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	03/27/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on observation, interview, and document review facility failed to perform a self-administration of medication assessment and obtain provider order to have medication left in room for 2 of 2 (R13 and R29) residents reviewed for self-administration of medication. R13's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R13 had intact cognition. Diagnoses included heart failure, hypertension and renal insufficiency. During an observation of R13's room on 3/24/25 at 3:17 p.m., a box with a tube of diclofenac cream was noted on the shelf to the right of the bed. During an interview on 3/24/25 at 3:17 p.m., R13 stated the staff utilize the diclofenac cream on her back and just leave it on the shelf so it would be available when they needed it. During a second observation of R13's room on 3/25/25 at 2:06 p.m., a box with a tube of diclofenac cream was again noted on the shelf to the right of the bed. R29's quarterly MDS dated [DATE], indicated R29 was cognitively intact. Diagnoses included anxiety, depression and post traumatic stress disorder. R29's Medication Admin Audit Report dated 3/27/25, indicated R29 had orders for Ipratopium-albuterol inhalation solution 0.5-2.5mg inhaled 4 times a day. On 3/26/25, a dose had been set up at 11:38 a.m. During an observation on 3/24/25 at 6:40 p.m., a nebulizer canister was observed full of a liquid substance, not running, and no medical staff were in the room with the resident. During a second observation on 3/26/25 at 12:53 p.m., again a nebulizer canister was observed full of liquid substance, not running, and no medical staff with him. At that time R29 turned on the nebulizer machine and started administering the liquid in the nebulizer canister. (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: 245495	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
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)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/25/25 at 2:10 p.m. licensed practical nurse (LPN)-B stated prior to a medication left at bedside there must be a self-administration of medication (SAM) form completed, which showed resident was safe to leave medication at bedside and that resident wanted to have medication left at bedside. After that an order would be obtained from the provider to leave medication at bedside. LPN-B entered R13's room and confirmed a tube of Diclofenac cream had been left at R13's bedside shelf. LPN-B then reviewed R13's medical record and indicated there was no SAM or order to keep any medication at bedside. During a second interview on 3/26/25 at 12:56 p.m., LPN-B entered R29's room and confirmed R29 had a full canister of liquid in the canister he was administering medication with. LPN-B reviewed R29's medication administration record (MAR) and stated the last documented administration of inhaled nebulizer medication was done at 11:38 a.m., and not at the current time. LPN-B stated based on the amount of liquid in the canister R29 had just started the nebulizer at the current time and not at 11:38 a.m., as documented. R29 did not have a SAM or provider order to keep medication of any kind at bedside, so the staff member should have made sure the nebulizer had been utilized at 11:38 a.m., when documented as administered. During an interview on 3/27/25 at 1:54 p.m., the director of nursing (DON) stated if the resident did not have a SAM assessment or provider order to leave medication at bedside. Staff should not leave at bedside and should stay with the resident while they took the medication. The facility Self-Administration of Medications policy last revised 2/24 indicated the facility would deem if a resident was safe to self administer medication through assessment forms and provider orders.

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 03/27/2025
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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47263 Based on interview and document review, the facility failed to ensure advanced directives for emergency care and treatment were accurately reflected in all areas of the medical chart to ensure resident wishes would be implemented correctly in an emergent situation for 1 of 16 residents (R200) reviewed for advanced directives. Findings include: R200's admission Minimum Data Set (MDS) dated [DATE], indicated R200 was cognitively intact with the diagnoses of congestive heart failure, diabetes, and respiratory failure. R200's careplan initiated on [DATE], included the focus area Current Code Status: see current POLST [Physician Orders for Life Sustaining Treatment]. Interventions included review advanced directives per resident and or family request and arrange for MD consult as necessary. During record review on [DATE] at 4:48 p.m., R200's scanned in POLST dated [DATE], signed by the provider on [DATE], directed do not resuscitate (DNR). However, the order entered in the chart on [DATE], was for Cardiopulmonary resuscitation (CPR) and R200's banner also instructed CPR. During an interview on [DATE] at 6:27 p.m., R200 stated they had been asked if they had a living will when they returned to the facility. R200 stated they had told staff they didn't want CPR at the facility, they only wanted to die once. R200 indicated they had family members that had broken ribs and didn't do good after CPR. R200 stated they didn't want brain damage or to be worse off after. They would be a full code if they were having a procedure done at the hospital but otherwise they wanted to be DNR. During an interview on [DATE] at 6:04 p.m., RN-A stated for an un-responsive resident they would go to the electronic medical record and look at the code status there to know what to do. RN-A opened R200's EMR and stated R200's POLST was DNR, but the banner and order were for CPR. RN-A stated they would have done CPR on R200 based on the banner, so in that instance the wrong things would have happened because the order and the banner were entered incorrectly based on the POLST. During an interview on [DATE] at 6:11 p.m., LPN-A stated to determine a resident code status they would look at the facesheet and if it was not there they would look at the banner because it was quickest. LPN-A opened R200's chart and stated based on the banner they would start CPR on R200 if they found R200 unresponsive. LPN-A confirmed R200's banner and chart did not match and stated they would contact the provider or supervisor to determine what action to take when the POLST and banner did not match. During an interview on [DATE] at 6:02 p.m., LPN-C stated they always went to the main EMR screen to determine a resident's code status. LPN-C opened a EMR record and pointed to the banner and code status location. LPN-C stated they only went to the POLST to look at code status if the banner status was empty. (continued on next page)

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 03/27/2025
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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 6:03 p.m., LPN-B stated on admit the POLST reviewed with the resident and once the resident signed the POLST their status was entered on the EMR banner. It then went to the HUC so it could be signed by the provider and scanned in. The POLST and the order/banner should match. If a resident stopped breathing, staff can go to the banner for the code status. During an interview on [DATE] at 6:56 p.m., the director of nursing (DON) stated as a health care professional it is a number one priority to make sure residents are safe and that their wishes are respected and honored. The DON stated the facility had a process in place to honor resident's wishes and ensure their code status was correctly documented. The banner is a quick place for nurses to identify if CPR should be implemented. In R200's situation because the banner did not match the order, if R200 had coded and received CPR, R200's wishes would not have honored. CPR could have also resulted in negative consequences for R200. With CPR, R200's medical condition could have potentially been worsened after CPR resulting in a lower quality of life for R200 post CPR. During an interview on [DATE] at 7:17 p.m., RN-B stated they corrected R200's order and banner to reflect R200's POLST which showed R200 wanted to be a DNR. RN-B stated they expected staff to look at the EMR banner for a resident's code status. RN-B confirmed R200 would have likely received CPR if they had coded prior to the banner and order being corrected. RN-B explained performing CPR on a resident who did not want it could be bad for the resident depending on the outcome. CPR could result in pain, broken ribs, and possibly medical deficits that were not there prior to CPR. During an interview on [DATE] at 7:27 p.m., the administrator stated respecting the wishes of the resident was very important and indicated the team had corrected R200's code status as soon as they had been made aware of the error. The administrator indicated the facility had a process in place to get the resident's wishes regarding code status at the time of admission and then an order and banner status in place so that resident wishes could be honored as soon as they were known, while waiting for the final POLST to be completed. The administrator indicated that their HUC completed weekly audits on code status for all residents, however they had just completed an audit on all residents in the building due to the error on R200's code status. They had fixed R200's code status as soon as they were made aware of the discrepancy, had audited code status for the whole building, and had began staff education. On [DATE] at 7:38 p.m., R200's banner and orders were reviewed and indicated R200's code status was now listed as DNR. On [DATE] at 9:00 a.m., the HUC stated they were responsible for scanning the POLST into the chart, they did not update the banner, nurses did that. The HUC indicated they had started to do code status audits weekly at the facility on the second week of February 2025. Their process was to go through every resident. They started with review of the code status on the banner and then made sure the POLST was signed, correctly completed and matched the banner and order. The HUC's audit book showed several completed weekly audits. The audit completed on [DATE], listed R200 as being in the hospital. The HUC indicated they had not completed their audit for this week yet, but if there was a discrepancy it would be found during the audit. During a follow-up interview on [DATE] at 8:54 a.m., RN-A stated they had notified the social worker R200's code status and POLST did not match once they had been made aware of it. RN-A stated they had checked R200's chart at shift start this a.m. and R200's code status had been fixed. (continued on next page)

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 03/27/2025
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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy POLST documentation dated ,d+[DATE], indicated the purpose of the POLST was to identify and document the code status consistent with the resident wishes so that staff know immediately what action to take or not take when an emergency arises. The policy identified a process for managing code status orders and the POLST and indicated routine audits of the POLST documentation should be conducted.

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	03/27/2025

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on interview and document review, the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS-10055) to 1 of 3 residents (R54) reviewed whose Medicare Part A coverage ended while in the facility. Findings included: R54's Notice of Medicare Non-Coverage (CMS-10123) dated 10/15/24, indicated R54's last day of skilled services was on 10/15/24 due to going on hospice services. The form was signed by R54 and dated 10/15/24. In addition, R54's medical record lacked evidence the required CMS-10055 had been reviewed and/or provided to R54 prior to their Medicare Part A coverage ending. R54's Census List indicated a payer change occurred on 10/16/24, to hospice private pay. R54's progress notes from 10/9/24 to 10/17/24, indicated R54 was a resident of the facility until discharge on [DATE]. During an interview on 3/27/25 at 8:01 a.m., the business office manager (BOM) stated she was responsible to give the residents the CMS 10123 and 10055 forms to the residents 3 days prior to discharge from Medicare-A services. The CMS-10055 was also known as the daily rate form so the resident would be aware of the approximate daily rate bill if they had to pay out of pocket. The BOM reviewed R54's record and acknowledged the 10055 had not been issued to R54, but R54 had remained in the facility after the last day of Medicare A coverage stopped. The BOM stated even though R54 was only in the facility for 1 day after the discontinuation of Medicare A coverage, a 10055 form should have been issued so R54 was aware of what each day of stay would cost. During an interview on 3/27/25 at 8:14 a.m., the administrator stated any resident that stayed at the facility after Medicare part A coverage stopped coverage needed to have the 10055 form given to them so they were aware of what a daily rate might be for their stay. The facility's policy titled ABN/NOMNC Policy and Procedure dated 2/20/23, indicated any resident that stayed in the facility after Medicare part A coverage ended would be issued a SNFABN: CMS-10055.

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 03/27/2025
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on interview, and document review the facility failed to notify the provider as ordered for a weight increase of 3 pounds (lb.) or more in 24 hours for 1of 2 residents (R27). The facility also failed to follow fluid restrictions as ordered for 2 of 2 residents (R27, R28). The facility also failed to address elevated blood glucose levels for 1 of 1 resident (R16). The facility also failed to have a resident assessed for usage of a walker for 1 of 1 resident (R12) reviewed for provider orders. Findings include: R27: R27's annual Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition. Diagnoses included anemia, coronary artery disease and renal failure. R27's care plan dated 9/25/24, indicated a risk for complications related to dialysis. Interventions included fluid restriction per order. R27's Order Summary Report (OSR) dated 2/4/25, indicated R27 was on an IDDSI level 7 regular texture diet with a 1500 milliliter (ml) fluid restriction. R27's OSR as indicated on 12/7/24 R27 was placed on a 2000 ml fluid restriction. Review of R27's MAR from 2/25 and 3/25 indicated the following: - During 2/25 R27 received more than 1500ml of fluid 2 times and lacked documented fluid amounts for at least one shift 10 days. - During 3/25 R27 received more than 1500 ml of fluid 2 times and lacked documented amounts for at least one shift 7 days. R28's quarterly MDS assessment dated [DATE], indicated intact cognition. Diagnoses included heart failure, hypertension and post kidney transplant. R28's care plan dated 3/19/25 indicated a potential for altered nutrition status with interventions of weekly weights and offer adequate fluids at and between meals. The care plan lacked information related to daily weights or fluid restrictions. R28's OSR dated 1/27/25, indicated a heart healthy diet with a 2000 ml fluid restriction. The OSR also indicated on 12/20/24, orders were placed to weigh daily and notify the provider with a weight gain of 3 lbs in 24 hours or 5lbs in 1 week. Review of R28's MAR and Treatment Administration Record (TAR) from 1/25 through 3/25 indicated a lack documentation the fluid restriction was being monitored as ordered. Review of R28's MAR and TAR from 1/25 through 3/25, indicated the following: (continued on next page)

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 03/27/2025
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A 24 hr 4 lb weight gain on 2/11/25, and a 4.6 lb weight gain on 2/13/25. Daily weights were missed 3 times. - A 24hr 6lb weight gain on 3/10/25. Daily weights were missed 6 times. R28's medical record for 1/25 through 3/25, lacked documentation the weights over 3lbs in 24 hrs or missed recieved a provider notification During an interview on 3/25/25 at 2:48 p.m., nurse assistant (NA)-C stated daily weight would be obtained by the NA's usually on day shift and then given to the nurse to enter into the medical record. For residents on a fluid restriction, the nursing staff would keep track how much fluid the resident took in during meals and throughout the day, minus fluids given with medications, and that would be given to the nurse to enter into the medical record and keep track of. During an interview on 3/27/25 at 12:48 p.m., registered nurse (RN)-B stated she was not sure how documentation would be done to show weights were called to provider or fluid restrictions were followed but did believe there was some documentation that went into the medical record to show it was completed. RN-B reviewed R27's and R28's medical record and indicated there was no documentation related to fluid restriction orders or weight orders being followed or that the provider was notified when needed. During an interview on 3/27/25 at 1:58 p.m., the director of Nursing (DON) stated staff should follow provider orders and follow the policy related to provider notifications. 47263 R16: R16's quarterly Minimum Data Set (MDS) dated [DATE], indicated R16 was cognitively intact and received insulin injections daily. R16's Diagnosis Report dated 3/27/25, included diagnoses of multiple myeloma, coronary artery bypass, diabetes type II with chronic kidney disease, diabetic neuropathy, heart failure, and hypertension. R16'a Careplan last reviewed on 3/19/25, included the following: Potential for alteration in blood sugar related to diagnosis of diabetes. Goal: resident will be free from hyper/hypo glycemic episodes with the following interventions: -Encourage diabetic HS snack. -Labs per MD order -Monitor resident for signs/symptoms of hyper and hypoglycemia. -Monitor residents blood sugar as ordered. (continued on next page)

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 03/27/2025
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Administer scheduled and sliding scale insulin as ordered. -Administer medication as ordered. -Diet as ordered. Encourage resident to follow prescribed diet. R16's Order Summary Report for 2/1/25 to 2/28/25, included an order, dexamethasone oral tablet 4mg give 5 tablets by mouth one time a day every seven days for cancer treatment. Start date 3/2/25. R16's Order Summary Report Active orders as of 3/27/25, included the following orders: -consistent carbohydrate diet -blood sugar monitoring via finger stick 4 times a day -monitor for s/s of hyper/hypoglycemia including but not limited to lethargy, sweating, weakness, confusion, pale, vomiting, and excessive thirst every shift -Lantus subcutaneous solution pen-injector. Inject 12 units subcutaneously at bedtime related to diabetes type 2 -Lantus subcutaneous solution pen-injector. Starting 3/27/25, inject 15 units subcutaneously at bedtime related to type two diabetes. -Novolog flex pen solution pen-injector. Inject 4 units subcutaneously three times a day related to diabetes type 2 R16's careplan and current orders lacked parameters for provider notification and instruction on actions to be taken in the event R16 became hyperglycemic or hypoglycemic. R16's careplan did not identify R16 was receiving steroids, nor did it include a focus area with goals and interventions for steroid use/monitoring. Prior to 3/24/25, R16's most current in-person provider encounter at the facility was documented as 1/23/25. R16's nursing notes included the following: -A note on 3/23/25 indicated the on-call provider had been notified of a blood sugar reading of 485. The provider did not give any orders. -A note on 3/24/25, indicated the on-call provider had been notified of a blood sugar reading of 598. A one-time order for NovoLog 4 units was received and would be administered to R16. R16's medical record lacked evidence of provider notification for blood sugar values greater than 400 on 3/26/25, 3/21/25, 3/20/25, 3/13/25, or 3/6/25, In addition the chart lacked evidence a provider had been notified R16's blood sugars had been trending up. (continued on next page)

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 03/27/2025
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R16's Essentia Health Lab Report result for a hemoglobin A1C drawn on 1/14/25, showed that R16's A1C was 6.4 which meant that R16 had an estimated average blood glucose of 137mg/dl. The blood glucose values listed on the Weights and vitals Summary effective 1/1/25 to 3/31/25, were reviewed. Summarized documented blood glucose values between 3/1/25 and 3/27/25, showed R16 had had 8 blood glucose readings greater than 400 mg/dl, 20 readings greater than 300 mg/dl, 17 blood glucose readings below 200 mg/dl, with all other values falling between 200 and 299 mg/dl during the time period reviewed (R16 blood glucose testing was ordered four times a day). During an interview on 3/24/25 at 3:00 p.m., R16 stated they had had a high blood sugar, and the doctor never treated it with insulin. R16 stated they knew the high sugars were not good for them, but the nurse had said the doctor didn't want to treat it. R16 indicated they had requested to talk to a doctor about their high blood sugars. During an interview on 3/27/25 at 8:16 a.m., R16 stated they continued to worry about their blood sugar values, and explained they could go into a diabetic coma if their blood sugars got to high. R16 also worried about their eye sight getting worse because of their blood sugars. R16 stated they had told staff they were very concerned about their blood sugars and had also asked to be seen by a provider, but nobody had seem them since January. R16 indicated their blood sugars had been better before they started steroids, usually below 200 and rarely over 300, but now they were high all the time and they knew they needed more than a one time dose of insulin to take care of it. During an interview on 3/27/25 at 12:34 p.m., the director of nursing (DON) pulled up and reviewed R16's blood sugar record in the EMR. The DON confirmed R16's blood sugars had been consistently high and stated R16 frequently ate high carb take meals. R16's prescribed steroids would also elevate blood sugars. The DON stated they would expect nurses to notify the provider when blood sugars were in the 400-500s. In addition, they expected the provider would be notified if a resident was trending with high blood sugars. Registered nurse consultant (RNC-D) was present at the interview and stated they did not see a note that indicated R16 had been seen by a provider in February or March. Nor did they see nursing documentation that a provider had been notified of trending blood sugars or greater than 400 values other than on 3/23 and 3/24/25. RNC-D reviewed R16's A1C lab results and stated R16's A1C had been good in January. The DON stated R16 was medically complicated with several chronic diseases including cardiac issues which could be negatively impacted by higher blood sugars. R16's organs would have to work harder and R16 was at risk for hospitalization and DNK [diabetes ketoacidosis, a life threatening condition where the body does not have enough insulin, the body then makes ketones, which leads to the blood becoming too acidic] due to the high sugars. (continued on next page)

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 03/27/2025
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)

F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During an interview on 3/27/25 at 12:59 p.m., R16's nurse practitioner (NP-E) stated they had been contacted for a high blood sugar, and had ordered insulin coverage however, they had not been informed R16's blood sugars had been trending high. NP-E stated they would expect a call immediately for a blood sugar over 400 so the blood sugar(s) could be addressed. In addition, they expected it would be communicated to them if a resident's blood sugar started trending up averaging in the 200s to 300s. NP-E explained trending high blood sugars could result in further amputations, kidney issues, changes in vision, organ stress or complications like DNK for R16. If it had been communicated to them that R16's blood sugars were averaging greater than 200 with values around or greater than 400, R16's insulin would have been adjusted to address those values in addition to treatment of the reported high value.

All polices and protocols related to blood glucose monitoring and management were requested. RN-D indicated the facility did not have a specific glucose management policy and indicated they would reference the Med and TX order policy for following provider orders.

The Medication and Treatment Orders policy dated 2/2024, was reviewed. The policy did not address or instruct staff on diabetes management, nor did it provide actions/intervention to take or instruct when to notify the provider in the event a resident experienced hyper/hypoglycemia.

49877

R12:

R12's annual minimum data set (MDS) dated [DATE], identified R12 was cognitively intact and diagnosed with arthritis, depression, schizophrenia, spondylosis in lower back (degenerative condition of spinal discs and joints causing pain and stiffness), and sciatica on the right side (pressure in the lumbar spine which causes radiating pain from the buttocks down the leg). MDS further identified R12 uses a wheelchair and requires partial to moderate assistance (worker does less than half of the effort) to transfer from a sitting to standing and standing to sitting position.

R12's care plan reviewed on 3/25/25, identified R12 required the assist of 1 with toileting and used a bedpan. R12 had alteration in mobility related to increased weakness and the need for assistance with mobility. R12 will move safely within the environment, used a wheelchair for locomotion, and required moderate assist of 1 for wheelchair to toilet transfers.

R12's active orders dated 3/5/25, identified physical therapy (PT) and occupational therapy (OT) to evaluate and treat for mobility.

R12's progress note dated 3/16/25, identified R12 had requested to be seen again by PT. No additional progress notes were made from 3/16/25 to 3/25/25.

R12's medical recorded lacked a risk versus benefit form related to the use of a walker completed prior to 3/25/25.

(continued on next page)

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 03/27/2025
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview and observation on 3/24/25 at 3:36 p.m., R12 stated she would like to use a walker to assist with bathroom transfers instead of using a bedpan. R12 identified over the past several weeks she has reported this to nursing staff, requested to be provided with a walker, and to be seen by PT but no action had been taken. Approximately two weeks ago R12's father purchased her a walker and had it delivered to the facility. R12 stated after the walker was delivered, she was assured maintenance would assist with assembly, but no action had been taken. An unopened box identified as containing a 4-wheeled walker was noted in R12's closet. During interview and observation on 3/25/25 at 1:29 p.m., R12 reported a housekeeper put in a maintenance request to have her walker assembled. Maintenance worker was observed removing the box which contained the walker from the R12's room. During interview on 3/25/25 at 1:32 p.m., licensed practical nurse (LPN)-E confirmed R12 had requested to be seen by PT. LPN-E identified R12 made this request approximately 2 weeks ago. LPN-E reported the request to the director of nursing (DON) and documented it in R12's progress notes. During interview on 3/25/25 at 1:49 p.m., occupation therapist (OT)-B explained any resident who was provided with or obtained a walker must be assessed prior to its use to assure the walker was the correct type, height, and safe to use. Assessment prior to the use of a walker was a standard of care. (OT)-B reviewed R12's therapy documents and confirmed R12's did not have a current PT/OT referral and R12's medical record did not contain any therapy related documents (progress notes, screenings, or plan of care) which occurred in the past 30 days. During observation on 3/26/25 at 10:38 a.m., R12 had an assembled 4-wheeled walker at the foot of her bed. During interview on 3/27/25 at 9:45 a.m., R12 explained maintenance had returned the assembled 4-wheeled walker on 3/25/25. R12 reports she has been using the walker for the past 2 days and was not assessed or provided with education from nursing or PT/OT staff prior its use. R12 identified feeling a little scared and shaky while using the walker because it moves faster than she had expected. During interview on 3/27/25 at 10:42 a.m., DON expects nursing leadership be made aware of a resident's request for a walker. Nursing leadership will notify the provider who will, if warranted, order a PT/OT evaluation. PT/OT will be made aware of the order no later than the following day. The timeframe in which a resident will to be evaluated by PT/OT was in the facility policy. If a resident brings a walker into the facility DON identifed immediate action needs to be taken to evaluate the resident for safety. Depending on the resident this may include PT/OT evaluation, resident education, or the completion of a risk verse benefit form. A policy for PT/OT evaluation and treatment was requested but not provided.

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 03/27/2025
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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on interview and document review the facility failed to perform prescribed dressing changes to a pressure ulcer as ordered for 1 of 3 residents (R27) reviewed for pressure ulcers. Findings include: R27's annual Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition. Diagnoses included anemia, coronary artery disease and renal failure. R27 was at risk for pressure ulcers and had an unhealed unstageable pressure ulcer. R27's Medication Administration Record (MAR) dated 3/25, indicated orders were present from 3/7/25 to 3/20/25 to cleanse pressure ulcer with vashe. Loosely fill wound with vashe damped packing strip, ensure filling in tunnel and undermining. Leave out tail for easy removal. Cover with bordered foam dressing. Change twice daily and as needed. R27's MAR dated 3/25 lacked documentation dressing changes were completed on the following days: - Day shift 3/9/25, 3/13/25, 3/14/25, 3/16/25 through 3/18/25, and 3/20/25 - Evening shift 3/8/25 through 3/10/25, 3/14/25 through 3/16/25 R/27's progress notes were reviewed from 3/8/25 through 3/20/25. Progress notes lacked documentation as to why scheduled dressing changes were missed or passed on to the next shift to make sure they were done. During an interview on 3/24/25 at 7:05 p.m., R27 stated there was a pressure ulcer on her coccyx region that nursing was doing dressing changes on. The staff would miss several of the dressing changes since the wound appeared. During an interview on 3/26/25 at 5:08 p.m., trained mediation aide (TMA)-B stated that either the nurse manager or a nurse from 200 hallway would do all of the dressing changes for 100 hallway when a nurse was not assigned. I know everybody is really busy, so I never know when they are done or not done. During an interview on 3/26/25 at 5:19 p.m., licensed practical nurse (LPN)-C stated the nurse on either 200 or 300 hallways would assist 100 hallway with dressing changes when there was not a nurse assigned to 100 hallway. We usually find time to run over to 100 hallway to get the dressing changes done. I can't think of any specific times, but I know there have been times when evening shift has not been able to get 100 hallway dressing changes done. When that would happen, we would report off to the next shift to get the dressing changes done and document in progress report why it was not done. After the next shift completed the dressing change, they would go into the MAR and document the completed dressing change. (continued on next page)

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 03/27/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/25 at 12:48 p.m., registered nurse (RN)-B reviewed R27's MAR and acknowledge several dressing changes were not documented on. Based on the documentation, there is no way to know if the dressing changes were completed. During an interview on 3/27/25 at 1:58 p.m. the director of nursing (DON) stated dressing changes needed to be done as ordered and documented on in the MAR. Facility policy Skin Assessment and Wound Management last revised 2/25 indicated ongoing treatments would be followed as ordered by the provider.

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	03/27/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on interview and record review, the facility failed to consistently monitor dialysis access site for 1 of 1 resident (R27) reviewed for dialysis care. Findings include: R27's annual Minimum Data Set (MDS) dated [DATE], indicated intact cognition. Diagnoses included anemia, end stage renal disease and diabetes. The MDS indicated R27 was on dialysis. R27's care plan dated 9/25/24, indicated R27 had a dialysis port to the right chest. The care plan lacked information related to R27's arteriovenous dialysis fistula in the right arm. R27's Order Summary report dated 2/6/24, indicated orders which included dialysis-monitor chest port post dialysis, dialysis-no IV. Blood draws, blood pressures on right arm. Fistula incision care and monitor dialysis site for bleeding. The order summary lacked to monitor the fistula bruit and thrill (swish sound coming from fistula indicating normal function) from fistula. Provider progress note dated 2/18/25, indicated R27 had right upper extremity fistula placed for dialysis on 2/13/25. During an interview on 11/16/25 at 1:24 p.m., licensed practical nurse (LPN)-E stated R32's access site got assessed for bruit, bleeding, and infection on the day shift but often not on dialysis days because R32 left the facility during the night shift at 5:30 a.m., and often did not return until later in the evening shift. During an interview on 3/27/25 at 9:41 a.m., the dialysis clinical manager (DCM) confirmed R27 had a AV fistula placed on 2/13/25, and was used by the dialysis team for dialysis treatments. The DCM stated the facility should start monitoring the fistula for the bruit and thrill at least daily right after the fistula is placed. Monitoring was important because there would be early warning signs of a potential bigger issue. During an interview on 3/27/25 at 9:57 a.m. trained medication aide (TMA)-A indicated R27 had a new fistula that the dialysis center just started using. TMA-A did not believe the nurse would evaluate the fistula at all. During an interview on 3/27/25 at 12:48 p.m. registered nurse (RN)-B stated staff had not started monitoring R27's fistula for bruit and thrill since the fistula was placed. RN-B was unsure how often the fistula should be monitored. During an interview on 3/27/25 at 1:58 p.m. the director of nursing indicated the bruit and thrill should be monitored per facility policy. The facility dialysis policy was not received.

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 03/27/2025
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)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47263 Based on observation, interview, and record review the facility failed to ensure licensed staff were educated and competent in the administration of intravenous medications (IV) and/or the management and care of peripherally inserted central catheters (PICC) [a long thin tube inserted into a vein on the inside of the upper arm that extends into a larger vein leading to the heart for medication, blood, and nutrition administration] for 1 of 1 residents (R200) reviewed for PICC line care and management. This deficient practice had the potential to impact all residents at the facility who had IV/PICC access and/or received medications through IV/PICC access. Findings include: R200's admission Minimum Data Set (MDS) dated [DATE], indicated R200 was cognitively intact with the diagnoses of congestive heart failure, diabetes, and respiratory failure. R200's careplan initiated on 2/18/25, did not include R200's PICC line nor did it include goals and interventions for care of R200's PICC line. The Order Summary Current Orders as of 3/24/25, included the following orders: -PICC/Midline-Change cap (needless access device) weekly with dressing change q wed in am -Vancomycin HCl Intravenous Solution (Vancomycin HCl) use 1500 mg intravenously every 24 hours related to methicillin resistant staphylococcus aureus infection as the cause of disease classified elsewhere (B95.62) for 20 Days. Inject 1500mg in NS over 90 minutes into the vein every 24 hours for 20 days. -PICC/Midline Change dressing location______(blank) using sterile technique weekly and as needed. Document in progress notes description of care and resident's response to procedure every Wed -PICC/Midline-Measure arm circumference 3 inches above insertion site weekly with dressing change in the morning every Wed -PICC/Midline-Measure total catheter length on dressing change. Location_____(blank) in morning. -PICC Line monitor for complaints of unusual sounds near the neck ear or the affected site every shift -PICC/Midline monitor site location_______(blank) every shift for s/s of infection and infiltration every shift (continued on next page)

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 03/27/2025
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)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/26/25 at 11:28 a.m., R200's PICC line was covered with a transparent dressing. The end or R200's PICC line did not have a lumen cap on it. R200 stated they had been told it was okay to not have the cap on the PICC line. R200 thought it had been that way for a couple of days. R200 also stated she had had a blood draw yesterday and the nurse had removed about 6 big syringes of air from their PICC line and they were afraid something bad might happen because of all that air. After an observation on 3/26/25 at 11:46 a.m., registered nurse RN-B confirmed R200's PICC line was missing the lumen cap attachment and indicated the missing cap was a concern for infection. RN-B opened the electronic medical record (EMR), and stated R200's cap was changed before R200's antibiotic was started on 3/25/25 at 1:15 p.m. RN-B indicated the cap would have likely been off sometime between the time the antibiotic was discontinued on 3/25/25, and now. During an interview on 3/26/25 at 11:51 a.m., the director of nursing (DON) stated the PICC line should have the lumen cap on the end of the PICC line as it is an infection prevention issue for it to be capless. The DON confirmed R200 was correct, five 10cc syringes of air had been pulled off of R200 PICC line during R200's blood draw completed on 3/25/25. The PICC line gets clamped so they were not sure how the air got in R200's line. The DON indicated the order instructed to flush, and didn't say anything to pull back before the flush, and indicated air could have entered the PICC line with flushing. The DON stated they thought they may need to do some PICC line education with staff. The DON confirmed the air had not been documented or a note made to indicate the provider had been notified of the air in R200's PICC line on 3/26/25. During an interview on 3/26/25 at 2:51 p.m., the DON stated they had a call out to infectious disease and had notified R200's provider that R200's lumen cap had been off. The DON indicated that it was possible the lumen could have been accidently removed during a flush or something and indicated R200's PICC like should have a lumen cap at the end of it at all times to prevent infection. The DON stated another resident had told the them that R200 was concerned about dying because of the air in their PICC line. They were also concerned about the air as well because of the risk for air embolism. The DON indicated they had updated the provider about the air in R200 line on 3/25/25 and indicated R200 had a follow-up appointment tomorrow, so R200 would see the provider then. During an interview on 3/26/25 at 3:08 p.m., R200 stated when they first got back from the hospital there was a green cap on the end of the PICC line but the facility didn't use that cap any longer. R200 stated they thought the clear cap (lumen cap) had been missing from their PICC line for a couple of days. R200 stated one day they sent a staff in that said they didn't know about PICC lines but they said they were told to do it anyway. R200 stated they were afraid they were going to get killed here with all that air in their line. During an interview on 3/26/25 at 5:12 p.m., RN-A stated when they hooked up R200's antibiotic yesterday, the clear lumen had been attached to R200's PICC. The antibiotic didn't get done until after they had left for the day so another staff would have disconnected the antibiotic when it was done. RN-A stated today when they went to hook up R200's antibiotic, the PICC line would flush, but there was no blood return so R200 was being sent to the emergency room for evaluation of their PICC line. RN-A stated they would definitely contact the provider for any air pulled back from a PICC line that was greater than 4cc because there should not be any air in the PICC line. RN-A stated they had not received any hand off report of R200 having had air in their PICC line on 3/25/25. (continued on next page)

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 03/27/2025
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)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/25 at 5:37 p.m., RN-B stated RN-A had reported R200's PICC line was not properly functioning. RN-B stated they had talked to R200 to see if they would like to go into to have it assessed or if they would like the nurse at the facility to try Cathflo. R200 had chosen to go to the hospital to have it addressed. During an interview on 3/26/25 at 5:59 p.m., RN consultant (RN-G) stated once they had been made aware R200's PICC line was missing the lumen cap they consulted the nurse practitioner who advised the access area be cleansed and re-capped right away followed by a call to infectious disease. RN-G stated they did as advised and had also successfully pulled back and flushed R200's PICC line after they had attached the new cap. During an interview on 3/27/25 at 9:39 a.m., licensed practical nurse (LPN-D) stated they never received PICC line training or IV medication administration training, or had they ever completed a hands on or any other competency for PICC lines. They did recall watching a PICC line demonstration at one time. LPN-D confirmed as part of their job they administered IV medications and flushes through PICC lines. During an interview on 3/27/25 at 12:07 p.m., the DON stated they had contacted LPN-A who had disconnected R200's antibiotic on 3/26/25. The DON showed a written statement signed by LPN-A which indicated LPN-A could not say for sure if the lumen cap had been removed when they disconnected R200's antibiotic on 3/26/25, or if the cap was in place when they completed the task. The DON stated the LPN would receive follow-up education on PICC lines. The DON stated air pulled from a PICC line was a serious concern because it could mean a resident was at risk for an air embolism. They would expect any nurse that encountered air in a PICC line to notify the provider and document the event in the progress notes. RNC-D and RNC-G were also present. RNC-D stated the facility did not do a competency for intravenous medication administration or IV and PICC line management when RN's or LPN's were hired, nor was there any education specific to PICC lines, however they had done PICC line review at their skills day with a dummy arm. The facility did not have specific education for PICC lines or competencies for blood draws or PICC line dressing changes. The DON confirmed the facility did not have a competency in place to ensure PICC line management competency or IV medication competency for RN's or LPNs. The DON indicated they did not have a process to make sure that LPN's were competent to administer IV medications through an IV or PICC line. The DON indicated when a nurse was hired, they were asked what they knew how to do. The DON felt the facility did on the spot training if a nurse did not know how to do a skill related to IV or PICC lines they would be taught on the spot. A list of licensed staff who had performed PICC line care and medication administration to R200's PICC line and their PICC line competencies for PICC line management, dressing changes, blood draws and IV mediation competencies specific to LPNs was requested. The facility identified three LPNs including LPN-A and LPN-D. Five RNs were identified. Information provided included: - The New hire LPN/RN Competency Check List provided by the facility did not include intravenous medication administration nor did it include PICC lines. -The Temporary Agency Staff Orientation Checklist dated 2/12/24, was provided for RN-A. The checklist did not include PICC lines or (continued on next page)

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 03/27/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Nurse Annual Skill Fair Competency Checklist listed several areas including IV/PICC line and medication administration however no additional documents were included to indicate what nurses were competent to do regarding IV/PICCs and medication administration. A completed check list dated 6/5/24, was provided for LPN-A, and one RN. -Education and or competency documentation was not provided for the other staff who worked with R200's PICC line. The facility policy Flushing Midline and Central Line IV Catheters dated May 2022, directed staff to aspirate the CVAD catheter for blood return to confirm patency prior to administration of medication and solutions. The section Complications gave instruction if there is resistance or lack of blood return during flushing stop the flush and consult the IV nurse specialist or provider. The documentation and reporting section both instruct staff to notify the provider if there are any complications. The facility policy Obtaining Blood Specimens From a Venous Catheter dated May 2022, directed staff to notify physician, supervisor, and oncoming shift of any problems or inability to get blood sample. Facility Policies Central Venous Catheter Dressing changes dated May 2022, directed staff to document date and time of dressing change, location and description of site, complications and interventions done, and if flushed: positive blood return and whether needleless connection device or extension tubing was changed. None of the facility policies provided specifically addressed cap changes or how to address air in a PICC line.

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 03/27/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on interview and document review the facility failed to make sure pharmacy recommendations were addressed timely for 2 of 5 residents (R28, R33) reviewed for unnecessary medications. Findings include R28's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition, and diagnoses included heart failure, hypertension, and renal failure. R28's order summary report dated 12/12/24, indicated R28 was started on Quetiapine Fumarate oral tablet 25 milligrams (mg) one time daily by mouth for a diagnosis of other specified anxiety disorders. R28's Consultant Pharmacist Medication Regimen (PMR) Review dated 2/13/25, recommended the facility address the diagnosis for Quetiapine Fumarate. The PMR indicated CMS guidance for antipsychotic utilization in nursing facilities required an FDA approved diagnosis in chart to use the medication which other specified anxiety was not. The form had not been addressed or signed as completed. During interview on 3/27/25 at 10:43 a.m., the consultant pharmacist (CP) explained monthly medication regimen reviews were done monthly on all residents. CP stated medication regimen reviews were tracked over time and provider responses of accepting or rejecting recommendations were noted. CP stated providers had a month to respond and if there was no response from the provider then the recommendation would be sent again. During interview on 3/27/25 at 12:49 p.m., the director of nursing (DON) stated an expectation for provider to respond to pharmacist medication regimen review recommendations with the next visit, but at least within 30 days. 49878 R33's quarterly MDS dated [DATE], identified intact cognition, and diagnoses including sequelae of cerebral infarction (aftereffects of a stroke), dyspnea (shortness of breath), post-traumatic stress disorder (PTSD), rib fracture, chronic kidney disease, protein-calorie malnutrition, depression, and psychosis. R33's order summary report dated 3/27/25, included the following order: -polyvinyl alcohol ophthalmic solution 1.4%- instill one drop in both eyes as needed for dry eyes. Order was written 1/15/25. R33's Consultant Pharmacist Medication Regimen Review dated 2/13/25, recommended the provider to please add frequency (e.g 4 times a day prn dry eyes) to complete order for polyvinyl alcohol ophthalmic solution. R33's medical record did not contain a provider response to this recommendation. (continued on next page)

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	03/27/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R33's Consultant Pharmacist Medication Regimen Review dated 3/12/25, recommended the provider to please add frequency (e.g 4 times a day prn dry eyes) to complete order (repeat) for polyvinyl alcohol ophthalmic solution. R33's medical record did not contain a provider response to this recommendation. During interview on 3/27/25 at 10:43 a.m., consultant pharmacist (CP) explained monthly medication regimen reviews were done monthly on all residents. CP stated medication regimen reviews were tracked over time and provider responses of accepting or rejecting recommendations were noted. CP stated providers had a month to respond and if there was no response from the provider then the recommendation would be sent again. During interview on 3/27/25 at 12:49 p.m., director of nursing (DON) stated expectation for provider to respond to pharmacist medication regimen review recommendations. Facility policy Consultant Pharmacist Services Provider Requirements policy was requested but not provided.

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 03/27/2025
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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on interview and document review the facility failed to have an appropriate diagnosis for use of medication for 1 of 5 residents (R28) reviewed for unnecessary medications. Findings include R28's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition, and diagnoses included heart failure, hypertension, renal failure and post kidney transplant. R28's order summary report dated 12/12/24, indicated R28 was on Tacrolimus Oral 1mg capsule, take one by mouth every 12 hours for health maintenance. During interview on 3/27/25 at 10:43 a.m., the consultant pharmacist (CP) stated medications appropriate for a diagnoses of health maintenance included several different vitamins and minerals that a resident took as a preventative or maintenance dosing program. The CP stated Tacrolimus was an antirejection drug for patients who have received a transplant. The CP reviewed R28's chart and indicated R28 had a history of post kidney transplant and post kidney transplant would have been the appropriate diagnoses for that medication. During interview on 3/27/25 at 12:49 p.m., the director of nursing (DON) stated all medications ordered by providers would have appropriate diagnoses assigned to them. Facility medication policy was not provided.

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 03/27/2025
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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on observation, interview, and document review the facility failed to ensure medications were properly labeled with direction for use for 1 of 1 resident (R13). Findings include: R13's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R13 had intact cognition. Diagnoses included heart failure, hypertension, and renal insufficiency. R13's Order Summary Report dated 3/29/24, indicated R13 had ordered Diclofenac sodium topical gel, apply 2gms topically to shoulders, upper and mid back 4 times a day. During an observation of R13's room on 3/24/25 at 3:17 p.m., a box with a tube of diclofenac cream was noted on the shelf to the right of the bed. The box and the tube lacked any kind of label with resident name, medication dosage or times to administer. During an interview on 3/24/25 at 3:17 p.m., R13 stated the staff utilize the diclofenac cream on her back and just leave it on the shelf so it would be available when they needed it. During a second observation of R13's room on 3/25/25 at 2:06 p.m., a box with a tube of diclofenac cream was again noted on the shelf to the right of the bed. The box and the tube lacked any kind of label with resident name, medication dosage or times to administer. During an interview on 3/25/25 at 2:10 p.m., licensed practical nurse (LPN)-B stated any medication left at the resident's bedside needed to have a label with the resident's name, dosage of medication to administer, and frequency to administer so everybody was aware of the correct order. LPN-B entered R13's room and observed the box and tube of diclofenac cream in R13's room. She confirmed there was no label on the box or the tube. Since there was no label on the box or the tube, nobody would know the appropriate dosage or if the resident should have the medication. There was an increased risk of a resident getting a medication not ordered or the incorrect dosage. During an interview on 3/27/25 at 1:54 p.m., the director of nursing (DON) stated any medication left at a resident bedside should have at least the name of the resident, the dosage of medication to give and the frequency the medication should be administered. Facility policy Medication and Treatment Orders last revised 2/24, indicated all ordered medications and treatments would include: a. Name and strength of the drug b. Number of doses, start and stop date, and/or specific duration of therapy. c. Dosage and frequency of administration (continued on next page)

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	03/27/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Route of administration e. Clinical condition or symptoms for which the medication is prescribed.

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 03/27/2025
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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49878 Based on observation, interview, and document review, the facility failed to maintain proper food storage temperature in a unit refrigerator containing resident food. Furthermore, the facility failed to ensure refrigerated food items were properly labeled and dated. This deficient practices had the potential to affect all residents and visitors using unit refigerators to store food. Findings include: During observation on 3/26/25 at 10:41 a.m., unit refrigerator on wing 3 was reviewed. Refrigerator temperature read 50 degrees on both thermometers inside fridge. The following items were found: -french onion dip container with expiration date of November 11, 2024. -package of sliced cheese labeled with resident name without opened on date. -package of sliced deli meat labeled with resident name without opened on date. -large bottle of pedialyte beverage labelled with open date of 11/25/24 and name of resident that discharged in December of 2024. During followup observation on 3/26/25 at 3:32 p.m., unit refrigerator on wing 3 was reviewed. Refrigerator temperature read 50 degrees on both thermometers inside fridge. During interview on 3/26/25 at 3:34 p.m., nursing assistant (NA)-B verified both thermometers inside unit refrigerator on wing 3 read 50 degrees. During interview on 3/26/25 at 3:48 p.m., registered nurse (RN)-B verified contents of unit refrigerator on wing 3. RN-B further verified temperature on both internal thermometers read 50 degrees. RN-B stated 50 degrees was too warm for safe food storage and all perishable foods from the fridge would be thrown out. RN-B stated staff should have made a maintenance request to have the fridge looked at due to high temperaure. During observation on 3/27/25 at 7:23 a.m., unit refrigerator on wing 3 had been removed from the unit. During interview on 3/27/25 at 1:04 p.m., administrator stated unit refrigerator from wing 3 had been removed for resident safety. Administrator confirmed 50 degrees to be an unsafe temperature for food storage as it could increase the chances for food-borne illness and adverse effects. Administrator also stated expectation for staff to label resident food with date and resident name. Undated Refrigerators and Freezers policy identified 'acceptable temperature ranges are 35 degrees to 40 degrees for refrigerators.' Policy stated 'supervisor will take immediate action if temperatures are out of range. ' Policy further identified 'all food shall be properly dated.'

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 03/27/2025
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based observation, interview and record review the facility failed to ensure nebulizer equipment was properly washed, dried and stored for 2 of 2 residents (R29, R14); that equipment for tube feeding tube flushes was properly dated, rinsed, dried and stored for 1 of 1 residents (R16); and the facility failed to ensure proper PICC line cap placement occured for 1 of 1 resident (R200) who were reviewed for infection prevention and control. Findings include: R29: R29's quarterly MDS dated [DATE] indicate R29 was cognitively intact. Diagnoses included anxiety, depression and post-traumatic stress disorder. R29's Medication Admin Audit Report dated 3/27/25, indicated R29 had orders for Ipratopium-albuterol inhalation solution 0.5-2.5mg inhaled 4 times a day. On 3/26/25, a dose had been set up at 11:38 a.m. During an observation on 3/24/25 at 6:40 p.m., a nebulizer cannister was observed full of a liquid substance. During a second observation on 3/26/25 at 12:53 p.m., again a nebulizer cannister was observed full of liquid substance, not running, and no medical staff with him. At that time R29 turned on the nebulizer machine and started administering the liquid in the nebulizer cannister. During an interview on 3/26/25 at 12:56 p.m., LPN-B entered R29's room and confirmed R29 had a full canister of liquid in the cannister he was administering medication with. LPN-B reviewed R29's medication administration record (MAR) and stated the last documented administration of inhaled nebulizer medication was done at 11:38 a.m. and not at the current time. LPN-B stated based on the amount of liquid in the cannister R29 had just started the nebulizer at the current time and not at the 11:38 a.m, which meant fluid had sat in the nebulizer cannister for over an hour, not moving, which increased the risk of infectious disease. During an interview on 3/27/25 at 1:54 p.m., the director of nursing (DON) stated the facility staff should follow the infection control protocols related to nebulizer treatments and cleaning. The facility Oral Inhalation Administration policy dated 5/22, indicated medication should be given right after setup. After medication is given rinse and disinfect the nebulizer equipment according to manufacturer's recommendations, or wash pieces with warm water, rinse with hot water and allow to air dry. 47263 R14: (continued on next page)

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 03/27/2025
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R14's Minimum Data Set (MDS) dated [DATE], indicated R16 was moderately cognitively impaired with the diagnoses of heart failure, end stage renal disease with dialysis, diabetes and respiratory failure. R14's care plan last reviewed 2/19/25, indicated R14 was at risk for alteration in oxygen/gas exchange due to their respiratory status with the goal of adequate gas exchange: no cyanosis, freedom from shortness of breath, oxygen saturations greater than 90%, and normal respiratory pattern. Interventions included administration of Inhaler per MD order and notification of provider with respiratory changes. R14's Order Summary Report Active orders as of 3/27/25, included the following orders: -Ipratropium-albuterol inhalation solution 0.5-2.5 (3) 3mg/3ml, 3 ml inhale orally via nebulizer (neb) every 4 hours as needed for shortness of breath. -Ipratropium-albuterol inhalation solution 0.5-2.5 (3) 3mg/3ml, 3 ml inhale orally via nebulizer every 4 hours as needed for shortness of breath. Give before dialysis on Monday, Wednesday, and Friday. -Change oxygen tubing and mask weekly every Saturday. -Rinse and dry nebulizer cup after each nebulizer treatment During an observation on 3/24/25 at 3:28 p.m., R14's bed was unmade. R16 pointed to the foot of their bed where there was a nebulizer treatment unit sitting directly on the bed sheet and stated they received neb treatments for breathing. The Neb treatment unit and mask were directly on the bed and the neb cup had liquid and moisture droplets on the sides of the cup. The tubing unit was not dated. During an observation on 3/25/25 at 2:11 p.m., R14's nebulizer treatment unit cord could be seen, the rest of the unit was on the bed with bed covers and a pillow over it. During an observation on 3/25/25 at 3:31 p.m., R14's nebulizer treatment unit and tubing was still at the foot of R14's unmade bed. The medication cup had fluid in it. During an observation on 3/26/25 at 8:24 a.m., R14's nebulizer treatment machine power cord was visible at the foot of the bed, the rest of the unit was covered with bedding. During an interview at 3/26/25 on 11:19 a.m., R14 stated they had had a neb treatment early in the morning but not recently. R14 lifted up their bed coverings to show the neb treatment unit at the foot of the bed. The medication cup was dated 3/24, and there was liquid in the nebulizer cup. During an observation on 3/27/25 at 7:23 a.m., R14's nebulizer treatment machine was laying at the foot of R14's bed. The medication cup had been removed. There was a short tube connected to the machine and the other end was open to air and laying on R200's mattress at the foot of the bed. (continued on next page)

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 03/27/2025
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/26/25 at 2:12 p.m., RN-A pulled up R14's MAR and stated R14 had had a nebulizer treatment last on 3/26/25 at 5:48 a.m. RN-A stated there was also an order on the medication administration record to sign off on for cleaning and letting the nebulizer treatment supplies air dry. RN-A went into R14's room and noted R14's nebulizer treatment had liquid in the administration cup. RN-A stated this should have been removed, cleaned and left to air dry and indicated they were going to take care of it. RN-A stated it was important to clean after each use because leaving moisture in the cup created a risk for respiratory infection. During an interview on 3/27/25 at 10:04 a.m., RN-B stated once a nebulizer treatment is done, staff should disconnect the tubing from the machine, rinse the medication cup, and then let it dry. RN-B stated it was important to do this after each use to prevent potential respiratory infections. In a perfect world the nebulizer unit should not be stored at the foot of a resident's bed. During an interview on 3/27/25 at 12:26 p.m., the DON stated after each nebulizer administration it should be rinsed and left to air dry. This was also one of R14's orders. The DON indicated there are lots of infection risks associated with nebulizer treatments. Lack of cleaning between uses could lead to bacteria growth in the tubing unit which could lead to thrush or growth of other forms of bacteria that could go directly into the lungs when used without cleaning. R14's unit should not be stored on the foot of R14's bed between uses. The facility policy Oral Inhalation Administration dated May 2022, directed staff to rinse and disinfect the nebulizer equipment according to manufacturer recommendation and once equipment was completely dry, store in plastic bag with the resident's name and date on it. R16: R16's quarterly Minimum Data Set (MDS) dated [DATE], indicated R16 was cognitively intact with the following diagnoses: multiple myeloma, diabetes with neuropathy, heart disease and end stage renal disease. R'16 careplan last updated 3/19/25, included the following interventions for R16's PEG tube maintenance: -fluid flushes per order -monitor PEG tube site for signs and symptoms of infection -PEG tube cares per protocol -change tube feeding bag and syringe every 24 hours. R16's Order Summary dated 3/27/25 included: -free water flushes 150 ml [milliliters] for a total of 600 ml of fluid via tube per day -GJ Tube-clean area and cover with split dressing every day. (continued on next page)

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 03/27/2025
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R16' electronic medical record lacked evidence to show the syringe and graduated cylinder used for R16's tube feeding water administration were/had been dated and replaced every 24 hours. During an interview on 3/24/25 at 6:22 p.m., R16 stated the nurses are supposed to change my dressing every day and flush my tube feeding tube a couple times a day. There was an undated graduated cylinder partially filled with water with an undated syringe sitting in it on R16 nightstand. R16 stated they usually had to ask for the dressing to be done unless registered nurse RN-A or licensed practical nurse (LPN-A) were working because they just did it. During an observation on 3/25/25 at 3:31 p.m., R16's graduated cylinder was dated 3/25/25. The cylinder contained water and an undated syringe. During an observation on 3/26/25 at 8:21 a.m., R16's graduated cylinder was dated 3/25/25. The cylinder contained water and an undated syringe. During an observation on 3/26/25 at 2:23 p.m., R16's graduated cylinder was still dated 3/25/25. The cylinder contained water and an undated syringe. During an observation on 3/27/25 at 7:27 a.m., R16's graduated cylinder was dated 3/25/25. The cylinder contained water and an undated syringe. During an interview on 3/27/25 at 8:27 a.m., R16 stated when staff were done putting water in their tube feeding tube staff didn't do anything special with the stuff, they just put the water holder (graduated cylinder) back on the nightstand with the syringe in it. During an interview on 3/27/25 at 10:07 a.m., RN-B stated the graduated cylinder, and syringe should be changed out per policy. RN-B stated they would have to review the policy to know how frequently staff should be exchanging the syringe and graduated cylinder, however, staff should not be leaving the syringe siting in water in the graduated cylinder. For infection prevention reasons, the cylinder and syringe should be left to air dry after use, and the policy should be followed. During an observation on 3/27/25 at 12:51 p.m., R16's graduated cylinder was dated 3/25/25. The cylinder contained water and an undated syringe. During an interview on 3/27/25 12:29 p.m., with the director of nursing (DON) and registered nurse consultants (RN-D) and RN-G. RN-D pulled up the facility policy and stated per policy the graduated cylinder should be left to air dry between uses and changed out daily. The DON stated the syringe should be pulled apart and left to air dry after use. It was an expectation staff would follow the policy for resident safety and infection prevention. During an observation on 3/27/25 at 1:50 p.m., R16's graduated cylinder was dated 3/25/25. The cylinder contained water and an undated syringe. The facility policy Enteral Feeding via Syringe (Bolus) dated 3/2024, instructed staff to make bolus syringe was labeled with the resident's name and marked with date and marked with date and time and if date and time were greater than 24 hours the syringe should be disposed of, and new supplies should be obtained. The syringe should be rinsed with hot water and dried and stored in designated area. (continued on next page)

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 03/27/2025
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R200: R200's admission Minimum Data Set (MDS) dated [DATE], indicated R200 was cognitively intact with the diagnoses of congestive heart failure, diabetes, and respiratory failure. R200's Order Summary Current Orders as of 3/24/25, included the following orders: -PICC/Midline-Change cap (needless access device) weekly with dressing change q wed in am -Vancomycin HCl Intravenous Solution (Vancomycin HCl) use 1500 mg intravenously every 24 hours related to methicillin resistant staphylococcus aureus infection as the cause of disease classified elsewhere (B95.62) for 20 Days. Inject 1500mg in NS over 90 minutes into the vein every 24 hours for 20 days. During an observation on 3/26/25 at 11:28 a.m., R200's PICC line was covered with a transparent dressing. The end or R200's PICC line did not have a lumen cap on it. R200 stated they had been told it was okay to not have the cap on the PICC line. R200 thought it had been that way for a couple of days. After an observation on 3/26/25 at 11:46 a.m., registered nurse RN-B confirmed R200's PICC line was missing the lumen cap attachment and indicated the missing cap was a concern for infection. RN-B opened the electronic medical record (EMR), and stated R200's cap was changed before R200's antibiotic was started on 3/25/25 at 1:15 p.m. RN-B indicated the cap would have likely been off sometime between the time the antibiotic was discontinued on 3/25/25, and now. During an interview on 3/26/25 at 2:51 p.m., the director of nursing (DON) stated they had a call out to infectious disease and had notified R200's provider that R200's lumen cap had been off. The DON indicated that it was possible the lumen could have been accidently removed during a flush or something and indicated R200's PICC like should have a lumen cap at the end of it at all times to prevent infection. During an interview on 3/26/25 at 3:08 p.m., R200 stated when they first got back from the hospital there was a green cap on the end of the PICC line but the facility didn't use that cap any longer. R200 stated they thought the clear cap (lumen cap) had been missing from their PICC line for a couple of days. R200 stated one day they sent a staff in that said they didn't know about PICC lines but they said they were told to do it anyway. R200 stated they had been worried about their PICC line. During an interview on 3/26/25 at 5:12 p.m., RN-A stated when they hooked up R200's antibiotic yesterday, the clear lumen had been attached to R200's PICC. The antibiotic didn't get done until after they had left for the day so another staff would have disconnected the antibiotic when it was done. During an interview on 3/26/25 at 5:59 p.m., RN consultant (RNC-A) stated once they had been made aware R200's PICC line was missing the lumen cap they consulted the nurse practitioner who advised the access area be cleansed and re-capped right away followed by a call to infectious disease. RNC-A stated they did as advised and had also successfully pulled back and flushed R200's PICC line after they had attached the new cap. (continued on next page)

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 03/27/2025
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/25 at 9:39 a.m., licensed practical nurse (LPN-D) stated they never received picc line training or iv medication administration training, or had they ever completed a hands on or any other competency for PICC lines, but they did recall watching a PICC line demonstration. LPN-D confirmed as part of their job they administered iv medications and flushes through PICC lines. During an interview on 3/27/25 at 12:07 p.m., the DON stated they had contacted LPN-A who had disconnected R200's antibiotic on 3/26/25. The DON showed a written statement signed by LPN-A which indicated LPN-A could not say for sure if the lumen cap had been removed when they disconnected R200's antibiotic on 3/26/25, or if the cap was in place when they completed the task. The DON stated the LPN would receive follow-up education on PICC lines.