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	12/19/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and document review the facility failed to ensure controlled substances were accurately reconciled to prevent loss and diversion for 6 of 6 residents (R1, R2, R3, R4, R5, R6,) reviewed for narcotic diversion. A report to the State Agency (SA) dated 11/25/25, indicated a police report identified medications were found in possession of a former employee of the facility. The report identified the following medications and empty packages.Prescribed to R1:Hydrocodone/acetaminophen 5 milligrams (mg) -325mg, total prescribed 18.Prescribed to R2:Clonazepam 0.5 mg empty, total prescribed 29.Prescribed to R3:Gabapentin 100 mg, containing 4 tablets, total prescribed 30.Prescribed to R4:Lorazepam 1mg, total prescribed 30. Prescribed to R5:Oxycodone 5 mg empty, total prescribed 28.Oxycodone 5 mg empty, total prescribed 8. Prescribed to R6:Morphine 5 mg containing 11 tablets, total prescribed 30 of 60.Morphine 5 mg containing 19 tablets, total prescribed 30 of 60.Gabapentin 600 mg, containing 1 tablet, total prescribed 30 of 90. Lorazepam 0.5 mg empty, total prescribed 30 of 60.Gabapentin 600 mg empty, total prescribed 30 of 90. Gabapentin 600 mg empty, total prescribed 30 of 90.R1's admission Record indicated diagnosis of sepsis, hypertension, anxiety and depression. R1 discharged from the facility 1/10/25.R1's Physician order Summary printed 12/23/25, identified the following order:Hydrocodone-acetaminophen oral tablet 5 mg - 325 mg. Give one tablet twice daily by mouth as needed.R2's admission Record indicated diagnosis of Spondylosis, chronic pain, anxiety and depression. R2 discharged from the facility 8/27/25.R2's Physician order Summary printed 12/23/25, identified the following order: Clonazepam oral tablet 0.5 mg. Give .5 mg twice daily.R3's admission Record indicated diagnosis of fracture of left pubis, rib fractures, coccyx fracture and weakness. R3 discharged from the facility 10/23/25.R3's Physician order Summary printed 12/23/25, identified the following order:Gabapentin oral capsule 100 mg. Give one capsule by mouth at bedtime.R4's admission Record indicated diagnosis of heart failure, diabetes, hemiplegia and chronic kidney disease. R4 discharged from the facility 4/15/25.R4's Physician order Summary printed 12/23/25, identified the following order:Lorazepam 1 mg tablet. Give one tablet my mouth every eight hours as needed.R5's admission Record indicated diagnosis of pneumonia, heart failure, anxiety, depression and dementia. R5 discharged from the facility 3/19/25.R5's Physician order Summary printed 12/23/25, identified the following order:Oxycodone hydrochloride 5 mg. Give one tablet every six hours as needed.R6's admission Record indicated diagnosis of palliative care, anxiety, depression and dementia. R6 discharged from the facility 2/14/25.R6's Physician Order Summary printed 12/23/25, identified the following orders:Gabapentin oral tablet, 600 mg. One tab my mouth three times daily.Lorazepam oral tablet, 0.5 mg. Give by mouth every four hours as needed.Morphine Solutab, 5 mg. Give every four hours as needed.Facility Document's titled Record of Disposal identified the following:11/27/24, Medications destroyed.12/10/24, Medications destroyed. 4/8/25, Medications destroyed.6/10/25, medications destroyed.6/13/25, medications destroyed.The disposal records lacked evidence of medication destruction from January 2025- March 2025 and May 2025. None of the destruction logs contained the names of the residents and correlating medications identified in the report. During interview on 12/18/25 at 11:31 a.m., the director of nursing stated the process for medication destruction was to perform a weekly inventory. The DON stated when she destroyed medications, she and another nurse brought the medications to the safe and destroyed them. The DON stated she kept a destruction log of all the medications destroyed. The DON stated the disposal system had a padlock and only herself and the pharmacy had keys.During interview on 12/18/25, at 11:35 a.m., the administrator stated the facility had received a call from the Sherrif on a Saturday that a former employee was in possession of medications from prior residents of the facility. The administrator stated the former employee had not worked at the facility since May of 2025. The administrator stated the facility had done an internal audit and were unable to locate destruction logs. The DON, present during the interview stated the pharmacy had to get the medications out of the safe but they did not reconcile the medications with facility staff. During interview on 12/18/25 at 1:03 p.m., trained medication aide (TMA)-A stated she had signed off on the narcotic log that medications had been destroyed and would go with the DON to place them in the box. TMA-A said there had been times when she was very busy and had signed off in the narcotic book without observing the destruction.During interview on 12/18/25 at 2:41 p.m., the DON said in order to pull the medication destruction box, both the facility and the pharmacy keys were required. The DON stated when she had destroyed medications with the former director of nursing, she had watched her place the medications into the box. The DON said there was no way the former DON could have gotten the medications back out of the