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| 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 12/04/2024 |
| 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367</p> <p>Based on observation, interviews, and documentation review the facility failed to properly provide maintenance to maintain bed wheel locks to prevent bed from moving during transfers for 1 of 3 residents (R2) resident reviewed for falls.</p> <p>Findings include:</p> <p>User-Service Manual for Joern's Bed Frames Easy-Care Bed dated 2020, identified to keep bed from rolling in the lowest position, press down on the locking lever to lock casters. The standard caster set comes with two locking casters placed at opposing corners of bed. Possible injury: before leaving the bed unattended, check that the lock feature was in locked position. Never leave an unlocked bed unattended. The Easy-Care Bed contained various parts that wear from normal use.</p> <p>R2's Fall Review Evaluation dated 10/2/24, identified at risk for falls. R2's displayed agitated behavior (verbally/physically abusive, socially inappropriate such as screams, disrobes, and self-abusive), unable to walk even when assisted by staff, and required hands-on assistance to move from place to place.</p> <p>R2's diagnoses document dated 10/11/24, identified hepatic encephalopathy (a brain disorder caused by severe liver disease and toxin buildup in the blood causing a change in mental status), urea cycle metabolism disorder (a genetic condition that causes ammonia to build up in the body, toxic, and symptoms of this condition target your brain and organ function, and alcohol/psychoactive (mind altering drug that affects the function of the brain) substance abuse, and cirrhosis of the liver (liver is scarred, permanently damaged, and prevents the liver from working normally and can become life threatening).</p> <p>R2's quarterly Minimum Data Set, dated dated dated [DATE], identified intact cognition, unclear speech with slurred or mumbled words and no behaviors. R2 had impairment of upper and lower extremity on one side and used a wheelchair for mobility. R2 was dependent upon staff for oral hygiene, toileting hygiene, shower/bath, putting on /taking off lower body clothing and footwear, sit to stand, and all transfers. R2 required substantial to maximal assistance with roll left and right, sit to lying, and lying to sit. R2 had no falls since admission to facility from 9/26/24 to 10/29/24.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>R2's incident review dated 11/16/24 at 8:04 p.m. identified nature of incident: lowered to the floor. Staff prepared R2 to be transferred from her bed to the toilet. Staff member had R2's legs placed on resident [sic], positioned her to start standing up, and R2's bottom slid off the bed. NA when [sic] to catch resident and both parties fell on the floor. Resident has ataxia (lack of muscle coordination) in her left leg. R2 was downgraded to Hoyer lift times (x) two staff until therapy could assess resident for transfers. VA report filed.</p> <p>R2's progress note on 11/16/24 at 4:21 p.m. nurse notified of a resident fall during the morning. No bruising/injury observed on this shift. Resident stated she had a fall this morning during a transfer, hit head and complained of headache. Head to toe assessment completed, notified family and director of nursing (DON). Resident sent to hospital to be evaluated.</p> <p>R2's progress note on 11/16/24 at 5:02 p.m. correction to type of lift device used during transfer was an easy stand not a Hoyer lift.</p> <p>R1's emergency department (ED) visit dated 11/16/24, from 4:13 p.m. to 7:00 p.m. identified presented via emergency medical services (EMS) from a local nursing home for an evaluation of a posterior headache status post fall. No blood thinners and past medical history significant for remote cerebral vascular accident (stroke) and pontine hemorrhage. Physical assessment identified R2 was alert, oriented to person, place, time, and no pain or distress. According to nursing home R2 fell out of the Hoyer lift. Cross-sectional imaging of R2's head and cervical spine was unremarkable for evidence of emergent etiology or intracranial catastrophe. At this point R2 could be safely discharged to her previous living arrangement with close follow-up.</p> <p>Review of an interview completed on 11/17/24 at 10:20 a.m. by DON and administrator for facility investigation of R2's fall with nursing assistant (NA)-A identified: NA-A brought the EZ stand lift machine into R2's room and placed machine up to next to her bed. NA-A sat R2 up on edge of bed, lowered the bed, placed leg lock (strap around lower legs) and fixed legs in the machine. NA-A placed sling behind her and the bed slide out a few inches. R2 kicked her legs out, her bottom slid off the bed, and was caught by NA-A. NA-A identified brakes on R2's bed wheels did not stay locked. NA-A thought they seemed like they were locked then slide off. NA-A had told many people about bed sliding and was unsure as to how to put into the tele (communication system) and seemed like no one knew how to.</p> <p>R2's progress note on 11/18/24 at 2:28 p.m. physical therapy (PT) confirmed R2 was to use a Hoyer lift and up dated care plan.</p> <p>R2's progress note on 11/18/24 at 12:00 a.m. follow up visit with provider identified R2 endorsed tenderness to the back of her head from her fall. Discussed and verified her fall from over the weekend placed orders for PT/OT to evaluate and treat to ensure the patient is properly able to use the lift.</p> <p>Review of Bed Inspection Excel Spreadsheet dated 11/18/24, identified a total of 89 beds were inspected by the maintenance assistant (MA). There were 86 beds identified passed the inspection and three beds that failed (104-2, 209-1, 210-2). R2's bed was documented as passed the inspection on the excel spreadsheet.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>R2's care plan dated 11/21/24, identified R2 was at risk for falls due to pontine intracranial hemorrhage (when an artery became blocked by a blood clot and then bursts in the largest component of the brain ((NAME]) causing slurred speech, facial drooping, and weakness on one side of the body). Staff were instructed to have placed R2's bed in low position and fall matt when in bed, follow PT and occupational therapy (OT) instructions for mobility function, and monitor and document on safety. R2 had an alteration in communication and staff were instructed to speak clearly, distinctly, repeat conversation as needed, allow R2 adequate time to communicate her needs, and ask simple questions. R2 had an alteration in mobility and instructed staff to follow PT instructions, transfer via Hoyer lift, and assist with movement in and out of bed.</p> <p>R2's incident review dated 11/22/24 at 9:12 a.m. identified nature of incident: fall from bed on 11/21/24 at 2:15 p.m. R2 was found sitting on the ground next to her bed leaning on the back of her bed. R2 stated she had slipped. Invoice dated 11/25/24, from an industrial products supply company identified an order placed for 11 bed casters and a ship date of 11/25/24.</p> <p>During an Interview/observation on 12/4/24 at 9:55 a.m. NA-A stated R2's bed was located over by the window on 11/16/24, wheels on her bed did not stay locked, and thought the bed was pushed all the way over to the wall prior to the transfer. NA-A stated R2 had random uncontrollable jerking movements and staff needed to stay near her when she sat up on side of her bed to transfer. NA-A stated she had positioned the EZ stand lift in front of R2 while she sat on edge of bed, then placed her left hand on the lift bar but was unable to hang onto it. NA-A stated R2 hung onto EZ stand bar with her right hand. NA-A stated while she placed the lift sling around R1's lower legs, she kicked out her left leg/foot and the entire bed slide out about two or three inches. NA-A stated R2 started to slide down the side of the bed. NA-A stated R2's legs were in a squatting position, grabbed the pants waistband, and pulled her up onto the side of the bed. NA-A stated and demonstrated at the same time how she locked the brakes on R2's bed wheels located at the lower end of the bed on each side. NA-A pushed the bed, and it moved at least two inches away from her. NA-A stated the bed was not safe like this and she had told other staff about the brakes would not hold.</p> <p>During an interview on 12/4/24 at 3:38 p.m. NA-B stated staff are expected to have notified maintenance if the bed wheel brakes do not lock properly to hold the bed. NA-B stated there were two ways to notify maintenance: get on channel 7 on the walkie or send a work order through a tele communication system. NA-B stated there was a period not too long ago some beds in the facility had problems with the wheels locking but thought maintenance had already replaced them.</p> <p>During an Interview on 12/4/24 at 3:45 p.m. with MA stated he had worked at facility for one year now. MA stated staff would be expected to either complete a work order or use a walkie to alert maintenance there was a concern about a resident's bed. MA stated many of the resident beds in the facility were old, unable to get parts for some of them anymore, and functional but insufficient due to being outdated. MA stated maintenance stayed on top of the requirements to assure the beds were safe and functional but because they were so old had more breakdowns. MA stated checks/audits were completed constantly on resident beds and included: wheels, brakes, control hand controllers, handrails, wear and tear, and mattresses to provide upkeep. MA stated the older beds had one wheel at each end of the bed with single casters (a single wheel mounted to the bottom of a larger object with a purpose to make an object move easier). MA stated the most updated bed had two wheel per leg and would have been better because the type of lock on it, the bed should not move side to side after the wheel was locked. MA stated the locks on the newer beds would be flipped in place and hold a more secure and safer position.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an Interview/observation on 12/4/24 at 3:55 p.m. with maintenance director (MD) stated had worked as director for about one year now and there was not a preventative task to periodically complete bed/part inspections. MD stated the self-schedule bed inspections were completed at least quarterly and just started documenting the inspections on an excel spread sheet. MD stated there were multiple styles of beds through the facility. Stated after R2's fall on 11/16/24, the administrator requested a break check on all facility beds. MD stated the inspection was started on 11/17/24 and it was noted three of the older bed required break replacement. MD stated the parts were ordered and came in last week. MD stated MA was installing the new breaks on those beds today. MD stated R2's breaks passed the test, not an issue with her breaks, and therefore were not replaced. At 4:05 p.m. MD and surveyor arrived at R2's room. R2 laid on her back in the bed awake. MD got down on the floor on his knees and verified R2's bed had one wheel on each bed leg located at each end of the bed. MD pushed on the end of the bed, and it moved approximately three to four inches. MD turned the mental [NAME] totter brake to one side to stop wheel from moving on both of the lower bed wheels, and pushed the bed it moved again approximately three to four inches. MD stated R2's bed breaks were not working and doing absolutely nothing to stop the bed from moving. MD stated R2's bed could had slid away during a transfer and caused an accident. At 4:10 p.m. MD reviewed the excel inspection spread sheet dated 11/18/24 and identified R2's bed inspection was checked off as completed and indicated passed inspection. MD stated was very surprised that R2's breaks did not work/pass today, but that style of wheel brake had a history of premature failure. MD stated the older bed life span was less than those of a new bed brake and depended on whether the bed had been moved with brakes on, would most likely wear them down quicker, and destroyed them by eating them up.</p> <p>During a follow up interview/observation on 12/4/24 at 4:20 p.m. R2 laid on her back in bed. MA stated he had completed the inspection on R2's bed, wheels, brakes, signed it off on the excel spread sheet with no replacements needed. MA turned the metal [NAME] totter brake on both bottom wheels, gave the bed a push. R2's bed rolled, and MA stated the brakes on the lower left end did not close tight, was not working properly, would be considered a safety issue, and needed to be replaced. MA stated the left lower wheel rubber was intact but worn down and the use expectancy of that wheel was close to the end. MA stated when the brake failed was based on use, wear and tear but was required to be within the standards. MA stated front left side wheel looked good but did not have a [NAME] totter brake on it at all, front right side wheel brake looked ok, the lower right side of bed wheel brake was on and appeared newly replaced. MA stated all four wheels were required to be locked to make sure bed does not move. MA stated unsure why the front left wheel did not have a brake on it. MA tested and retested the left lower wheel lock and stated it would not lock when he pushed the bed and it moved. MA stated the wheel failed to lock and could increase the risk for falls and was critical to assure the hardware was up to date and functional. MA stated the design on the wheel brake was insufficient, unable to do what it was designed to do over a period and wore out fast. MA stated older beds required more repairs.</p> <p>During an interview on 12/4/24 at 4:40 p.m. administrator stated during the facility investigation of R2's fall on 11/16/24 there could have been a possible issue with her bed wheels/brakes. Administrator stated maintenance was contacted and asked to inspect all resident beds to assure the brakes on the bed wheels were in working order. Administrator stated she understood R2's bed had passed the inspection and was not aware of any other issues.</p> | | |