

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245495	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2024
NAME OF PROVIDER OR SUPPLIER The Emeralds at Grand Rapids LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 South Highway 169 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)
<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35569</p> <p>Based on interview and document review the facility failed to ensure 1 of 1 residents (R1) was re-assessed for supervision with eating following a diet change order.</p> <p>Findings include:</p> <p>R1's Admission Record indicated she admitted to the facility on [DATE], with diagnosis that included dysphagia (difficulty swallowing).</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment. The MDS indicated R1 required supervision or touching assistance to eat and identified a mechanically altered diet.</p> <p>R1's care plan updated 1/17/24, indicated Diet: mechanical soft diet, nectar thick liquids, no straws. Per speech therapy close supervision at meals. Remind R1 to clear between cheek/lip and teeth with tongue. R1 demonstrated good tongue range but low motivation/awareness to clear on her own. R1's care plan was updated to resolved on 3/20/24, following surveyor inquiry.</p> <p>R1's Speech Therapy SLP (Speech and language pathologists) Evaluation and Plan of Treatment dated 12/22/23, identified a diagnosis of dysphasia (difficulty swallowing) and indicated she was evaluated for swallow function. The evaluation indicated R1 previously received therapy in the hospital and indicated unsure of exact dates of therapy, prior living environment indicated she resided in a private residence and indicated prior cognitive assistance as no supervision required, even though R1 had been at the facility since 2021, and previous assessments indicated she required direct supervision. The evaluation identified impaired oral motor structure and function and indicated a diet recommendation of mechanical soft textures and nectar thick liquids. The assessment indicated supervision due to swallow safety 0 - 25% of the time.</p> <p>R1's facility Progress Note date 3/9/24, indicated staff member arrived to unit as NA had discovered R1 was unable to speak. LPN on shift performed an abdominal thrust partially clearing R1's airway. R1 was sent to the hospital.</p> <p>(continued on next page)</p>

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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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's hospital Discharge Diagnosis included: Aspiration into airway, on mechanical assisted ventilation. Hospital course indicated admission to the hospital due to respiratory failure due to aspiration event requiring intubation. Upon extubation, R1 was noted to have a piece of pineapple lodged near her vocal cord.</p> <p>Review of facility Week At A Glance menu from 3/3/24 thought 3/9/24, did not identify pineapple on the menu but did identify mixed fruit was served on 3/5/24.</p> <p>R1's Progress Note dated 3/13/24, indicated family was contacted and had not brought R1 pineapple.</p> <p>R1's Progress Note dated 3/18/24, indicated another resident was attempting to feed R1. The other resident did not have the ability to retain direction. Appeared safest to keep R1 out of the dining area during meals.</p> <p>During interview on 3/20/24 at 12:55 p.m., certified occupational therapy assistant (COTA)-A reviewed R1's care plan and stated close supervision meant staff should have been sitting with R1. COTA -A stated staff were to ensure R1 was clearing her mouth and taking sips of liquids between bites to prevent aspiration.</p> <p>During interview on 3/20/24 at 1:44 a.m., LPN-B state when she arrived in the evenings, R1 was occasionally still eating dinner. LPN-B stated staff was usually seated with R1 and said R1 benefited from staff support. LPN-B stated with a mechanical diet staff needed to feed R1.</p> <p>During interview on 3/20/24 at 2:04 p.m., NA-B stated staff needed to watch R1 when she was eating to make sure she swallowed her food. NA-B said staff usually sat with R1 or pop in and check on her.</p> <p>During interview on 3/20/24 at 2:31 p.m., the director of nursing (DON) stated when R1 was eating in the dining area of the unit she was checked on often and said staff would stop by and give her a bite here and there. The DON described R1's level of supervision as checking frequently, in eyesight and going back to offer bites.</p> <p>During interview on 3/21/24 at 10:17 a.m. SLP-A stated she had not completed the assessment on 12/22/24, but had completed a swallowing assessment for R1 on 3/20/24. SLP-A stated when an assessment was completed related to swallowing ability the assessment did not always assess the need for feeding assistance. SLP-A stated if R1 had a modified diet and was safe to tolerate the diet, she could have had deficits but still safely tolerate the ordered diet. SLP-A said when she assessed R1 the previous day, R1 had done well with the mechanical soft diet and thin liquids but she recommended close supervision due to the recent choking episode and the inconsistencies in the previous assessment. SLP-A further stated the previous SLP may have thought occupation therapy had assessed the need for supervision and had only assessed R1's ability to swallow. SLP-A stated feeding assistance on the evaluation did not address need for feeding assistance or level of supervision.</p> <p>During interview on 3/21/24 at 12:41 p.m. the administrator stated R1's care plan for close supervision while eating should have been discontinued in December of 2023, based on the updated diet orders on 12/22/23. The administrator stated the assessment did not indicate R1 needed assistance. The administrator stated R1's medical record lacked evidence the facility had re-evaluated R1's need for supervision following the SLP evaluation on 12/22/23.</p> <p>(continued on next page)</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 3/21/24, NA-A stated on 3/9/24, she had been supervising R1 and another resident while they ate in the common area of the unit. NA-A stated she kept an eye on both of them during the meal. NA-A said after dinner, the other resident wheeled R1 over in front of the television and said she was about to go on her break and heard the other (severely cognitively impaired) resident stating the boy, the boys, the boys over and over. Upon hearing this, NA-A stated she went to remove R1 from the area and saw her gasping for air.</p>		

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<p>F 0803</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35569</p> <p>Based on interview and document review the facility failed to provide the physician ordered textured diet for 1 of 3 residents (R1) who subsequently choked and required the Heimlich Maneuver. This was an Immediate Jeopardy (IJ) for R1 who required hospitalization following the choking incident where she was determined to have aspirated and required mechanically assisted ventilation.</p> <p>The IJ began on 3/9/24, at approximately 6:30 p.m. when R1 was found by nursing assistant (NA)-A in the common area of the unit observed as pale, lips blue and unable to speak. R1 was administered the Heimlich Maneuver, suction and was sent to the hospital where she subsequently required mechanically assisted ventilation. The IJ was identified on 3/22/24, and the administrator was notified of the IJ on 3/22/24, at 1:00 p.m. The immediate jeopardy was removed on 3/13/24, and the deficient practice was corrected prior to the start of the survey and was therefore issued at past noncompliance.</p> <p>R1's Admission Record indicated she admitted to the facility on [DATE], with diagnosis that included dysphagia (difficulty swallowing).</p> <p>R1's physician orders dated 12/29/23, identified regular diet, mechanical soft texture, nectar consistency, no straws.</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment. The MDS indicated R1 required supervision or touching assistance to eat and identified a mechanically altered diet.</p> <p>R1's care plan dated 1/23/24, indicated Diet: mechanical soft diet, nectar thick liquids. No straws. The care plan was updated to NPO (nothing by mouth) on 3/15/24.</p> <p>Facility Diet Spreadsheet dated 3/9/24, indicated chicken strips were on the menu the evening of 3/9/24.</p> <p>R1's Progress Note dated 3/9/24, indicated as registered nurse (RN) came onto the floor, R1 had just been discovered by NA (nursing assistant) to be very pale with blue lips and unable to speak. LPN (licensed practical nurse) on shift attempted abdominal thrust which was effective to open the airway partially, but wheezing persisted. Additional thrust ineffective. RN directed LPN to initiate oral suction. Emergency services called and R1 left the facility to the hospital. Hospital staff reported R1 required intubation and was air lifted to a Duluth hospital.</p> <p>R1's hospital History and Physical (H and P) dated 3/10/24, indicated she admitted to the hospital on 3/9/24, with acute respiratory failure and required mechanical ventilation after she aspirated (when food, liquid, or other material enters a person's airway and eventually the lungs by accident) while eating at her nursing home. R1's hospital Discharge Diagnosis included: Aspiration into airway, on mechanical assisted ventilation. Hospital course indicated admission to the hospital due to respiratory failure due to aspiration event requiring intubation.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Facility Diet Spreadsheet dated 3/9/24, indicated chicken strips were served for the evening meal. The spreadsheet indicated for a mechanical soft diet, the chicken strips should have been ground.</p> <p>A facility internal plan of correction document, dated 3/11/24, indicated an identified opportunity for improvement: Diet extension accuracy when serving meals to residents with different textured diets. Potential contributing factors: chopped chicken strips given to resident instead of ground.</p> <p>During interview on 3/21/24, NA-A stated on 3/9/24, she had been supervising R1 and another resident while they ate in the common area of the unit. NA-A stated she kept an eye on both of them during the meal. NA-A said after dinner, the other resident wheeled R1 over in front of the television and said she was about to go on her break and heard the other (severely cognitively impaired) resident stating the boy, the boys, the boys over and over. Upon hearing this, NA-A stated she went to remove R1 from the area and saw her gasping for air.</p> <p>During interview on 3/20/24 at 1:08 p.m., the culinary director (CD) described the diet extension as a spread sheet that explained what food was to be prepared for each diet type. The CD stated on the evening of 3/9/24, when R1 choked on her meal, her diet slip had been correct. The CD stated the cook who prepared the meal told her he did not grind the chicken strips as directed on the diet extension but had chopped them with a knife instead.</p> <p>The administrator and director of nursing (DON) were interviewed on 3/20/24, at 2:27 p.m. the administrator stated upon investigation into the incident that led to R1's hospitalization , it was determined staff had served R1 chopped chicken strips instead of ground as directed by her diet order. The administrator stated the culinary staff were educated regarding the diet extensions and following the orders. The DON stated she had educated the nursing staff to ensure the correct diets were being followed prior to delivering a meal to a resident.</p> <p>A facility policy related to preparation of modified diets was requested but not received. Per administrator, refer to diet extensions.</p> <p>The past noncompliance immediate jeopardy began on 3/9/23. The immediate jeopardy was removed, and the deficient practice corrected by 3/13/23 , after the facility implemented a systemic plan that included the following actions:</p> <ul style="list-style-type: none"> - Training was implemented to all culinary staff to ensure diets were prepared and served according the the diet extensions and physicians orders. - Training was implemented for all nursing staff to ensure the proper diets were sent from the kitchen prior to distributing meals to residents. - Diet extension audits were implemented. <p>The education and audits were verified through interview and document review.</p>		