STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emeralds at Grand Rapids LLC	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)
F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on interview and document review, the facility failed to ensure discharge summary requirements were met, which included a recapitulation of resident's stay (a concise summary of the resident's stay and course of treatment in the facility) and a final summary of the resident's status at discharge, as well as communicating resident's condition upon discharge with receiving the facility for 1 of 1 residents (R1) reviewed. Findings include: R1's discharge Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included encounter for orthopedic aftercare following surgical amputation, and type 2 diabetes. Further MDS identified R1 had two or more falls with no injury and one fall with injury since previous assessment. Review of R1's Progress Notes revealed the following: -On 3/15/24, R1 was in bed and self-transferred to wheelchair. R1 did not press call light for assistance. R1 hit her head on the base of the table stand causing a 2 cm laceration to right forehead. R1 required first aid including laceration cleaned, approximated, and steri strips applied. The area stopped bleeding and ice pack was applied. -On 3/16/24, R1's bilateral eyes were noted to have bruising and slightly swollen, and the left eyebrow had steri strips intact with no bleeding noted. -On 3/21/24, R1 was seen by nurse practitioner (NP) and was noted to have bruising on the face, different shades of color (green to purple), 4 steri strips over left eyebrow, right eyebrow had a goose egg approximately quarter size and raise about 3/4 of an inch. R1's Discharge Instructions and Summary dated 3/20/24, revealed R1 was admitted to the facility on [DATE] and was discharging back to her home in an assisted living facility on 3/26/24, due to meeting requirements to return. Further, R1's summary identified skin treatment instructions related to R1's below the knee amputation but lacked evidence of R1's injuries she had sustained from her fall on 3/15/24. In addition, R1's discharge summary lacked a recapitulation of R1's stay and a final summary of R1's status which would include physical functioning and structural problems, skin condition and special treatments and procedures. (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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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 11:22 a.m., in a confidential interview, it was stated R1 was observed on 3/26/24, to have racoon eyes, swelling to both eyebrows, and looked like she had been in a war. During the confidential interview, the facility failed to notify receiving provider of R1's condition, by either paperwork or a nurse-to-nurse report, related to R1 having a fall while at the facility as well as R1's current skin condition. On 4/5/24 at 9:55 a.m. registered nurse (RN)-A stated she was a newer employee and was not sure on the facility's policy related to discharging a resident. Further, RN-A stated she was R1's nurse on the day R1 discharged the facility, however she did not complete a nurse-to-nurse report with the receiving provider and did not give R1 any paperwork and someone else had to have. On 4/5/24 at 10:16 a.m. RN-B stated on day of discharge she would coordinate with the receiving facility to ensure the receiving facility had everything needed for the resident's return as well as providing a copy of the discharge paperwork which would include the Discharge Instructions and Summary. However, RN-B stated she was not working at the facility on the day R1 discharged but reported to the floor nurse R1 would be leaving. RN-B stated staff were expected to document in the resident's medical record relate to when the resident left the facility, what items the resident left the facility with, if discharge paperwork was provided to the resident and if a nurse-to-nurse report was completed with the receiving facility. RN-B confirmed R1's medical record lacked this information. In addition, RN-B confirmed R1's medical record lacked evidence of a recapitulation of R1's stay and there was no final summary of R1's status in R1's record. On 4/5/24 at 11:22 a.m., director of nursing (DON) stated staff would be expected to complete a nurse-to-nurse report with the receiving provider on the day of the resident's discharge. Further the resident would sign a copy of the Discharge Instructions and Summary, which would include the resident's recapitulation of stay and the final summary of resident's status, to confirm they understood, and the paperwork would then be sent with to the receiving provider. In addition, DON confirmed R1's Discharge Instructions and Summary did not contain the recapitulation of resident's stay, or the final summary of the resident's status as required, and R1's record lacked evidence R1 signed the paperwork or a nurse-to- nurse report was completed prior to R1 discharging the facility. Review of facility policy titled Discharge Summary and Recapitulation and Plan revised 12/3/18, indicated when a resident's discharge was anticipated, a discharge instructions and summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment. The discharge instruction and summary will include a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of the discharge. The Social Services Department will review the plan with the resident, family, or guardian twenty four hours before discharge would take place and the resident, family or guardian would sign off on discharge instructions and summary indicating they understood the medication instructions and other instruction given by healthcare professional.

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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	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on interview and document review, the facility failed to ensure injuries following a fall were monitored for healing for 1 of 3 residents (R1) reviewed. Findings include: R1's discharge Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included encounter for orthopedic aftercare following surgical amputation, and type 2 diabetes. Further MDS identified R1 had two or more falls with no injury and one fall with injury since previous assessment. R1's Incident Review and Analysis dated 3/18/24, indicated R1 was found on floor on 3/15/24, after R1 had attempted to stand up from bed and fell forward. R1 had hit left forehead on the metal part of the bedside table causing bleeding and a 2-centimeter (cm) laceration. R1 had a new right below the knee amputation and thought she could stand independently. Review of R1's Progress Notes revealed the following: -On 3/15/24, R1 was in bed and self-transferred to wheelchair. R1 did not press call light for assistance. R1 hit her head on the base of the table stand causing a 2 cm laceration to right forehead. R1 required first aid including laceration cleaned, approximated, and steri strips applied. The area stopped bleeding and ice pack was applied. -On 3/16/24, R1's bilateral eyes were noted to have bruising and slightly swollen, and the left eyebrow had steri strips intact with no bleeding noted. -On 3/21/24, R1 was seen by nurse practitioner (NP) and was noted to have bruising on the face, different shades of color (green to purple), 4 steri strips over left eyebrow, right eyebrow has a goose egg approximately quarter size and raise about 3/4 of an inch. R1's Weekly Skin Inspection dated 3/17/24, R1 was noted to have an abrasion to left eyebrow related to prior known fall, area is well approximated without active drainage, proximal redness, or persistent swelling. R1's Weekly Skin Inspection dated 3/23/24, indicated no new skin concerns and R1's surgical site was cleansed and covered as ordered. R1's skin inspection failed to identify R1's injuries from 3/15/24, and the healing progress. R1's medical record lacked evidence of staff monitoring R1's injuries following R1's fall on 3/15/24, to ensure healing. On 4/4/24 at 11:22 a.m., in a confidential interview, R1 was observed on 3/26/24, to have racoon eyes, swelling to both eyebrows, and looked like she had been in a war. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/5/24 at 9:55 a.m. registered nurse (RN)-A stated she was the floor nurse on the day of R1's fall when R1 sustained an injury to her eyebrow which was bleeding. RN-A stated another floor nurse completed the assessment. Further, RN-A was unaware of facility protocol for monitoring injuries following a fall. On 4/5/24 at 10:16 a.m. RN-B stated following R1's fall she had a laceration above the eye that required steri strips, however the provider did not give any new orders. Further, RN-B following a fall the licensed nurse responding the resident's fall would be expected to notify the provider of any injuries following the fall and the provider would give an order on how to monitor the wound as well as nursing would initiate monitoring of injuries in the resident's electronic medical record to ensure staff were monitoring for infection and ensuring the injuries were healing appropriately. RN-B confirmed there were no additional monitoring of R1's injuries following R1's fall in R1's medical record. On 4/5/24 at 11:22 a.m. director of nursing (DON) stated following a fall with an injury staff were expected to implement a monitoring treatment in the residents record to ensure the injury was healing and continue to monitor until healed. DON confirmed there was not any monitoring of R1's injuries following the fall on 3/15/24. Review of facility policy titled Fall Prevention and Management revised 2/2024, indicated documentation would include any observed signs or symptoms of pain, swelling, bruising, deformity, and or decreased mobility and any change in level of responsiveness and overall function. Further policy identified the resident's medical record should include assessment data (vital signs and any obvious injuries) as well as interventions, first aid, or treatment administered. The policy lacked evidence of staff direction on follow-up and monitoring of the resident's injury/injuries sustained from the fall.