STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Village	923 Hale Lake Pointe Grand Rapids, MN 55744

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and document review the facility failed to ongoing assessment of respiratory status for 1 of 3 residents (R1) who experienced a change in respiratory status. In addition, facility staff administered medications to R1 while he displayed symptoms of respiratory distress resulting R1 requiring medications to be suctioned out of the back of his throat.Findings include: R1's face sheet printed 5/15/26, indicated he was admitted to the facility 11/12/25. Diagnoses included Traumatic subdural hemorrhage, hydrocephalus, and dysphagia. R1's 5-day Minimum Data Set (MDS) 12/22/25, identified severe cognitive impairment. MDS indicated R1 required substantial/maximal assistance to eat, displayed coughing/choking during meals and complaints of difficulty or pain when swallowing. R1's care plan dated 2/18/26, identified a self-care deficit and indicated he required assistance from staff to eat. The care plan identified altered communication and problem with nutrition related to neurological symptoms. Staff were directed to monitor/report as needed any symptoms of dysphagia (difficulty swallowing): pocketing, choking, drooling, holding food in mouth, several attempts at swallowing, refusal to eat or appearance of being concerned during meals. R1's Progress Notes indicated the following: 4/2/26, 10:09 p.m., R1 did not eat supper this shift. R1 wanted to go to bed. R1 seemed weaker and did not hold his head up in his wheelchair. Medications were crushed and given by syringe. R1 seemed to have a harder time swallowing. 4/4/26, 4:51 a.m., R1 had increased respirations of 22-24 breaths per minute (bpm). R1's oxygen saturation was at 90% on room air. R1 had a slight gurgle when breathing and was unable to cough to clear it. Head of bed elevated to help with respirations. Staff continue to monitor. 4/4/26, Writer was notified by cart nurse, R1 had respirations of 44 and oxygen saturation level of 73 percent. Oxygen was initiated. Pulse was 135. Blood pressure 120/83 and temperature was 97.2 degrees Fahrenheit. Instructed cart nurse to call the family to see if they would like him to be seen in the ED [emergency department] as R1 was unable to make his own decision at this time. R1 had clear lung sounds but audible gurgles upon inhalation and exhalation. R1 was not at baseline and was not responding to questions at this time. Family did call cart nurse back and wanted him sent in. 911 called at 8:35 a.m., and nurse to nurse given with hospital registered nurse (RN). 4/4/26, R1 was sent to the emergency department (ED) via North ambulance due to increased respiratory rate of 44 bpm, Oxygen saturation was 71% on room air. R1 was placed on oxygen, family member was updated and requested R1 be seen in ED, R1 was sternum breathing and gurgling with breathing. ˆ 4/4/26, 6:26 p.m., Received update from hospital RN. Per RN, R1 was admitted to hospice for aspiration pneumonia. R1's Vitals Report (date) indicated: Respirations 4/4/26- 44bpm Pulse 4/1/26- 71 4/4/26- 135 Oxygen saturation 4/1/26- 95% room air 4/4/26- 71% room air R1's April Medication Administration Record indicated R1 received oral medications on 4/4/26, despite audible gurgling. Medications were administered at 6:00 a.m., and during morning medication pass. Review of R1's April 2026, TAR lacked evidence of monitoring of R1's respiratory status. R1's record lacked evidence of ongoing respiratory assessment and/or vital signs between 4/2/26 and 4/4/26. R1's hospital ED provider Note dated 4/4/26, indicated R1 presented for concern related to shortness of breath. Oxygen saturation was in the 70's for emergency medical services. On quick exam there were pills stuck in the back of his throat. Suspected aspiration pneumonia which had been ongoing. Increased work of breathing and aspiration (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	events in recent days. During interview on 5/12/26 at 1:21 p.m., family member (FM)-A said when R1 went to the emergency department, the doctor had reported to them R1 had aspirated. FM-A stated she was told by facility staff, R1 was having trouble breathing at approximately 2:00 a.m., and was not called until 8:30 a.m. FM-A was concerned R1 may have been struggling for many hours. During interview on 5/13/26 at 8:44 a.m., medical doctor (MD)-A stated while reviewing R1's chart it was noted he had pills stuck in the back of his throat when he first got to the emergency department. MD-A stated the risk associated with aspirating pills included pneumonia and could lead to respiratory arrest. During interview on 5/13/26 at 9:44 a.m., licensed practical nurse (LPN)-A said she remembered the note written on 4/2/26, and said if there had been a change of condition she would have notified the RN supervisor but did not remember who that would have been. During interview on 5/13/26 at 10:00 a.m., RN-B stated she had been working the overnight shift on 4/4/26, when R1 had increased respirations. RN-B remembered R1's head of bed was raised to help with breathing. RN-B stated the floor nurses were supposed to monitor R1 and let her know if any changes occurred. RN-B expected vital signs and oxygen saturation were checked, especially with concerns related to respirations. During interview on 5/13/26 at 1:11 p.m., NP-A stated she had not been notified of R1' s condition between 4/2/26 and 4/4/26. Staff could have notified someone sooner and medications could have been held. If concerns occurred over the weekend, an on-call provider would have sent R1 to the hospital. During interview on 5/13/26 at 1:25 p.m., RN-C stated before R1 was sent to the ED, his oxygen saturation declined and was being monitored. RN-C was told R1 was placed on monitoring that included temperature, lung sounds, oxygen saturation, and secretions. The monitoring documentation should have been in the treatment administration record (TAR). RN-C recalled, a couple hours later, R1 declined and was admitted to the hospital. RN-C stated if R1 was having difficulty she should have been notified so she could have updated the provider but said she had not been aware. During interview on 5/13/26 at 2:09 p.m., the director of nursing (DON) stated during the middle of the night on 4/4/26, R1's oxygen saturation levels dropped, and respirations increased. The nurses on duty questioned if R1 should be evaluated in the ED. DON stated within a few hours R1 declined further so the physician was updated and R1 was sent to the ED for eval. During interview on 5/14/26 at 8:35 a.m., RN-B acknowledged she had administered medication to R1 at 6:00 a.m. on 4/4/26. RN-B stated she would have given the medication crushed in applesauce or dissolved in water if R1 was having difficulty swallowing. RN-B stated she had not considered holding his medications due to R1's status because she had been told he did that sometimes, referring to the gurgling sound. During interview on 5/14/26 at 10:10 a.m., LPN-B acknowledged she had administered medication to R1 on 4/4/26 during morning medication pass. LPN-B stated when she received report from the previous shift, the nurse reported R1 had been breathing weird. LPN-B stated when staff got R1 up for breakfast he was breathing with his mouth open which was weird. LPN-B stated R1 was not at his baseline, but she administered his pills in pudding. LPN-B recalled, R1 held the medications in his mouth. LPN-B said had not noticed R1's breathing until after she gave the medications. During interview on 5/14/26 at 3:29 p.m., DON stated when R1 displayed a change of condition, a respiratory assessment should have been completed including respirations, lung sounds, and a full set of vital signs. DON stated staff should have let a manager know if R1 was having difficulty swallowing. A policy related to change of condition was requested but not received.