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	06/04/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and document review the facility failed to reduce the risk of falls for 1 of 3 residents (R1) reviewed when R1 was care planned to use two staff for transfers with a mechanical lift and nursing assistant (NA)-A attempted a mechanical lift transfer with one staff, R1 fell from the sling onto the floor sustaining a left femur fracture, head laceration and injury to left toes. The immediate jeopardy began on [DATE] when NA-A attempted a mechanical lift transfer with one staff, R1 fell from the sling onto the floor sustaining a left femur fracture, head laceration, and injury to left toes. R1 was care planned to use two staff for transfers with a mechanical lift and was identified on [DATE]. The administrator and director of nursing (DON) were notified of the IJ on [DATE] at 2:48 p.m. The immediate jeopardy was removed on [DATE] when the facility provided staff education and lift inspections, and the deficient practice corrected on [DATE], prior to the start of the survey and was therefore Past Noncompliance.Findings include: On [DATE] at 12:33 p.m., a tour was completed of the campus which identified seven mechanical EZ-Way lifts (Model L500PN) in the hallways for use. There were no slings present with the machines and each of them demonstrated no obvious defects when pushed, pulled, brakes locked/locked and inspected. R1's current care plan, initiated [DATE] indicated R1 was at risk for falls due to her impaired mobility and listed a goal [R1] will be safe and free from falls. The plan listed interventions to help R1 meet that goal including Hoyer lift with 2 staff for all transfers. The plan continued and identified R1 had deficits related to Transfer/Bed/Mobility/Ambulation and listed interventions Assist of two with Hoyer for all transfers. Resident prefers to have sling left on when in wheelchair. Resident is a M beige full body sling. R1's Lift/Mobility Status Form dated [DATE], identified R1 frail skin, and contractures, R1 required a full body mechanical lift with two staff assistance. In the comments/notes column it indicated R1 was to be an assistance of two staff with mechanical (Hoyer) lift. R1's quarterly Minimum Data Set (MDS), dated [DATE], identified R1, required assistance of two or more staff for all transfers. R1 had normal cognitive function with no or very minimal memory or thinking impairment. R1's progress note, dated [DATE] at 12:50 p.m., indicated R1 was found lying on the floor with blood on left side of her head and left toes. NA-A reported R1 slide out of the Hoyer sling during transfer onto the shower chair and that the transfer was done by one staff member. R1 was alert and oriented x 4 but in excruciating pain left lower extremity 10/10 and could not move left lower extremity. 911 was called and R1 was sent to the hospital emergency department (ED) for evaluation. R1's ED after visit summary note dated [DATE], indicated R1 sustained left femoral fracture. Orders included Morphine Sulfate (Concentrate) Solution 20 mg/ml, give 20 mg by mouth every 3 hours for pain, and brace to left leg. R1's Radiology Report, dated [DATE], identified acute mildly displaced and moderately angulated fracture of the distal femoral shaft. The report identified, [Shoulder] Results: Fracture of the surgical neck. No dislocation of the head . Conclusion: Acute appearing fracture of the surgical neck as noted. R1's progress note, dated [DATE] at 3:40 p.m., indicated R1 returned to facility from hospital new order received. Brace on at all times per her comfort. A provider note dated [DATE] at 9:06 a.m. indicated R1 fell from lift and sustained a left femoral fracture, laceration to scalp and cut to toe. Plan at this (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	time after major discussion with family agreed on hospice consult. Given the fact that she does have a major bone fracture at this time, not going to be ambulatory, and is generally declining. Patient was agreed to having comfort cares at this time. On [DATE], at 10:18 a.m., during an interview NA-B stated staff used the mechanical lifts regularly during their shift to help transfer residents if they are care planned for the lift. NA-B explained use of the device while demonstrating the use of machine while transferring a resident with the assistance of NA-C. NA-B stated each resident had their own personal sling, the sling is placed underneath them and crossing the leg straps, securing it to the metal hanger bar using the colored loops. They need to make sure and check the sling for any rips or tears as well as that it is securely looped through and that the sling is centered prior to initiating the transfer. NA-B stated resident sling size was determined by the individual resident's weight which is noted on the resident's care plan sheet. Each machine also has the sling size label posted on the mechanical lift as well as a sling color chart located in linen closets on each unit for reference. NA-B stated they received education on use of the mechanical lifts when they started at the care center as well as annually. All staff recently had training on the along with additional education in the past few days as someone had fallen from the lift. On [DATE], at 1:19 p.m. during an interview NA-C stated two staff must always be assisting with mechanical lifts. Residents' care plan indicates for staff if the resident is one or two staff assistance for transfers, however for mechanical lifts there are always two staff needed for the transfer. NA-C stated there were enough staff for safe transfers and would use the radio/walkie talkie to call for staff assistance with a transfer. Recently we have had re-education for safe use of mechanical lifts. On [DATE] at 3:32 p.m. during interview, NA-A stated she made the decision to transfer R1 with the use of the mechanical lift by herself rather than ask another staff to come and assist. R1 was care planned for assistance with all transfers with the Hoyer and two staff at all times. She did not use her walkie to call for another staff member to assist but should have. NA-A stated if there had been another staff present for the transfer one staff could have been operating the lift remote and the other staff would have been with the resident guiding the resident in the sling. Facility training and policy was to follow the care plan which directed all transfers for R1 required assistance of two with the mechanical lift. When R1 fell she immediately yelled for assistance, R1 was on the floor in pain. She was suspended right after and then terminated for not following R1's care plan and facility policy. Received educated on using the mechanical lifts and importance of two staff assisting with the transfer prior to the incident on [DATE]. On [DATE] at 8:51 a.m. during an interview, director of nursing (DON) DON stated all nursing staff receive training on mechanical lifts upon hire as well as annually through competencies/training. Important and expectation was for all staff to follow individual residents' care plans to provide care in a safe setting. DON verified NA-A had not followed R1s care plan nor had she followed facility policy/procedure. R1 required assistance from two staff with the use of a mechanical lift for all transfers. As a result of NA-A not following R1's care plan, R1 sustained significant injuries which included left femur fracture, head laceration, and injury to left toes. Her expectation was all staff are following not only residents individual care plans but all facility policies and procedures to ensure care is being provided in a safe setting and in this case it was not. On [DATE], at 11:27 a.m. during an interview, facility administrator stated she arrived at the facility immediately after she was notified R1 had fallen from a mechanical lift. Facility DON arrived shortly after she had arrived. NA-A admitted to her at that time she did not follow R1's care plan and transferred R1 by herself. NA-A was suspended pending the investigation and terminated on [DATE]. NA-A did not follow R1's care plan by transferring R1 without a second staff member for transfer using a mechanical lift resulting in a fall from the Hoyer lift and substantial injury. All staff present at the time were interviewed and the incident was reported to the state agency. Education was started immediately with all staff members on mechanical lifts and following residents' care plans. We also educated all staff members on reporting immediately if they observe any staff, not following residents' care plans and our facility policy. The facility also interviewed residents who were cognitive and required the assistance of two (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	staff members to ensure no other incident occurred. Maintenance staff inspected all mechanical lifts in the building to ensure all were in proper working order. All staff are trained to follow the individual resident care plan and facility policy/ procedure. This was not followed on [DATE], and as a result R1 was significantly injured. On [DATE], at 12:55 p.m., during interview R1's family member (FM)-A stated he had received a telephone call on [DATE] in the morning from R1 stating she had fallen out of the mechanical lift and was hurt. FM-A stated NA-A told him that she had attempted to transfer R1 with the mechanical lift by herself and she should have had another staff member assisting with the transfer. FM-A stated because of the fall R1 sustained a left hip fracture and laceration to the head. R1 returned to the facility that same day and quickly declined. R1 was placed on hospice and died on [DATE]. FM-A stated if there had been two staff members as required with the mechanical lift, maybe this would not have happened. The EZ Way Classic Lift Operator's Instructions, undated, provided by the facility identified directions for the lift devices used by the care center. This included a section labeled, Safety Notes, which directed multiple items including, The EZ Way Smart Lift? was designed to be operated safely by one caregiver. However, depending on the situation, facility policy, and the patient's condition, two caregivers may be necessary. The facility Safe Resident Handling Program Policy, revision date 11/2025, directed all resident care will be provided in a safe, appropriate, and timely manner in accordance with the individual resident's care plan. A facility Care Planning policy, revision date 11/2024, directed the care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purpose of providing care or services to the residents. A facility policy was requested specifically for Mechanical Lifts/Hoyer; however, the facility did not provide. The past noncompliance immediate jeopardy began on [DATE]. The immediate jeopardy was removed on [DATE] and the deficient practice corrected by [DATE], after the facility implemented a systemic plan that included the following actions: Education and competencies for all clinical staff on safe use of mechanical lifts, and safe resident handling policy, as well as vulnerable adult policy for all facility staff.