STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emeralds at Grand Rapids LLC	2801 South Highway 169 Grand Rapids, MN 55744

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to keep linen carts covered that were in the communal hallways. The facility also failed to offer hand hygiene to the residents prior to meal service. Lastly the facility failed to identify and investigate a foodborne pathogen that was diagnosed in a resident. This had the potential to affect all residents in the facility. Findings include: Linen: During an observation on 6/14/26 at 2:05 p.m., the hallway clean linen cart on 300 hallway was not covered. During an observation on 6/15/26 at 9:47 a.m., the 300 hallway extra linen cart was again not covered. the green flap that should cover the cart was flipped all the way backwards and was covered with Kleenex and gloves so the flap could not be flipped forward to a closed and covered position. During an interview on 6/15/26 at 9:50 a.m., nursing assistant (NA)-A stated all carts that hold clean linens for resident use should be covered unless staff are actively at the cart removing items to use for resident care. NA-A looked at the 300-hallway cart and confirmed it had been left uncovered and no staff had been around it for several minutes. During an observation on 6/16/26 at 1:12 p.m., the 300-hallway linen cart was again uncovered. During an interview on 6/17/26 at 9:48 a.m., the director of nursing/infection preventionist (DON/IP) stated clean linen carts in the resident hallways should be covered at all times to assist decreasing contamination and possible spread of infection that might be in the facility. Hand Hygiene: During an observation on 6/14/26 at 4:59 p.m., in the main dining room, several staff were lined up outside the kitchen and take the meals plate by plate to the residents seated at tables. Residents were observed being assisted to put on clothing covers, but there were no hand cleaning wipes being offered. During an observation on 6/15/26 at 11:39 a.m., in the main dining room with several staff assisting residents to cover their clothing, bring their lunch plates, and assist some of the residents to eat their meals. Hand hygiene was not offered to any of the residents. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a continuous observation on 6/16/26 beginning at 7:13 a.m., in the main dining room it was noted there were no hand sanitizing wipes or solutions located in the work area by the entrance of the kitchen or on the dining tables where residents ate. R5 wheeled themselves into the dining room and to a table. A kitchen staff member cleared dishes from the table R5 had selected, wiped the table down, and took R5's order. Hand sanitization was not offered to R5. -At 7:25 a.m., a staff member delivered R5's food. R5 was not offered hand sanitization at that time. -At 7:28 a.m., a female resident wheeled self into dining room and to a table. Dining staff removed dirty dishes from the table and wiped the surface down. The female resident was not offered hand sanitization on arrival or when food was delivered. -At 7:32 a.m., staff wheeled in a female resident and parked resident at a table. R35 wheeled themselves in from the outside smoking area and parked themselves at a table. The female resident and R35's breakfast was delivered at 7:36 a.m. Neither resident was offered hand sanitization prior to eating breakfast. -At 7:49 a.m., a male staff wheeled a male resident in a Broda chair up to a table in the back of the dining room. Two other residents who had wheeled themselves into the dining area were moved to a table by the resident in the Broda chair. The male staff then washed their hands at the sink in the dining area and placed clothing protectors on the 3 residents. No hand sanitization was provided to the three residents before they ate their breakfast. R4: R4's significant change Minimum Data Set (MDS) dated [DATE], indicated R4 was cognitively intact. R4's admission Record (also known as face sheet) dated 6/17/26, identified a diagnosis of Enteritis due to Yersinia Enterocolitica with onset date 6/2/26. Additional diagnoses included: neuromuscular dysfunction of bladder, enterocolitis due to clostridium difficile, congestive heart failure, stage IV pressure ulcer, osteomyelitis, and paraplegia. R4's care plan identified the review start date as 4/8/26. The care plan identified R4 was on contact precautions, had a foley catheter, an ostomy, and stage IV sacral pressure ulcer. R4's Grand Itasca emergency department note dated 6/1/26, identified R4's Enteric panel had tested positive for Yersinia enterocolitica. R4 had copious amounts of output from rectal stump with proctitis and sigmoid colitis that appeared infectious/inflammatory on CT imaging. The identified plan was to administer seven days of Bactrim. R4's Grand Itaska discharge documentation dated 6/2/26, indicated R4 had been hospitalized from [DATE] to 6/2/26, with the primary diagnosis of Colitis due to Yersinia enterocolitica. Follow-up appointments were scheduled for an ultrasound and surgeon visit. Additional recommendations included primary care follow-up at the facility and to ensure R4 had an infectious disease appointment. The CDC website Yersinia Infection Clinical Overview of Yersiniosis dated March 3, 2026, indicated yersinia enterocolitica was the most common form of yersiniosis with an incubation period of 4 to 6 days which could range from 1 to 14 days. Common clinical presentation included abdominal pain, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	diarrhea (can be bloody and persistent for several weeks), pain that mimics appendicitis, and sore throat. The Minnesota Department of Health Yersiniosis (Yersinia enterocolitica) fact sheet dated June 2007, indicated Yersinia enterocolitica was found in wild and domestic animals. Especially pigs, but it could also be found in birds, reptiles, rodents, rabbits, sheep, cattle, horses and dogs. Human infections usually resulted from: eating contaminated food, especially raw or under cooked pork products, contact with farm animals or pets, consuming unpasteurized milk or contaminated water, touching contaminated surfaces and then touching mouth, or eating food prepared by someone infected with yersinia who did not sanitize hands properly. The facility symptom tracking log provided by the facility IP included R4 and four other residents who did not have gastrointestinal symptoms. R4's documented symptoms included lethargy, malaise, increased BMs, and fever with an onset date of 5/29/26. R4 had stool sampled and received Sulfamethoxazole/trimethoprim for 7 days. The June log did not include any other residents with gastrointestinal symptoms or a positive Yersinia result for R4. The Bowel Movement report dated 5/15/26 to 5/30/26, included documentation of BM date, time, and consistency for all residents at the facility. The BM consistency of resident BM's was predominately documented as not required which made it difficult to ascertain accurate resident diarrhea rates. Other consistency descriptions included: formed/normal, putty like and loose/diarrhea-report to nurse ASAP! (as soon as possible). Report documentation identified the following residents as having had two or more loose/diarrhea stools during the report time period: R2, R11, R13, R14, R4, R15, R16, R5, R6, R21, R22, R26, R29, R33, R36, R37, and R3. During an observation on 6/14/26 at 5:10 p.m., R4's door had a contact isolation sign on the door. On 6/15/26 at 3:32 p.m., contact isolation signage remained on R4's door. On 6/16/26 at 1:24 p.m., contact isolation signage remained on R4's door. On 6/17/26 at 10:00 a.m., contact isolation signage remained on R4's door. During an interview on 6/15/26 at 2:41 p.m., the Minnesota Department of Health Infection Control Assessment and Response (ICAR) Program nurse specialist (PNS) stated Yersinia enterocolitica should be looked at as a foodborne illness. Illness often resulted from undercooked meat, or cross contamination during preparation of raw meat in the kitchen. Raw meat would be the most likely source, especially raw or improperly handled pork. However, there are other sources from outside of the facility that could have caused the yersinia. PNS stated they would expect the facilities infection prevention to work their review process when a resident was identified with a known foodborne illness. During an interview on 6/15/26 at 3:32 p.m., R4 stated they had been in the hospital so many times for different infections, that they couldn't recall what they had been told about what infection, they thought their significant other would know more. R4 stated they all just ran together. Contact was attempted, but R4's significant other was not available for interview on 6/16/26. On 6/16/26, and 6/17/26, R4's nurse manager was not available for interview. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/17/26 at 9:38 a.m., the director of nursing DON and infection preventionist stated the facility performed real time symptom tracking on staff and residents. In addition, the antibiotic stewardship program also tracked symptoms, diagnostic testing and treatments. Resident symptoms such as diarrhea should be reported to the nurse, and then to IP so systems and status changes can be tracked and reviewed. The goal is to identify and detect outbreaks or illnesses like c-diff early. The DON showed symptom mapping done in May and June, each symptom was color coded. Diarrhea fell into the category described as other. Two residents were coded as other. Any resident who has experienced two or more episodes of diarrhea, should be reported to IP along with associated symptoms. The May staff log showed one non-direct care staff member had experienced diarrhea and probable norovirus (based on confirmed norovirus in their household). The facility had performed contract tracing in response to the staff illness. Resident paperwork should be reviewed by the receiving nurse when a resident is admitted or has returned to the facility after an appointment, ER visit, or hospitalization. Any infection prevention/control concerns like assessment findings, new antibiotics, lab results, or diagnoses, should then be reported to the IP for further review and tracking. R4's yersinia diagnosis should have been reported to IP when R4 returned from the hospital. Had the yersinia been identified and reported, a comprehensive review would have been completed. The dietary area would have been reviewed to see if there were any opportunities for education, BM logs would have been reviewed for possible correlations. Any needed follow-up would have been reviewed and acted upon. During an interview on 6/17/26 at 11:11 a.m., the culinary director stated most facility foods, especially the proteins and meats were raw. Raw foods went directly into the freezer and did not get pulled out until 3 days prior to them being served to allow them to thaw the correct way. When raw meat is being prepared to cook, the meat is placed in a lipped container. Only the raw meat can be on the prep table when it is being prepared. A review of the facility menu cycles on 6/17/26, showed that the facility regularly served pork products. The facility Handwashing Policy dated 2/2024, instructed to prevent the spread of infection hand washing should occur before, during and after preparing food, before eating, and after caring for someone who is sick, after using the toilet, after changing incontinent products, after touching animal or animal waste, after handling pet food or treats and after handling garbage. The facility Infection Prevention and Control Program dated 11/2024, identified the program mission was to maintain an infection prevention and control program to ensure a safe, sanitary, environment and to help prevent the development and transmission of communicable diseases and infections. The program addressed residents and staff IP and control. Key components identified included: surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection and employee health. Coordination and oversight included committee review to ensure information about culture results or antibiotic resistance was transmitted accurately and in a timely fashion and whether there was appropriate follow-up of acute infections. Culture reports, sensitivity data, and antibiotic usage reviews were to be included in surveillance activities. Prevention of infection activities included identifying possible infections or potential complications of existing infections and instituting measures to avoid complications or spreading. Monitoring Employee health included policies and procedures that included reporting infections including, but not limited to draining wounds, respiratory infection/symptoms, and frequent loose stools. The Prevention of infection section identified the IP program included identifying possible infections, instituting measures to avoid complications, and enhancing screening for possible significant pathogens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident and staff symptom tracking policies were requested but not received. Resident symptom tracking for May and June were requested in addition to the antibiotic stewardship logs but not received.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to have a new order and a face-to-face provider visit every 14 days performed prior to renewing an as needed antipsychotic medication. This affected 1 of 5 (R34) residents reviewed for unnecessary medications.Findings include: R34's significant change Minimum Data Set, dated [DATE], indicated R34 had significant cognitive impairment. Diagnoses included dementia with agitation and anxiety disorder. R34's care plan dated 3/2/26, indicated an alteration in behavior due to severe dementia with agitation, major depressive disorder, and anxiety disorder. Interventions included administer medications as ordered, monitoring for potential side effects. R34's care plan dated 4/3/26, also indicated on hospice cares related to Alzheimer's dementia with interventions that included medications as needed. R34's Order Summary Report dated 5/5/26 through 6/17/26, indicated an order for Olanzapine (antipsychotic medication) 2.5 milligrams (mg) by mouth every 6 hours (hr) as needed (PRN) for 14 days. This order had been reordered every 14 days through the listed time frame. R34's electronic medical record (EMR) dated 5/5/26, indicated hospice wrote the last order for Olanzapine 2.5mg by mouth every 6 hr PRN for 90 days. R34's EMR lacked documentation related to new orders for Olanzapine PRN written every 14 days as entered into the Order Summary Report since 5/5/26. R34's EMR also lacked documentation the provider did a face-to-face visit with the resident and justified the continued need for the antipsychotic prior to a new order being entered.During an interview on 6/15/26 at 11:25 a.m., registered nurse (RN)-B stated when a resident is on hospice and has behavior concerns, the hospice organization will order prn antipsychotics for the facility to utilize to assist in keeping the client non-behavioral and comfortable. RN-B was not sure how long the prn antipsychotic orders were good for or who made sure all of the required information is gathered prior to a new order is received. During an interview on 6/15/26 at 3:44 p.m., RN-C-cares stated hospice took care of writing and monitoring the prn medications for comfort such as pain medications and antipsychotics like Olanzapine. When hospice would write the orders for prn antipsychotics, the orders would usually be written for at least 90 days so the provider did not have to write the orders so often. The provider would only come on site and do actual face to face visits every 90 days for recertification visits. The provider never comes to the facility just for a medication renewal. The medication renewals were based on what the hospice staff reported to the provider. RN-C reviewed R34's EMR and confirmed hospice was responsible for renewing the Olanzapine 2.5mg every 6 hrs as needed order and the last written order was on 5/5/26.During an interview on 6/15/26 at 4:19 p.m., the director of nursing (DON) stated PRN antipsychotic orders were only good for 14 days, then there had to be a request made for a new order. The DON stated she was not sure of what else was required prior to getting a new order for PRN antipsychotics. There was an expectation the staff followed the policies related to medications and medication orders.Facility policy Psychotropic Medication Use dated 5/25, indicated prn orders for antipsychotics would be limited to 14 days, and not be renewed unless the provider evaluated the resident for appropriateness of the medication. The policy lacked information explaining if the evaluated needed to occur face to face or not.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure the use of thromboembolism-deterrent stockings (TEDs) as ordered for edema care. This affected 1 of 1 (R45) resident reviewed for edema.Findings include:R45's 5-day Minimum Data Set (MDS) dated [DATE], indicated R45 was moderately cognitively impaired. Diagnoses included left lower leg closed fracture, hypertension, and arthritis.R45's provider orders dated 6/10/26, included TEDs stockings right leg on in a.m., off in p.m. every morning and at bedtime.R45's care plan reviewed 6/15/26, did not include right pedal edema or the prescribed intervention of TEDs.R45's treatment administration record (TAR) dated 6/2026, included TEDs stockings to right leg on in a.m., off in p.m. every morning and at bedtime, start date 6/10/26.During an observation on 6/14/26 at 3:31 p.m., R45 was sitting in bed with legs elevated, right foot noted to be edematous with no TEDs stocking. R45 stated they were concerned about their swollen right foot, and their provider told them to keep it elevated.During an observation on 6/15/26 at 12:57 p.m., R45 was in their wheelchair with feet elevated on bed, non-slip sock on right foot, no TEDs stocking.During an observation on 6/16/26 at 10:46 a.m., R45 was in their wheelchair in the dining room. R45 stated their right leg felt tight and lifted their pant leg to rub on right shin and calf. Right leg noted to be edematous into calf, with a sock and shoe on the right foot, no TEDs stocking. R45 stated they were going to physical therapy. During an interview on 6/15/26 at 2:08 p.m., nursing assistant (NA)-B stated when TEDs are ordered, day shift puts them on the resident and evening shift removes them at bedtime. NA-B stated R45 had an ACE wrap on the left foot and stated they were not aware R45 was to wear TEDs on the right leg.During an interview on 6/15/26 at 2:09 p.m., licensed practical nurse (LPN)-A stated the aides put TEDs stockings on residents when ordered. LPN-A stated R45 was new to them. After reviewing R45's orders, LPN-A confirmed R45 had an order for TEDs to the right leg, and stated the TEDs were important for treating R45's edema.During an interview on 6/16/26 at 12:31 p.m., director of nursing (DON) confirmed R45 had orders for TEDs to the right leg. DON reviewed TAR documentation and stated the nursing staff charted the TEDs application and removal for the last few days.During an interview on 6/16/26 at 1:33 p.m., other staff (O)-C stated R45 came to their therapy appointment around 11 a.m., with a sock and shoe on the right foot, and O-C applied TEDs to R45's right leg during the therapy appointment. O-C stated R45 had right foot and lower leg edema.Medication and Treatment Orders policy dated 2/2024, instructed orders for medications and treatments will be transcribed accurately and in a timely manner.

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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** Based on observation, interview and document review, the facility failed to provide monitoring to a dialysis site following a dialysis treatment for 1 of 1 resident (R9) reviewed for dialysis care.Findings include:R9's quarterly minimum data set (MDS) dated [DATE], identified intact cognition and diagnoses of end-stage renal failure, and anemia in chronic kidney disease. The MDS also reflected R9 had dialysis treatments while a resident.R9's provider orders dated 8/27/25, identified to offer rest and a snack after dialysis, to take and record vital signs after dialysis, to monitor fistula (a surgically created connection between an artery and a vein to provide access for dialysis treatment) for bruit (a whooshing sound heard with a stethoscope) and thrill (a powerful pulse felt at the top of the fistula) every shift and to notify provider if these were not found, and to monitor dialysis site every shift for bleeding and to call 911 if bleeding was noted.R9's care plan dated 9/25/24, identified a focus statement for alteration in blood formation and coagulation related to use of anticoagulant medication and included interventions to give anticoagulant medication as ordered, to monitor and notify provider of bleeding. On 6/18/25, a focus statement for risk for complications related to dialysis and included interventions to call 911 for uncontrolled bleeding at fistula, dialysis on Mondays, Wednesdays, and Fridays, to provide treatment and dressings to dialysis site per provider order, send communication folder to dialysis with each run, and fluid restrictions per provider order.During observations and interview on 6/15/26 at 4:04 p.m., R9 was sitting in her wheelchair at the counter in the activity area eating. R9 stated she had just returned from dialysis and the nurse had not seen her yet, normally they take her blood sugar and blood pressure. At 4:07 p.m., R9 was at the nurse's station and registered nurse (RN)-A was checking her vital signs, R9 was observed to be wearing a long-sleeve sweatshirt and RN-A asked her if the left arm was ok for blood pressures and R9 said yes. RN-A remarked her blood pressure was a little high and was recording the value on a clipboard. R9 headed to her room, then came back down the hall at 4:15 p.m. with some coloring materials and went outside to the smoking area. At 4:21 p.m. RN-A stated the first thing they should do was to check vitals, check the thing in their arm, and give them their meal. RN-A confirmed she had not looked at R9's fistula yet.During an interview on 6/17/26 at 8:25 a.m., dialysis clinical manager (CM)-A stated it was important they were checking her fistula site once a shift, but it should be visualized and monitored right after she returns from the dialysis run because the resident would be at risk for bleeding or complications. During an interview on 6/17/26 at 10:36 a.m., the director of nursing (DON) stated her expectation was after a dialysis run, making sure to check the site any excessive bleeding, doing the vitals and any follow up with the communication they send back and forth.A policy, Hemodialysis dated 11/22/19, identified the facility will ensure that residents who require dialysis, receive such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Ongoing assessment and evaluation of the resident's condition and monitoring for complications should occur before and after dialysis treatments (i.e. infection and patency of fistula or graft).

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and document review the facility failed to ensure daily staffing data was posted over the weekend. This deficient practice had the potential to affect any resident, family member, or visitor who wished to view the posting.Findings include: During an observation on 6/14/26 (Sunday) at 1:30 p.m., the facility staffing data sheet was posted in the main entrance. The documented read Day of week: Friday, Today's Date: 6/12/26.During an observation on 6/14/26 at 6:57 p.m., it was noted the 6/12/26 posted staffing data sheet had been taken down and replaced with a staffing data sheet for Sunday, 6/14/26. During an interview on 6/17/26 at 12:36 p.m., The administrator stated staffing sheets should be posted each morning and indicated it was the night staff's responsibility to review, make changes if needed, and then post. The administrator confirmed Saturday and Sunday staffing sheets had not been posted in the morning as expected.