STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Village	923 Hale Lake Pointe Grand Rapids, MN 55744

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on interview and document review, the facility failed to provide the opportunity for an admission care conference for 1 of 3 residents (R49) reviewed for care planning. Findings include: R49's admission Minimum Data Set (MDS) assessment dated [DATE], identified R49 was cognitively intact. Diagnoses included renal insufficiency, diabetes, and arthritis. Review of R49's electronic medical record (EMR) lacked documentation of a care conference since admission to the facility. During an interview on 8/26/24 at 7:09 p.m. R49 stated he had not been invited to, or attended any care conference to discuss the plan of care (POC) since admission to the facility on [DATE]. During an interview on 8/28/24 at 2:29 p.m. registered nurse (RN)-B stated the facility would rarely have an admission care conference. They would build the care plan and just let the resident review it after completion. Staff usually never met with the resident until closer to discharge, to discuss the discharge planning. Turn around times on the rehab unit did not allow to meet with each resident at admission to discuss the POC with them. During an interview on 8/29/24 at 10:28 a.m., the social services designee (SSD) stated care conferences would be scheduled by her and social services, nursing, therapies, and other departments would attend them with the resident and family members. The SSD reviewed R49's EMR and confirmed there was no documentation related to a care conference. The SSD also confirmed R49 had not had a care conference since admission. During an interview on 8/29/24 at 10:49 a.m., the director of nursing stated an expectation that all care conferences would be done within 7-12 days of admission, as stated in the policy and the resident admission handbook. Facility Welcome to Grand Village resident handbook last revised 4/11/24 indicated 7-12 days after admission an interdisciplinary team (IDT) meeting called a resident care conference would be held to discuss the residents care at the facility. The meeting would include several staff at the facility, the resident, and the resident family. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy Individualized Care Plan last revised 6/24, indicated the IDT would meet with the resident and family related to the POC. The policy lacked documentation of when the care conference should take place.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 48013 Based on observation, interview and document review, the facility failed to ensure residents were comprehensively assessed for self-administration of medications for 1 of 1 resident (R2) reviewed and observed for self-administration of medications. Findings include: R2's significant change Minimum Data Set (MDS) dated [DATE], identified R2 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. During observation on 8/27/24 at 10:46 a.m., R2 was sitting in her recliner with the nebulizer mask on her face. Nebulizer cup contained a clear solution and nebulizer machine was running with no staff present in room. Nurse walked from the medication cart into R2's room, stated to R2 that the treatment was all done and shut the nebulizer machine off. Nurse washed nebulizer mask and cup and left it to air dry. During record review on 8/26/24, the self-administration of medications assessment that was completed on 7/11/24, identified R2 required frequent prompting, cues and reminders, and was not safe to self-administer own medications. Assessment also indicated that R2 did not wish to self-administer any medications. During interview on 8/29/24 at 8:34 a.m., licensed nursing staff (LPN)-A stated there were no residents on this unit that were able to self-administer medications. LPN-A stated if a resident was able to self-administer medications, it would be displayed in the resident's banner in the electronic health record (EHR). LPN-A confirmed that R2 did not have an order to self-administer medications which included nebulizer treatments. LPN-A stated an assessment would need to be completed before a resident was able to self-administer medications. LPN-A stated the assessment was important to ensure that the mask was properly place on resident's face and that the resident was able to keep mask on during treatment as nebulizer could be running with the resident not receiving any solution making the treatment ineffective. During interview on 8/29/24 at 10:17 a.m., registered nurse (RN)-C stated an assessment would need to be completed by the RN prior to a resident being able to self-administer medications. RN-C confirmed R2 did not have an order for self-administration of medications. RN-C stated it was important to complete the assessment to ensure that the resident was cognitively able to use the nebulizer without monitoring and to ensure the resident could remove nebulizer mask from face if resident was experiencing adverse side effects such an increased heart rate with palpitations during nebulizer treatment. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 8/29/24 at 10:38 a.m., director of nursing (DON) stated self-administration of medications assessments are completed by the nurse manager or the MDS nurse. DON stated assessments are completed at time of admission, annually, or with a significant change in status. DON confirmed that nebulizer treatments, when nurse leaves the room, needed to be assessed and a self-administer order would need to be obtained from the provider. It was important for the resident to be assessed for self-administration of medications to ensure that the resident was safe to be left alone with the nebulizer treatment running. The facility Self-Administration of Medications policy, dated 4/23, identified a self-administration of medications assessment would be completed for any resident requesting to administer any medication without the direct supervision of a nurse. Residents who have nebulizer treatments may only self-administer if assessed for self-administration of nebulizer assessment and a physician order is received to self-administer.

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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** 48013 Based on observation, interview, and document review, the facility failed to ensure proper wheelchair equipment was used to prevent potential complications for 1 of 1 resident (R55). Findings include: R55's significant change Minimum Data Set (MDS) dated [DATE], identified R55 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R55's diagnoses included progressive neurological conditions, degenerative disease of nervous system, non-Alzheimer's Dementia, and unspecified abnormalities of gait and mobility. During observation on 8/26/24 at 1:28 p.m., R55 left the unit with staff to go to activities. Staff assisted R55 with propelling down hallway in his wheelchair that did not have foot pedals. R55 was experiencing difficulty with holding his feet up while staff pushed wheelchair. R55's feet dropped on floor and bounces. R55's foot pedals were laying on top of dresser in room. During observation on 8/29/24 at 9:13 a.m., R55 left the unit with staff to go down to therapy. Staff assisted R55 with propelling down hallway in his wheelchair that did not have foot pedals. R55 was experiencing difficulty with holding his feet up while staff pushed wheelchair. R55's feet dropped on floor and bounced. R55's foot pedals were laying on top of dresser in room. During record review on 8/28/24, R55's care plan indicated staff were to ensure bilateral foot pedals were on wheelchair when assisting resident to and from destinations due to limited physical mobility related to weakness. During interview on 8/29/24 at 8:36 a.m., licensed practical nurse (LPN)-A stated if R55 was going a long distance or off unit, staff assisted R55 with propelling wheelchair down hallway. LPN-A stated R55 does not have foot pedals for his wheelchair. During interview on 8/29/24 at 8:40 a.m., nursing assistant (NA)-A stated if R55 was going off unit, staff assisted R55 with propelling wheelchair down hallway. NA-A stated R55 does not use foot pedals on his wheelchair. During interview on 8/29/24 at 10:11 a.m., registered nurse manager (RN)-A confirmed R55 was to have foot pedals on his wheelchair when been propelled for longer distances. RN-A stated it was important for foot pedals to be used on wheelchair, so the resident does not fall forward out of wheelchair and/or sustain injuries. During interview on 8/29/24 at 10:31 a.m., director of nursing (DON) stated nursing evaluated whether or not foot pedals needed to be used for the resident and if foot pedals were needed it would be added to the care plan. DON stated that if a resident was not able to hold their legs up that foot pedals should be used. DON stated it was important for foot pedals to be used per care plan to ensure resident safety. A wheelchair/foot pedal policy was requested but was not provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 48013 Based on observation, interview and document review, the facility failed to provide timely assistance with repositioning to minimize the development of pressure ulcer risk for 1 of 2 residents (R50) reviewed for wound care. Findings include: R50's quarterly Minimum Data Set (MDS) dated [DATE], identified R50 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R50's diagnoses included hypertension, renal failure, non-Alzheimer's dementia, anxiety disorder and other symptoms and signs involving the musculoskeletal system. MDS also identified that R50 was at risk for developing pressure ulcers/injuries and is on turning and repositioning program. R50's care plan undated, identified R50 had altered skin integrity related to fragile skin due to closed lumbar fracture and was at risk for the development of pressure ulcers. R50's care plan directed staff to reposition R50 every two hours while in bed and/or wheelchair. During continuous observations on 8/27/24 from 1:12 p.m. to 3:37 p.m. R50 was lying on his back in his bed. At 1:12 p.m., R50 was observed to be lying on his back in bed. At 2:30 p.m., R50 remained in same position in bed. At 2:54 p.m., nurse went into R50's room and obtained vitals but did not reposition R50 and R50 remained in same position in bed. At 3:01 p.m., staff brought in new water pitcher into room and did not reposition R50. At 3:32 p.m., R50 remained in same position in bed. At 3:37 p.m., staff went into R50's room and assisted R50 with repositioning. During interview on 8/27/24 at 3:29 p.m., nursing assistant (NA)-B stated R50 was unable to reposition himself in his bed and needs staff to assist with repositioning. NA-B stated R50 was to receive assistance with repositioning every two hours. During interview on 8/27/24 at 3:40 p.m., licensed practical nurse (LPN)-B stated R50 was to receive assistance with repositioning every two hours when in bed or wheelchair. LPN-B stated R50 was not able to reposition himself in his bed. During interview on 8/29/24 at 8:36 a.m., LPN-A stated R50 had a wound on his spine that was not open at this time. LPN-A stated R50 had a protective bandage, placed along his spine, due to him having thin skin. LPN-A stated R50 was to receive assistance with repositioning every two hours as it was important to ensure that R50's skin on back/spine does not break down. During interview on 8/29/24 at 8:40 a.m., registered nurse clinical manger (RN)-A stated R50 currently does not have any open wounds as the pressure ulcers that he had has resolved. RN-A stated R50 had a preventive protective dressing that was placed on his spine for a bulge that staff has been monitoring closely. RN-A stated R50's skin was very thin and the bulge on his spine was protruding with the area being blanchable. RN-A stated R50 was to receive assistance with repositioning every two hours as it was important due to R50's skin being so vulnerable and his history of pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 8/29/24 at 10:35 a.m., the director of nursing (DON) stated the staff were to provide assistance with repositioning in accordance with the care plan. DON stated repositioning a resident was important to prevent skin breakdown. The facility Positioning the Resident policy dated 6/24, indicated that it was the policy of the facility that staff reposition identified residents to relieve pressure, prevent skin breakdown, pain, and promote proper body alignment. The facility Individualized Care Plan policy dated 6/24, indicated the facility would develop a comprehensive care plan using the comprehensive assessments, will individualize the plan of care to accurately reflect resident's functional capacity and medical, nursing, psychosocial, activity and other identified needs.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on observation, interview, and document review, the facility failed to ensure oxygen tubing was changed according to facility policy and failed to ensure nebulizer tubing/cannister was cleaned and allowed to air dry after each use for 1 of 1 resident (R38) reviewed for oxygen therapy. Findings include: R38's admission Minimum Data Set (MDS) dated [DATE], identified R38 was cognitively intact and had continuous oxygen therapy since admission to the facility. R38's provider order dated 8/13/24, identified oxygen at 2 liters/minute by nasal cannula (NC) continuously and budesonide inhalation suspension 0.5 milligrams/2 milliters inhaled via nebulizer two times a day. R38's care plan dated 8/7/24, identified R38 needed continuous oxygen therapy and to administer oxygen and respiratory medications as per orders. The care plan lacked documentation when to change oxygen tubing and when/how to clean nebulizer tubing/cannister. R38's treatment administration record for 8/24 indicated oxygen tubing and nasal cannula had been changed on 8/11/24, 8/18/24, and 8/25/24. On 8/26/24 at 3:09 p.m., R38 was observed wearing continuous oxygen via NC. The date on the green extension tubing and the NC was 8/18/24. A nebulizer canister and tubing was observed sitting on the bedside table and was also dated 8/18/24. The cannister was noted to be closed and had visible liquid in the cannister along with condensation along the inner walls of the cannister. During interview on 8/26/24 at 3:09 p.m., R38 stated the staff very rarely change the oxygen tubing the way they were supposed to. The staff will never clean out the nebulizer cannister after my treatment. They start out the day by bringing me the vials of nebulizer liquid for all treatments that day and R38 would set up and self-administer the nebulizer treatments when scheduled. The staff never came back to clean the nebulizer cannisters after each use. On 8/27/24 at 1:29 p.m., all the oxygen tubing in R38's room was observed to be dated 8/18/24 along with the nebulizer tubing and cannister. The nebulizer cannister was again noted to have liquid and condensation built up inside the cannister. During interview on 8/27/24 at 1:34 p.m., licensed practical nurse (LPN)-A stated all oxygen tubing and nebulizer tubing/cannisters would be changed every 7 days based on when the resident was admitted . Documentation of the change would be done in the TAR and the tubing would be labeled with tape and the current date on the tape. LPN-A stated nebulizer cannisters needed to be cleaned after each use and allowed to air dry before the next treatment was given. Cleaning should occur immediately after the medication in the nebulizer was administered. LPN-A entered R38's room and confirmed the date on all oxygen tubing was 8/18/24. Based on that date the tubing should have been changed on 8/25/24. LPN-A also confirmed the nebulizer had not been cleaned out since the last treatment that day which had been at 8:00 a.m. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 8/29/24 at 10:38 a.m. registered nurse (RN)-A stated all oxygen tubing and nebulizer tubing/canisters should be changed every 7 days, on Sunday evening shft. RN-A stated nebulizer cannisters should be cleaned immediately after each use to prevent bacteria growth that can occur in left over moisture in the cannister. During interview on 8/29/24 at 10:48 a.m. the director of nursing (DON) stated an expectation all staff would follow the facility policy related to oxygen tubing changes and nebulizer cleaning schedules. Facility policy Nebulizer Treatment last revised 12/23, identified after each use the nebulizer would have all excess fluid removed from the nebulizer and placed on a paper towel to air dry completely. Nebulizer pieces would be changed weekly, which included tubing. A facility policy for oxygen tubing changes was requested but not provided.