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	05/21/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to notify the physician when a weight gain of greater than 3 pounds (lbs) in 48 hours or a weight gain of greater than 5 lbs in a week was identified for 1 of 1 (R124) residents reviewed for edema. Findings include: R124's undated admission Record identified R124 was [AGE] years old and was admitted on [DATE]. R124 had diagnoses that included acute respiratory failure with hypoxia (low oxygen levels), hypertensive heart disease, and congestive heart failure (CHF). R124's care plan dated 5/15/25, identified R124 had an altered respiratory status and staff were directed to observe for signs of increased edema (swelling) /increased weight related to fluid retention. Document and report to medical provider as necessary R124's physician orders dated 5/15/25, directed staff to obtain daily weights: Update nurse practitioner (NP) for weight gain of 3 pounds (lbs) or greater in 48 hours or 5 lbs in a week. R124's Weights and Vitals Summary dated 5/21/25, identified the following: - On 5/17/25 at 7:51 a.m., R124 weighed 318.8 lbs. - On 5/18/25 at 11:01 a.m., R124 weighed 325.2 lbs. However, the summary failed to identify a weight increase of increase 6.7 lbs. - On 5/19/25 at 9:03 a.m., R124 weighed 326.0 lbs. However, the summary failed to identify a weight increase of 0.8 lbs in 24 hours or increase of 7.2 lbs in 48 hours. - On 5/20/25 at 3:40 p.m., R124 weighed 331.4 lbs. However, the summary failed to identify a weight increase of 5.4 lbs in 24 hours or but total increase 12.6 lbs in 72 hours. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R124's nursing progress note dated 5/20/25 at 4:56 p.m., identified staff spoke with R124 regarding his pain. R124 had a hospital follow up in house with the nurse practitioner (NP) that morning. R124 had no pain then and did not need any pain medication so R124 did not ask for it from the NP when the NP was here. Now R124 was asking for morphine or codeine for leg pain from leg swelling from his water weight. R124 had 2+ edema (2+ edema is a moderate pitting edema. It is characterized by indentation that subsides rapidly. Edema is graded on a scale of 1 to 4, with 2+ being a moderate level of edema and is characterized by 3-4 millimeter (mm) of depression, rebounding in 15 seconds or less.) to his lower legs. R124 had his legs slightly elevated in bed and was refusing to move to have his legs elevated my more. R124 would not allow lower part the bed elevated either. No new orders have been received from the NP at this time from hospital follow up visit. Due to R124 having new onset of new pain, R124 would need to be evaluated in the emergency room (ER); however, R124 refused to go into the ER. R124's medical lacked evidence the provider was contacted prior to 5/20/25. During an observation on 5/20/25 at 8:29 a.m., R124 was up and dressed for the day. R124 sat in his wheelchair at the dining room table eating breakfast. R124 was wearing oxygen via a nasal cannula. R124's face, hands and legs were swollen. During an interview on 5/20/25 at 3:47 p.m., registered nurse (RN)-D reviewed R124's weights and stated R124 did have a significant weight gain because R124 had gained greater than 3 lbs in 48 hours. RN-D reviewed R124's medical record and stated she did not see where staff notified R124's NP of R124's weight gain. During an interview on 5/20/25 at 4:17 p.m., RN-B stated R124's NP had been notified of R124 earlier in the day, but RN-B hadn't had time to document it yet. However, staff should have notified the provider on 5/18/25 of R124's weight gain or the staff may have waited until 5/19/25 due to the weekend but RN-B wasn't notified until 5/20/25. During interview on 5/20/25 at 4:27 p.m., the director of nursing (DON) stated staff were expected to follow the physician orders and should have notified R124's provider on 5/18/25 when R124's weight increase was identified. During an interview on 5/21/25 at 2:00 p.m., the administrator stated staff were expected to follow physician orders to ensure residents received the care they deserved. During a phone interview on 5/22/25 at 12:35 p.m., NP-A stated she evaluated R124 on 5/20/25 and was told R124 gained 5.2 lbs over the course of 5 days. NP-A contacted R124's cardiologist for guidance and R124 was evaluated by cardiology. NP-A was unaware of R124's physician order to contact the provider if a weight gain of 3 lbs in 48 hours and would have expected nursing to contact a provider on 5/18/25 to obtain care sooner. The facility policy Edema Scale and assessment dated 5/2013, identified It is the policy of this facility to provide standardized assessment of lower leg edema and associated issues. Document any untoward results and as necessary by degree of problem, notify the Health Care Provider. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Change of Condition/Notification revised 3/25, identified Attending physician/NP, or physician on-call, is to be immediately contacted (not by voicemail) of residents change in condition/health status based on a comprehensive assessment. I. Facility must immediately inform the resident, consult with the physician, and notify representative when there is: A. An accident involving the resident which results in injury and has the potential for requiring physician intervention. B. A significant change in the resident's physical, mental, or psychosocial status. C. A need to alter treatment significantly - due to adverse consequences or new form of treatment. D. A decision to transfer or discharge the resident from the facility.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a gradual dose reduction (GDR) or a clinical justification of a psychotropic medications was documented for 1 of 5 residents (R42) reviewed for unnecessary medication and were taking psychotropic medications. Findings include: R42's quarterly Minimum Data Set (MDS) dated [DATE], identified R42 had moderate cognitive impairment. R42 had verbal behaviors directed toward others and behaviors not direct toward others 1 to 3 days a week. R42's diagnoses included bipolar disorder (a mental health condition characterized by extreme mood swings, ranging from periods of intense highs to periods of deep lows) and anxiety. R42 received an antipsychotic medication and an antidepressant medication. The MDS identified the last gradual dose reduction (GDR) of medications was done 2/23/21, and a GDR was not documented as clinically contraindicated. R42's most recent Physician Order Report dated 5/21/25, identified haloperidol (typical antipsychotic medication) to be given twice a day related to bipolar disorder and was dated 11/22/23. R42 also received Zoloft (an antidepressant medication) given one time a day for depression related to bipolar disorder and was dated 11/29/22. R42's monthly pharmacy reviews were reviewed from 6/2024 to 5/2025, with no irregularities identified with antipsychotic medications or antidepressant medications. R42's medical record was reviewed and lacked evidence a GDR had been attempted or identified a medical justification for continued use and R42 was on the lowest effective dose, within the past calendar year for the haloperidol. During an interview on 5/21/25 at 1:13 p.m., registered nurse (RN)-H, nurse manager, stated the resident's medications were reviewed on a regular basis and discussed with nursing and pharmacy consultant (CP). RN-H stated they did not look for when a GDR was due but waited for the CP to make a recommendation for a GDR. During a telephone interview on 5/21/25 at 2:00 p.m., the CP stated GDRs on psychotropic medications were done twice a year for new medications and yearly for established medications. The CP identified the last GDR attempt was done 2/2024. During an interview on 5/21/25 at 2:37 p.m., the director of nursing (DON) stated it was the expectation nursing staff would work with pharmacy to ensure psychotropic medication GDRs were addressed for the health of the residents. The facility's Psychopharmacological Drug Use policy dated 5/2025, the resident drug regimen must be free of unnecessary drugs. An unnecessary drug is any drug when used in an excessive dose, for an excessive duration, or without adequate indications for use.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure medications were coded correctly on the Minimum Data Set (MDS) for 1 of 3 residents (R24) reviewed for injectable diabetes medications. Findings include: R24's quarterly Minimum Data Set (MDS) dated [DATE], identified R24 had diabetes (a disorder characterized high blood sugar levels due to either insufficient insulin production or the body's inability to effectively use insulin). The MDS identified R24 received an insulin injection and was receiving hypoglycemic medication (used to lower blood sugar levels). R24's Medication Administration Record (MAR) for the month of February 2025, identified R24 received Trulicity (a medication which increased insulin release, reduced glucagon secretion; however is not insulin) for diabetes. The February 2025, MAR did not identify R24 had received any insulin during the month. During an interview on 5/21/25 at 1:45 p.m., registered nurse (RN)-B stated the MDS was coded incorrectly and should not have identified R24 had received insulin. R24 had only received Trulicity during the assessment period and not insulin. During an interview on 5/21/25 at 2:47 p.m., the director of nursing (DON) would expect the MDS to be completed correctly and stated Trulicity was not insulin. The facility's Resident Assessment policy dated December 2013, identified staff needed to utilize information found in Point Click Care (an electronic health record) to complete sections required on the MDS.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to implement interventions for edema for 1 of 1 resident (R124) reviewed for edema. Findings include: R124's undated admission Record identified R124 was [AGE] years old and was admitted on [DATE]. R124 had diagnoses that included acute respiratory failure with hypoxia (low oxygen levels), hypertensive heart disease, and congestive heart failure (CHF). R124's care plan dated 5/15/25, identified R124 had an altered respiratory status and staff were directed to observe for signs of increased edema (swelling) /increased weight related to fluid retention. Document and report to medical provider as necessary R124's physician orders dated 5/15/25, directed to obtain daily weights: Update nurse practitioner (NP) for weight gain of 3 pounds (lbs) or greater in 48 hours or 5 lbs in a week. R124's Weights and Vitals Summary dated 5/21/25, identified the following: - On 5/17/25 at 7:51 a.m., R124 weighed 318.8 lbs. - On 5/18/25 at 11:01 a.m., R124 weighed 325.2 lbs. However, the summary failed to identify a weight increase of increase 6.7 lbs. - On 5/19/25 at 9:03 a.m., R124 weighed 326.0 lbs. However, the summary failed to identify a weight increase of 0.8 lbs in 24 hours or increase of 7.2 lbs in 48 hours. - On 5/20/25 at 3:40 p.m., R124 weighed 331.4 lbs. However, the summary failed to identify a weight increase of 5.4 lbs in 24 hours or but total increase 12.6 lbs in 72 hours. R124's nursing progress note dated 5/20/25 at 4:56 p.m., identified staff spoke with resident regarding his pain. R124 had a hospital follow up in house with the nurse practitioner (NP) that morning. R124 had no pain then and did not need any pain medication so R124 did not ask for it from the NP when the NP was here. Now R124 was asking for morphine or codeine for leg pain from leg swelling from his water weight. R124 had 2+ edema (2+ edema is a moderate pitting edema. It is characterized by indentation that subsides rapidly. Edema is graded on a scale of 1 to 4, with 2+ being a moderate level of edema and is characterized by 3-4 millimeter (mm) of depression, rebounding in 15 seconds or less.) to his lower legs. R124 had his legs slightly elevated in bed and was refusing to move to have his legs elevated my more. R124 would not allow lower part the bed elevated either. No new orders have been received from the NP at this time from Hospital follow up visit. Due to R124 having new onset of new pain, R124 would need to be evaluated in the emergency room (ER). R124 refused to go into the ER. R124's medical lacked evidence if a nursing assessment was conducted and new interventions implemented. Further there was no evidence the provider was contacted prior to 5/20/25 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/20/25 at 8:29 a.m., R124 was up and dressed for the day. R124 sat in his wheelchair at the dining room table eating breakfast. R124 was wearing oxygen via a nasal cannula. R124's face, hands and legs were swollen. During an interview on 5/20/25 at 3:47 p.m., registered nurse (RN)-D reviewed R124's weights and stated R124 did have a significant weight gain because R124 had gained greater than 3 lbs in 48 hours. RN-D reviewed R124's medical record and stated she did not see where R124's weight gain or edema had been addressed. During an interview on 5/20/25 at 4:17 p.m., RN-B stated R124's NP had been notified of R124 earlier in the day but RN-B hadn't had time to document it yet. However, RN-B was not notified of R124's weight gain until 5/20/25. During interview on 5/20/25 at 4:27 p.m., the director of nursing (DON) stated staff were expected to monitor daily weights and ensure the appropriate actions were taken when a significant weight increase was identified. During an interview on 5/21/25 at 2:00 p.m., the administrator stated staff were expected to monitor daily weights and take appropriate action when a significant weight gain was identified. During a phone interview on 5/22/25 at 12:35 p.m., NP-A stated she evaluated R124 on 5/20/25 and was told R124 gained 5.2 lbs over the course of 5 days. NP-A contacted R124's cardiologist for guidance and R124 was evaluated by cardiology. NP-A was unaware of R124's physician order to contact the provider if a weight gain of 3 lbs in 48 hours and would have expected nursing to contact a provider on 5/18/25 to obtain care sooner. The facility policy Edema Scale and assessment dated 5/2013, identified It is the policy of this facility to provide standardized assessment of lower leg edema and associated issues. Document any untoward results and as necessary by degree of problem, notify the Health Care Provider.

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the consulting pharmacist (CP) identified the need for a gradual dose reduction (GDR) or medical justification of use for 1 of 5 residents (R42) reviewed for unnecessary medication and were taking psychotropic medications. Findings include: R42's quarterly Minimum Data Set (MDS) dated [DATE], identified moderate cognitive impairment with verbal behaviors directed toward others and behaviors not direct toward others 1 to 3 days a week. R42's diagnoses included bipolar disorder (a mental health condition characterized by extreme mood swings, ranging from periods of intense highs to periods of deep lows) and anxiety. R42 received an antipsychotic medication and an antidepressant medication. The MDS identified the last gradual dose reduction (GDR) of medications was done 2/23/21, and a GDR was not documented as clinically contraindicated. R42's most recent Physician Order Report dated undated, identified haloperidol (typical antipsychotic medication) to be given twice a day related to bipolar disorder and was dated 11/22/23. R42 also received Zoloft (an antidepressant medication) given one time a day for depression related to bipolar disorder and was dated 11/29/22. R42's monthly pharmacy reviews were reviewed from 6/2024 to 5/2025, with no irregularities identified with antipsychotic medications or antidepressant medications. R42's medical record was reviewed and lacked evidence a GDR had been attempted or identified a medical justification for continued use within the past calendar year for antipsychotic or antidepressant medications. During an interview on 5/21/25 at 1:13 p.m., registered nurse (RN)-H stated the consulting pharmacist (CP) reviewed the residents' medication lists and identified if any residents were due to a GDR, and that is how she was flagged if a resident was due for one. RN-H stated R42's medical record lacked any evidence a GDR had be attempted or a clinical justification for continued use. During a telephone interview on 5/21/25 at 2:00 p.m., the CP stated a resident's medication lists were reviewed monthly and medications were monitored, this included reviewing psychotropic medications (drugs that affect mental processes and behavior, often used to treat mental health conditions like anxiety, depression, and psychosis) for adverse reactions, monitor GDR or clinical contraindication for medication reduction. GDR's are to be attempted yearly. The CP stated the last documented GDR was from 2/2024, and a GDR or clinical contraindication should of be documented and was not. During an interview on 5/21/25 at 2:37 p.m., the director of nursing (DON) she would expect GDR's to be attempted or documented contraindication to be done yearly. The facility's Psychopharmacological Drug Use policy dated 5/2025, identified the CP would review resident medication records on a monthly basis for documentation/justification for the drug use and will recommend dosage reductions or modifications as appropriate.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and document review, the facility failed ensure beard coverings were worn when preparing resident meals, to prevent the spread of food born illness. This had the potential to affect 68 out of 68 residents that received food out of the kitchen or kitchenette. Findings included: During initial kitchen tour on 5/19/25 at 11:19 a.m., cook-A was observed in the kitchen not wearing a beard covering. Cook-A stated he had just finished making lunch. On 5/20/25 at 8:27 a.m., cook-B was observed in a unit kitchenette serving food to residents without a beard net. Cook-B's facial hair went from below the ears to the top of the neck and under the chin, and was approximately 1.5 inches long and shaggy in areas. Cook-B stood over an open loaf of bread with one slice of bread on the countertop and putting a plate of food into the microwave. After several seconds cook-B removed the plate of food from the microwave, walked to the counter and handed the plate to another staff member who brought the plate to a resident. Cook-B stated his facial hair was long and needed to be trimmed. Cook-B stated beard coverings should be worn prior to the start of work although had not put on a beard covering because he was uncertain where to locate them. Cook-B stated the potential risks of not covering facial hair was that hair could fall into the food. On 5/20/25 09:02 a.m., dietary manager (DM) stated staff were instructed to always wear hair/beard coverings, including when prepping, cooking, serving foods, and anytime they are working with food. DM stated she was aware cook-B was not wearing a beard covering and stated she just hadn't had time to tell him to put one on. DM stated the potential risks of staff not wearing a hair/beard covering was hair could fall into the residents food and cause bacteria to grow. The Employee Sanitary Practices policy revised 7/19, identified staff were to wear hair restraints to prevent hair from contacting exposed food, including a beard net, when an employee had a beard. According to section 2-402.11 of the FDA Food code: A hair restraint keeps dislodged hair from ending up in the food and may deter employees from touching their hair. This is crucial to prevent cross-contamination. Staphylococcus aureus is an example of a common pathogen that is found on skin and hair. If enough of the bacteria is ingested, it could cause illness. Common symptoms of this illness include vomiting, nausea, and stomach cramps.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure conflicting notes and orders transmission based precautions were clarified to ensure an accurate medical record was maintained for 1 of 1 resident (R127) whose medical record was found to lack admission notes. Findings include: R127's entry Minimum Data Set (MDS) dated [DATE], identified R127 was [AGE] years old and was admitted to the facility on [DATE]. R127's Diagnosis Report dated 5/21/25, identified R127 had diagnoses that included enterocolitis due to Clostridium difficile (C. diff, or costridioides difficile, is a bacterium that can cause severe diarrhea and colitis (inflammation of the colon). It is often associated with antibiotic use, which can disrupt the normal gut flora, allowing C. diff to proliferate. Symptoms of a C. diff infection can range from mild diarrhea to severe, life-threatening conditions. Treatment typically involves specific antibiotics to target the infection.) R127's History and Physical dated 5/7/25, identified R127 had been diagnosed with C. diff, completed a 10-day course of oral vancomycin (an antibiotic used to treat C. diff) and R127's diarrhea had resolved. R127's admission Screening dated 5/9/25, was a handwritten paper form that identified R127 had C. diff 4/22. R127's Nursing Home Visit progress note dated 5/12/25, identified R127's C. diff was resolved. R127's nursing progress notes dated 5/9/25 through 5/21/25, failed to identify an admission note or a nurse-to-nurse communication (nurse-to-nurse communication refers to the exchange of information, opinions, and ideas between nurses, either face-to-face, through written reports, or electronically) regarding R127's hospital discharging condition. During an interview on 5/20/25 10:33 a.m., RN-B stated the admission nurse completed R127's admission screening. The admission nurse completed the nurse-to-nurse communication and entered an admission note. During an interview on 5/20/25 at 10:40 a.m., RN-F stated the hospital usually sent a referral packet for any potential resident: history and physical, notes, etc. RN-F reviewed everything from medications to therapy notes to ensure the facility could meet the resident's needs. If the resident was accepted, that information was loaded into the electronic medical record. R127's C. diff diagnoses was on 4/22/25 and RN-F entered that on R127's screening form. R127's C. diff may have been resolved but that was the cue for the admission nurse to talk to the hospital nurse regarding R127's stool. That information should be entered into an admission note, however, RN-F was unable to find an admission note in R127's medical record. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/25 at 11:13 a.m., RN-C stated he did R127's admission, however, could not recall a nurse-to-nurse communication about R127 because he completed 3 admissions that day. RN-E did not enter an admission note because all that information was on the admission nurse's screening form. RN-C may have hand written notes of the conversation on that paper form, however, that form was sent to the shred box for destruction. Yea, I guess if I don't enter a note and don't scan that form, it's not documented. RN-C stated days were rapid fire and staff got through what we needed to get done to get people settled. It was staff's responsibility to be aware of what residents needed. The IP nurse did send out a list every morning in an email and RN-C thought the cart nurses did get that email but who had time to read their emails. Really, staff just did what they had to do to get through it. During an interview on 5/20/25 at 4:27 p.m., the director of nursing (DON) stated staff were expected to either enter an admission note or scan handwritten notes in the medical record to ensure the resident's medical record was complete and to document what condition the resident was in on admission. During an interview on 5/21/25 at 2:04 p.m., the administrator stated staff were expected to ensure a resident has a complete medical record to ensure the resident receives the quality of care they deserve. The facility policy Documentation Standards Policy dated 10/24, identified the following: a. All documentation must reflect the resident's condition, care provided, and any status changes. b. Documentation must be completed at the time of care or as soon as possible after care is provided.

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	05/21/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was completed during personal cares for 1 of 3 residents (R121) whose cares were observed. Findings include: R121's 5-day Minimum Data Set (MDS) dated [DATE], identified R121 required set up to touching assistance for most care areas including toileting. R121's care plan revised 5/19/25, identified R121 required assist of one staff for toileting, dressing and grooming. During an observation on 5/20/25 at 3:02 p.m., nursing assistant (NA)-A assisted R121 to the bathroom for toileting. NA-A failed to use hand sanitizer and put on a pair of gloves R121 stood up from the toilet and NA-A stated R121 had a medium bowel movement (BM) and used a disposable wipe to clean feces from R121's buttocks. NA-A with the contaminated gloves assisted R121 to sit down on the toilet. NA-A then assisted R121 to put on a clean pull-up brief and pajama pants without completing hand hygiene or changing gloves.NA-A flushed the toilet, continued to wear the same soiled gloves and assisted R121 back to his bed. NA-A hung R121's gait belt on R121's door and picked up R121's urinal off his overbed table and dumped it in the toilet. NA-A gave R121 the call light and removed her soiled gloves. During an interview on 5/20/25 at 3:19 p.m., NA-A stated she was always told you wear the same gloves from the start of a care until the care was finished. During an interview on 5/20/25 at 3:22 p.m., licensed practical nurse (LPN)-A stated staff were expected to change gloves after wiping BM because you don't want to cross contaminate anything with feces. During an interview on 5/20/25 at 3:27 p.m., registered nurse (RN)-A stated staff were expected to remove their soiled gloves after doing BM cares, before touching clean items to prevent cross contamination of clean items. During an interview on 5/20/25 at 4:27 p.m., the director of nursing (DON) stated staff were expected to immediately removed gloves soiled with feces and to put on clean gloves before completing cares to prevent cross contamination of clean items. During an interview on 5/21/25 at 2:00 p.m., the administrator stated staff were expected to change gloves whenever going from dirty to clean to prevent transferring feces or bacteria on the resident's clothing. The facility policy Hand Hygiene revised 4/24, identified staff were expected to change gloves during patient care if the hand would move from a contaminated body site (e.g., perineal area) to a clean body site. Staff were directed to perform hand hygiene when removing gloves and before putting on a new pair of gloves.