed bedrails raised on the right and left side of the resident's bed. The bedrails were secured to the hospital bed frame. R4's diagnoses included hypertension, regional pain syndrome and Alzheimer's disease. R4's service agreement dated March 14, 2019, indicated the resident received the following services: morning cares, vital signs monthly, reassurance checks, evening cares, bathing assist and medication management. On March 16, 2022, at approximately 10:31 a.m., LALDD-C stated the bedrails were to assist with mobility and both bedrails were secured to the bedframe. LALDD-C measured the bedrail with the surveyor present. The of the bedrail measured 31.5 inches wide by 22.5 inches tall. The gap between the rails was 3 inches and 4 inches and was in compliance with FDA guidelines for bedrails. LALDD-C confirmed an assessment for the bedrail had not been completed. R5 On March 16, 2022, at approximately 10:12 a.m.,	02310		

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	30227	A. BUILDING: _____ B. WING _____	03/17/2022

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02310	Continued From page 84	02310		

the surveyor observed a bedrail on the left side near the head of the resident's bed. The bedrail was an open loop style secured between the mattress and box spring with extension bars and a strap wrapped around the frame and box spring.

R5's diagnoses included Parkinson's disease, osteoarthritis, carpal tunnel and memory loss.

R5's service agreement dated October 29, 2021, indicated the resident received the following services: dressing, grooming, reassurance checks, vital sign check monthly, assistance with bathing, housekeeping, laundry and medication administration.

On March 16, 2022, at approximately 10:37 a.m., LALDD-C stated the bedrail was to assist R5 with mobility and repositioning. LALDD-C measured the bedrail with the surveyor present. The hoop style bedrail measured 14 inches wide by 37 inches tall. The gap between the diameter was 14 inches and was not in compliance with FDA guidelines for bed rails. On March 4, 2020, a RN conducted a bedrail assessment, however, the assessment did not include documentation of a review of risks and benefits for the resident's use of bedrails and did not include a measurement of the bedrails.

On March 16, 2022, at approximately 9:52 a.m., RN-A confirmed there would not be documentation of measurements for any residents using bedrails and stated, "I didn't know we needed to do measurements".

The licensee's Siderails policy dated November 2019 indicated when bedrails were used, the RN would conduct an assessment prior to installation

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02310	Continued From page 85 or when reported to nurses and at least every twelve months face-to-face with the resident. The policy failed to address what the assessment would include and how the licensee would address bedrails that did not meet FDA standards. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The FDA recognized that zones 6 and 7 present a risk of either neck or chest entrapment and acknowledged that this space may change when raising or lowering the head or foot sections of the bed. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided.	02310		

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02310	Continued From page 86 TIME PERIOD FOR CORRECTION: IMMEDIATE An immediate correction order was identified on March 16, 2022, issued for SL30227015, tag identification 2310. On March 17, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope and level of I. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than	03090		

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03090	Continued From page 87 a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 15, 2022, at approximately 11:30 a.m., during the tour of the facility, the surveyor observed cameras throughout the facility, but no electronic monitoring notice posted on entry or in the facility with the statutory required language. On March 15, 2022, at approximately 11:55 a.m., licensed assisted living director designee (LALDD)-C acknowledged the licensee failed to post the required electronic monitoring notice. LALDD-C stated, " those cameras have not worked for years." A policy pertaining to electronic monitoring was requested, but not received. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

MINNESOTA DEPARTMENT OF HEALTH
Food, Pool,& lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/15/22*
Time: 11:55:11
Report: 7939221059

Food and Beverage Establishment Inspection Report

Location:
The Emeralds At Grand Rapids A
2815 Highway 169 South
Grand Rapids, MN55744
Itasca County, 31

Establishment Info:
ID #: 0038983
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2183268567
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 50PPM at Degrees Fahrenheit
Location: WARE WASH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: CICKEN
Temperature: 180 Degrees Fahrenheit - Location: COOKING
Violation Issued: No

Process/Item: STEAM TRAY
Temperature: 133 Degrees Fahrenheit - Location: POTATOES
Violation Issued: No

Process/Item: SOUP
Temperature: 167 Degrees Fahrenheit - Location: COOKING
Violation Issued: No

Process/Item: POLISH
Temperature: 136 Degrees Fahrenheit - Location: HOT HOLDING ON STOVE TOP
Violation Issued: No

Process/Item: GTRAVY
Temperature: 34 Degrees Fahrenheit - Location: 2 DOOR FRIDGE
Violation Issued: No

Process/Item: MAYO
Temperature: 40 Degrees Fahrenheit - Location: 2 DOOR FRIDGE
Violation Issued: No

Type: Full
Date: *03/15/22*
Time: 11:55:11
Report: 7939221059
The Emeralds At Grand Rapids A

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

DISCUSSION
SANITIZER TESTING

BARE HAND CONTACT AND GLOVE USE

SKESSLER@MONARKMN.COM

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the MINNESOTA DEPARTMENT OF HEALTH inspection report number 7939221059 of 03/15/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed: NA

SUSAN KESSLER
MANAGER

Signed: _____

RYAN TRENBERTH
SAN III
BEMIDJI DISTRICT OFFICE
218-308-2133
ryan.trenberth@state.mn.us