STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRAND VILLAGE	923 HALE LAKE POINTE 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)
E 0041 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement emergency and standby power systems.** Based on document review and staff interview, the facility failed to test and maintain the emergency generator in accordance with the requirements of the NFPA 101 The Life Safety Code 2012 edition (LSC) sections, 9.1.3 and NFPA 110 Standard for Emergency and Standby Power Systems 6-4, 6-4.1, and 6-4.2.2. This deficient practice could affect the safety of 119 of 119 residents. Findings include: During the facility tour on 3/3/20, between 9:30 a.m. and 1:30 p.m. review of all available emergency generator maintenance documentation revealed the facility could not provide documentation for 52 of 52 weekly inspections of the emergency generator. The maintenance supervisor verified the findings.
F 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to accommodate resident meal preferences for 1 of 2 residents (R42) reviewed for choices. Findings include: R42's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R42 was cognitively intact. R42's quarterly MDS dated [DATE], indicated R42 had [DIAGNOSES REDACTED]. The MDS also indicated R42 was independent with eating. R42's Mood Care Area Assessment (CAA) dated [DATE]7/19, indicated R42 had a supportive family and was a strong advocate for himself. The CAA indicated the facility would continue to encourage participation in activities, planning and participation in his own plan of care, family visits and family participation in plan of care. R42's Care Plan reviewed 1/14/20, indicated R42 had altered nutrition related to potential changes in weight, oral intake, cognition, dehydration, and decline in ADLs (activities of daily living) evidenced by weight loss or gain and oral intake. The care plan included a goal for R42 to tolerate a diet and texture: reduced concentrated sweets/2 gram sodium, no nuts, seeds, skins from fruits/vegetables, no celery. The care plan directed the dietitian to review quarterly and as needed for changes. The care plan also directed menus to be posted for alternatives, assistance offered at meals as needed, snacks provided as desired, and update physician with changes. R42's Order Summary Report dated 1/29/20, included a diet order for regular texture, regular (thin) consistency, and diabetic diet: meals in dining room. Utilize chin tuck. Alternate food and liquids. Small sips. Small bites. Oral hygiene after meals. Seat at 90 degrees. Medications whole in pudding or applesauce. Add moisture to dry crumbly foods, butter, mayo, gravy, broth, etc. for RCS (reduced concentrated sweets), 2 gram sodium. The order start date was 11/29/18. On 3/2/20, at 1:53 p.m. R42 stated he did not like the food at the facility and often only had a sandwich for supper. R42 verified he had an altered texture diet which included ground meat and stated he did not like it. When asked why he required ground meat, R42 clenched his fists and shook them while stating in a raised voice, I choked one damn time, and now there's no going back! On 3/2/20, at 4:53 p.m. the evening meal menu was observed posted on a white board outside the [LOC] dining room. The menu for the evening meal included blueberry stuffed pancakes, scrambled eggs and warm cinnamon apples with a substitute meal of creamy potato soup with tuna sandwich. -At 5:07 p.m. R42 was served a salad with lettuce and ranch dressing and coffee. R42 ate approximately one half of the salad, independently. -At 5:21 p.m. R42 was served one blueberry stuffed pancake, scrambled eggs, and cinnamon apples. Staff offered R42 more coffee, which he refused. R42 stated the meal was good so far. -At 5:24 p.m. R42 wheeled himself away from the table and indicated he was getting out of there. R42 stated he ate his one pancake. Nursing assistant (NA)-R offered R42 another pancake for which he refused. Although R42 had not taken a bite of the eggs or apples, he stated he did not want any of his eggs as they were always cold and he did not want any of his apples either. R42 proceeded to wheel himself out of dining room. On 3/4/20, at 8:12 a.m. R42 was observed to have finished eating the breakfast meal which consisted of oatmeal, and left the dining room. On 3/5/20, at 11:45 p.m. R42 was observed seated at table in dining room eating minestrone soup. Licensed practical nurse (LPN)-E verified R42 received ground meat and indicated it was because he had experienced a choking episode. LPN-E stated R42 had been evaluated by speech therapy (ST) and for safety had been started on a ground diet. LPN-E also indicated R42 tended to eat his food very fast. On 3/05/20, at 3:57 p.m. registered nurse (RN)-H retrieved the ST evaluation from the facility computer system and indicated it appeared to her R42 had been discharged from ST with a regular diet and instructions to use techniques with swallowing. On 3/05/20, at 3:57 p.m. the registered dietitian (RD) stated R42 had an episode of choking after which she had visited with him and changed his diet to soft to which he had agreed. RD stated she reviewed diets with residents quarterly and she had just done so with R42 on 1/14/20, and he had indicated he was ok with his diet at that time. RD stated she certainly didn't want R42 on something he didn't want, however, didn't want him to choke either. RD stated they could get another swallowing evaluation for R42 and she could also discuss R42 with ST to get a better picture and hone in on R42's needs. RD verified the diet order in the computer system was for a regular diet, regular texture and indicated they should have had an updated diet order. RD reviewed R42's paper chart and identified an order sheet with 4 order blanks. The first order blank included an order for [REDACTED]. On 3/06/20, at 9:18, a.m. speech therapist (ST)-A verified she had seen R42 and evaluated him in February. ST stated upon discharge R42 was ok for a regular consistency diet. ST-A stated she had notified the RD and the head nurse of this and to her knowledge the resident should have been receiving a regular diet. The ST-Therapist Progress & Discharge Summary dated 2/10/20, indicated discharge plans and instructions included to continue to utilize his swallowing strategies including consuming solids at a slow pace. On 3/06/20, at 9:20 a.m. dietary aide (DA)-A indicated according to R42's diet slip dated 3/6/20, he received a soft diet which indicated he required ground meat. On 3/06/20, at 9:28 a.m. NA-S verified R42 did not like the ground food and stated they had explained the only way he would be able to go back to a regular diet was to be reevaluated. On 3/06/20, at 11:39 a.m. RN-F verified R42 should have received a regular diet once cleared by the speech therapist. On 3/06/20, at 3:42 p.m. the director of nursing verified she would have expected R42's diet to be advanced per recommendations after ST discharge. The Quality of Life - Accommodation of Needs policy revised August 2009, indicated resident's individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered.
F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to thoroughly complete an admission Minimum Data Set (MDS) assessment in accordance to the Resident Assessment Instrument (RAI) manual for 1 of 1 resident (R66) identified with incomplete cognitive and mood sections of the MDS. Findings include: The Centers for Medicare and Medicaid Services (C[CONDITION]) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2019, identified the

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

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F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) MDS as an assessment tool which facilities are required to use. The manual provided instructions to ensure accurate and complete coding for each section of the assessment as follows: Section C: Cognitive Patterns, with a written intent of determining the residents attention, orientation and ability to register and recall new information. These items were listed as crucial factors in many care planning decisions. Section D: Mood, with a written intent of addressing mood distress which was labeled as a serious condition, which was under-diagnosed and under treated in the nursing home setting. R66's admission MDS dated [DATE], indicated R66's [DIAGNOSES REDACTED]. Section C (cognitive patterns) and Section D (mood) were not coded rather each field was dashed or had no other values recorded. Section Z of the MDS was signed by the MDS coordinator and dated 11/27/19, which indicated the assessment was complete. On 3/6/19 at 2:53 p.m. registered nurse (RN)-G confirmed Section C and D were incomplete and stated those sections were to be completed by social services. In addition, RN-G verified R66's clinical record lacked documentation as to why the assessments were not completed. On 3/6/20, at 3:15 p.m. Licensed Social Worker (LSW)-A stated the social services department was responsible for completing sections C and D and the MDS nurses were responsible to complete all the other sections of the MDS. LSW-A stated when social services was out of the office, the MDS nurses were responsible for completing sections C and D. LSW-A verified R66's MDS was incomplete and stated the MDS nurses had been directed to complete those sections, and should have. The Resident Assessment Instrument Policy revised September 2010, indicated all persons who have completed any portion of the MDS Resident Assessment Form MUST sign such document attesting to the accuracy of such information.
F 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to thoroughly complete a significant change Minimum Data Set (MDS) assessment in accordance to the Resident Assessment Instrument (RAI) manual for 1 of 1 resident (R66) identified with incomplete cognitive and mood sections of the MDS. Findings include: The Centers for Medicare and Medicaid Services (C[CONDITION]) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2019, identified the MDS as an assessment tool which facilities are required to use. The manual provided instructions to ensure accurate and complete coding for each section of the assessment as follows: Section C: Cognitive Patterns, with a written intent of determining the residents attention, orientation and ability to register and recall new information. These items were listed as crucial factors in many care planning decisions. Section D: Mood, with a written intent of addressing mood distress which was labeled as a serious condition, which was under-diagnosed and under treated in the nursing home setting. R66's significant change MDS dated [DATE], indicated R66's [DIAGNOSES REDACTED]. The MDS did not have any questions answered for Section C (cognitive patterns) or Section D (Mood) with each field being dashed and no other values recorded. Section Z of the MDS was signed by the MDS coordinator and dated 2/5/20, indicating the MDS was complete. On 3/6/20, at 3:15 p.m. Licensed Social Worker (LSW)-A stated the social services department was responsible for completing sections C and D and the MDS nurses were responsible to complete all the other sections of the MDS. LSW-A stated when social services was out of the office, the MDS nurses were responsible for completing sections C and D. LSW-A verified R66's MDS was incomplete and stated the MDS nurses had been directed to complete those sections, and should have. The Resident Assessment Instrument Policy revised September 2010, indicated all persons who have completed any portion of the MDS Resident Assessment Form MUST sign such document attesting to the accuracy of such information.
F 0638 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assure that each resident's assessment is updated at least once every 3 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to thoroughly complete required quarterly Minimum Data Set(s) for 2 of 6 residents (R42, R2) reviewed for assessment accuracy. Findings include: The Centers for Medicare and Medicaid Services (C[CONDITION]) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2019, identified the MDS as an assessment tool which facilities are required to use. The manual provided instructions to ensure accurate and complete coding for each section of the assessment as follows: Section C: Cognitive Patterns, with a written intent of determining the residents attention, orientation and ability to register and recall new information. These items were listed as crucial factors in many care planning decisions. Section D: Mood, with a written intent of addressing mood distress which was labeled as a serious condition, which was under-diagnosed and under treated in the nursing home setting. R42's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R42 had [DIAGNOSES REDACTED]. Section C, question C0100 of R42's MDS indicated a Brief Interview for Mental Status be conducted, however, the remaining questions were blank or dashed and no values were recorded. In addition, Section D of the MDS did not have any questions answered with each field being either dashed or blank with no values recorded. Section Z of the MDS was signed by registered nurse (RN)-H and dated 10/25/19, indicating the MDS was complete. R2's quarterly MDS dated [DATE], indicated R2's [DIAGNOSES REDACTED]. Section C, question C0100 of R2's MDS indicated a Brief Interview for Mental Status be conducted, however, questions C0200-C1000 were blank or dashed and no values were recorded. Section D, question D0100 indicated a resident mood interview should be conducted, however questions D0200-D0300 were dashed or blank with no other values recorded and the staff assessment of resident mood was entered. Section Z of the MDS was signed by RN-H dated 12/6/19, indicating the MDS was complete. On 3/6/20 at 2:53 p.m. RN-G stated sections C and D of the MDS were completed by social services and verified the sections were blank for R42's quarterly MDS assessment dated [DATE]. RN-G also verified R42's record lacked documentation as to why the MDS sections were not completed. RN-G also confirmed Sections C and D were incomplete for R2's MDS assessment dated [DATE], and verified R2's record lacked documentation as to why the MDS sections were not completed. On 3/6/20, at 3:15 p.m., licensed social worker (LSW)-A stated the social services department was responsible for completing sections C and D and the MDS nurses completed the other sections of the MDS. LSW-A stated when social services staff were gone, the MDS nurses were responsible for completing sections C and D. LSW-A verified the aforementioned sections were incomplete and stated the MDS nurses had been notified to complete those sections, and should have. On 3/6/20, at 3:38 p.m. the director of nursing (DON) verified she would expect the MDS assessments be completed in their entirety, as required. The Resident Assessment Instrument Policy revised September 2010, indicated all persons who have completed any portion of the MDS Resident Assessment Form MUST sign such document attesting to the accuracy of such information.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide personal assistance with grooming including nail care and shaving for 2 of 3 residents (R51, R65) who required assistance with personal grooming. Findings include: R51's significant Change Minimum Data Set ((MDS) dated [DATE], identified R51 with moderate cognitive impairment and [DIAGNOSES REDACTED]. The assessment indicated R51 required extensive assistance of one staff for personal hygiene. R51's Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 1/30/20, indicated R51 required assistance of two staff with dressing and personal hygiene/grooming. R51's Care Plan dated 1/30/20, directed the licensed staff to complete nail care on bath day due to the [DIAGNOSES REDACTED]. R51's Documentation Survey Report v2 (documentation of personal cares) indicated R51 had received a bath on [DATE], 2/10/20, 2/16/20, [DATE], [DATE], and 3/2/10. The documentation did not identify if nail care was provided. On 3/2/20, at 7:22 p.m. R51 was observed resting in bed. R22's fingernails were observed jagged and extended approximately a half inch past the end of the fingertips. R22 stated her nails were in need of cutting. On 3/5/20, at 8:27 a.m. R51 was observed to receive assistance with personal cares by nursing assistant (NA)-O and NA-P. The NA's did not offered nor provide nail care. -At 11:07 a.m. registered nurse (RN)-F stated the licensed nursing staff were to complete nail care for R51 on bath day. RN-F observed R51's nails at which time R51 informed RN-F her nails were too long and she would like them cut. RN-F stated she would return and assist R51 with nail care. On 3/6/20, at 3:21 a.m. RN-F stated diabetic nail care was to be completed on bath days and the facility utilized bath slips which were 3 inch x 4 inch slips of paper used by the NA staff to take notes on during cares to communicate any concerns. RN-F stated she had found the bath slips for R51's bed bath on 2/16/20, which indicated R51 had refused nail care and the slip from [DATE], which indicated R51 needed the licensed staff to complete nail care. RN-F confirmed R51's nails should have been trimmed [DATE]. Following this interview, RN-F completed R51's nail care. The facility's Care of Fingernails/Toenails policy dated 10/10, directed the staff to provide regular nail care trimming. The policy directed the staff not to trim the nails of

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) diabetic residents however, it did not direct the staff as to whom was to trim diabetic resident nails. The policy also directed the staff to document when nail care was completed. R65's admission MDS dated [DATE], indicated R65 had severe cognitive impairment and [DIAGNOSES REDACTED]. The MDS also indicated R65 had clear speech, clear comprehension and responded adequately to simple, direct communication only. The MDS further indicated R65 required limited assistance of one person with dressing and extensive assistance of one person with personal hygiene R65's Communication Care Area Assessment (CAA) dated 2/4/20, indicated R65 was noted to have minimal difficulty hearing staff. He was sometimes understood when trying to communicate. R65 was alert and oriented x 3 and sometimes able to communicate his needs. He had clear speech and could use his call light appropriately. R65 had a [DIAGNOSES REDACTED]. Staff were to ask yes or no questions and present one idea/question at a time. Staff were to explain every procedure or treatment to R65 in a loud, clear voice while facing him. Staff were to allow R65 time to comprehend what was being said. R65's Care Plan dated 1/27/20, indicated R65 had an ADL (activities of daily living) self-care performance deficit related to impaired balance and limited mobility and directed staff to implement interventions which included but were not limited to: set up/supervision for upper body dressing grooming/hygiene, set up and supervision by 1 staff for personal hygiene twice daily and as needed, encourage R65 to participate to the fullest extent possible with each interaction. On 3/2/20 at 6:42 p.m. R65 was noted to have facial hair on his chin and cheeks. R65 stated he shaved himself but indicated he had some difficulty with shaving some areas. On 3/3/20, at 2:41 p.m. R65 wheeled himself independently in a wheelchair through the [LOC] hallways from the dining room area toward his room. Facial hair was observed on his cheeks and chin and noted to be shorter in the center of the face and longer along the jawline area. On 3/4/20, at 8:12 a.m. R65 was observed eating breakfast independently in the dining room. Facial hair in the middle of R65's face was noted to be shorter and approximately 1/8 inch, however the hair toward the edges of the face and most notably the right side of the face was much longer and was over approximately 1/2 inch long. On 3/5/20, at 8:20 a.m. R65 was observed seated at the dining table, independently eating breakfast. R65 remained unshaven. On 3/6/20, at 9:34 a.m. NA-S stated some days R65 would get up and do cares on his own, but she thought he required standby assistance. -At 12:18 p.m. NA-U verified he had gotten R65 up today and indicated R65 needed assistance with transfers, but could do most of the rest of his cares himself. NA-U stated the staff would usually have R65 start his cares and provide assistance to finish, if needed. NA-U verified R65 had facial hair on his face and stated he looked like he needed a shave. -At 2:01 p.m. RN-F stated she would expect the staff to encourage residents to do as much of their activities of daily living as possible on their own and provide assistance to complete the tasks, if the resident allowed. RN-F stated NA-U had reported to her that R65's razor had not been working well and asked if he could shave R65 with a razor. RN-F stated she would have expected the staff to identify if R65 appeared like he needed a shave and assist with the task. -At 2:26 p.m. NA-U confirmed he had provided R65 assistance with shaving. -At 2:27 p.m. R65 was observed seated in a wheelchair in the doorway of his room and was clean shaven. R65 stated it felt great and he felt more like himself. On 3/6/20, at 3:40 p.m. the DON verified she would have expected staff to determine if R65 needed additional assistance with shaving, as assist him as needed. The Shaving the Resident policy revised October 2010, outlined the steps to perform the procedure using either an electric or disposable razor. The policy did not address completion of shaving begun by the resident nor address non-functioning equipment.
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** Based on observation, interview and document review, the facility failed to provide timely repositioning assistance for 1 of 7 residents (R93) who was identified at risk for pressure ulcers and required staff assistance to reposition. Findings include: R93's Medicare 5 day Minimum Data Set ((MDS) dated [DATE], indicated R30 had a moderate cognitive impairment and [DIAGNOSES REDACTED]. The MDS indicated R93 had a stage II (partial loss of the dermis) pressure ulcer, was at risk for pressure ulcers (PU), required extensive assist of one for transfers, ambulation, locomotion, dressing, toileting, hygiene and extensive assist of 2 for bed mobility. R93's ADL Potential/Rehabilitation Potential Care Area Assessment CAA dated 1/9/20, indicated R93's triggered for ADL Functional/Rehabilitation Potential, Urinary Incontinence and Pressure Ulcers due to R93's limited mobility, presence of indwelling Foley, history of falls resulting in fracture, complaints of pain, altered communication, and presence of deep tissue injury and Stage II PU on admission. R93 was at risk for potential injury, infection, altered mood/behavior, falls, altered communication, pain and pressure and moisture related skin impairments. R93 was being treated with skilled physical therapy/occupational therapy for left [MEDICAL CONDITION] following a fall. R93 had a prosthetic to right lower leg and was at high risk for falls due to weakness and pain. The CAA indicated R93 received up to extensive assist of 2 with bed mobility, transfers, toileting, and dressing and set up with meals. The CAA further indicated R93 was being treated for [REDACTED]. R93 was to be assisted with repositioning and was provided pressure reducing mattress and cushion for his wheelchair. R93's Care Plan initiated 1/4/20, indicated had a PU and directed staff to assist with regular repositioning and offloading every one hour while awake and every two hours at night, and as needed. The Care Plan further directed staff that if R93 was sitting, one staff person was to assist with standing with the front wheeled walker/or hand rail, for one full minute to offload (relieve pressure). R93's Braden Scale (a tool for predicting pressure ulcer risk) dated 2/10/20, indicated R93 was at high risk for pressure ulcer/injury. On 3/4/20, at 8:26 a.m. R93 was observed in bed, on his back, as nursing assistant (NA)-M entered the room and asked R93 if he was ready for morning cares. R93 responded, no, lazy today. - At 8:52 a.m. R93 remained in bed, on his back, with the head of the bed elevated 45 degrees. - At 9:19 a.m. NA-M stated R93 was independent with bed mobility therefore did not require assistance or any type of reminders to reposition. At this time, NA-M went to R93 and proceeded to assist him to reposition to his left side. NA-M opened R93's point of care (POC) electronic record and reported the directive to reposition R93 was not indicated. On 3/4/20, at 9:26 a.m. licensed practical nurse (LPN)-C was observed to change R93's PU dressing and obtain wound measurements. LPN-C stated R93 was independent with bed mobility. Following the observation, LPN-C reviewed R93's Care Plan and stated ok when reading R93 required the assistance of one staff to reposition. On 3/4/20, at 11:46 a.m. registered nurse (RN)-D stated she had reviewed R93's Care Plan and verified R93 was independent with transfers, but added, R93 continued to require assist of one for bed mobility. RN-D stated she had spoken with her staff regarding R93's POC and found that the task had already been signed off as complete for the shift therefore the staff were unable to identify R93's repositioning needs. RN-D stated at that time, she had educated the staff on the importance of repositioning R93. RN-D also stated she conducted routine wound assessments and verified R93's PU was improving. RN-D verified the staff were expected to follow R93's Care Plan, as directed On 3/6/20, at 10:34 a.m. the director of nursing (DON) verified the staff were expected to follow R93's Care Plan for repositioning/offloading needs. The facility policy titled Repositioning, revised May 2013, directed staff to review the resident's care plan to evaluate for any special needs of the resident.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide restorative nursing services for 1 of 1 resident (R42) according to assessed need. Findings include: R42's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R42 was cognitively intact. R42's quarterly MDS dated [DATE], indicated R42 had [DIAGNOSES REDACTED]. The MDS also indicated R42 required extensive assistance of two persons for bed mobility, transfer, and toilet use, extensive assist of one person for locomotion on and off the unit, dressing and personal hygiene and was independent with eating. The MDS indicated R42 had not walked in his room or in the corridor during the entire seven day assessment period. The MDS further indicated R42 had functional limitations on both sides of his lower extremities (hip, knee, ankle, foot). Additionally, the MDS indicated R42 had not received physical therapy, occupational therapy or restorative nursing services during the assessment period. R42's ADL (Activities of Daily Living) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated [DATE]7/19, indicated R42 continued to have limited range of motion (ROM) noted to bilateral knees. No ROM limitations noted to upper extremities (UE). He had a [DIAGNOSES REDACTED]. R42 was to place feet on stool in room x 10 minutes when up in wheelchair (w/c) three times per day to help with contractures in his knees. He continued to participate in an active range of motion (AROM) and walking restorative program. He was also participating with physical therapy (PT) as of 2/27/19. R42's Care Plan reviewed 1/14/20, indicated R42 required restorative nursing due to a [DIAGNOSES REDACTED]. The care plan indicated R42 continued to have limited ROM to bilateral knees with the ability to

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F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) extend left knee to at least 25 degrees and extend right knee to at least 24 degrees and transfers on/off the toilet with assist of 1 staff and front-wheeled walker. The care plan directed staff to provide appliances as ordered and appropriate, observe for decline in ROM, update physician and family as needed, and provide restorative program as directed in the facility computer system Task section. R42's Restorative Care Program dated 1/29/20, and signed by the physical therapist, indicated R42 was discharged from PT on 1/30/20. Recommendations included: NuStep level 4 bilateral UE and LE with reminders to utilize full ROM. Stretching both legs all the way out on knee extension. Hamstring stretch to B (bilateral) LE's feet on ball 10 minutes. On 3/2/20, at 2:06 p.m. R42 indicated he had limitations in his knee joints however, stated the wellness room was never open so he could not do his exercises. R42 stated he would go there every day if they were open. On 3/3/20, at 3:46 p.m. R42 was observed in his room watching TV while seated in a wheelchair. -At 3:57 p.m. the wellness room was observed to be dark with the door locked. A calendar was posted on the door with a name designated on each day of the month. No times were noted on the calendar. On 3/5/20, at 9:23 a.m. an unidentified staff member invited R42 to go down to the therapy room. However, Licensed practical nurse (LPN)-E stated R42 had not eaten breakfast so the staff wheeled R42 to the dining room for breakfast. On 3/6/20, at 9:28 a.m. nursing assistant (NA)-S stated R42 was scheduled for restorative therapy at 2 p.m. every day and indicated his attendance depended on the day. NA-S stated they would not take him therapy if he was leaning in his chair, or transferring poorly as he needed to transfer to get onto the exercise bike. NA-S stated if the wellness room was open, R42 would go. However, if the facility were short-staff, restorative services was sacrificed. NA-S stated the therapy room was closed more often than they would like. On 3/6/20, at 9:39 a.m. NA-T stated he worked on the floor and also as a restorative aide. NA-T also stated he would stop working in the wellness room at approximately 3 p.m. so that he could do in room restorative visits. NA-T verified there were times he was pulled from restorative services in order to work on the floor. NA-T estimated this happened approximately half of the time or two of the four shifts he was scheduled to work in restorative services per pay period, and it occurred primarily on the weekends. NA-T stated he sometimes had to close the wellness room early, but could usually make arrangements in the schedule to provide services for the scheduled residents. -At 10:26 a.m. A binder with R42's Restorative Care Program as listed above was reviewed with NA-T who verified R42 received hamstring stretching on the ball for 10 minutes and then worked on the NuStep for approximately 10 minutes to focus on big movements and full ROM. NA-T indicated R42 was supposed to attend exercises every day but usually only attended three of the days he (NA-T) was scheduled to work. NA-T indicated the restorative staff documented resident restorative services provided in the facility electronic medical record and also highlighted the resident name on a paper schedule when they attended exercises that day. The paper schedules for February were reviewed with NA-T who confirmed the schedules identified R42 had attended x 3, did not attended x 3 and were blank x 23. NA-T stated there had been a couple of months that had been rough for getting pulled from restorative services more than usual, and noted it occurred more often that they were covering the floor from 2 p.m. to 4 p.m. until coverage could be found for the evening shift and thought it may have been a bit worse lately. Review of R42's Documentation Survey Report v2 dated February 20, and March 20 revealed the following: February: services provided x 2, resident refused x 2, resident not available x 1, not applicable x 2, blank x 22 of 29 opportunities March: blank x 5 of 5 opportunities. On 3/6/20, at 11:39 a.m. registered nurse (RN)-F verified R42 had a 2 p.m. standing appointment every day for restorative services if the wellness room was open. RN-F confirmed the restorative staff would sometimes get pulled to work the floor if there were call ins or staffing needs. RN-F stated R42 should be receiving services as often as possible but was not sure if he had a prescribed number of times to go per week. The documentation report was reviewed with RN-F who then indicated nursing staff should be documenting on the TAR (Treatment Administration Record) if R42 had refused restorative services or not. Review of the TAR dated 2/1/20-2/29/20, included an order for [REDACTED]. The chart codes legend identified 9 indicated Other/See Progress Notes and 2 indicated declined. Progress notes for the corresponding days revealed: [DATE]: Restorative therapy daily at 1400. document refusals in progress note one time a day. 2/12/20: Restorative therapy daily at 1400. document refusals in progress note one time a day. Restorative closed 2/16/20: Restorative therapy daily at 1400. document refusals in progress note one time a day. 2/25/20: Restorative therapy daily at 1400. document refusals in progress note one time a day. RN-T also indicated they had gotten a new order on 2/20/20, for R42 to be evaluated for weakness and leg pain by PT and stated R42 had just been discharged from physical therapy at the end of January and they had put him right back on the services. On 3/6/20, at 2:12 p.m. physical therapist (PT) was observed to assist R42 to ambulate in the hallway with the use of a gait belt and front-wheeled walker while pulling a wheelchair behind him for 30 feet. R42 indicated this was the first time he had walked in a long time, but did state he had received restorative services the previous day. The physical therapist verified R42 had been discharged from PT at the end of January with a restorative nursing program in place and stated she would have expected services to be provided. The therapist stated it did not have to be a restorative aid who provided the service as a NA could do it as well. On 3/6/20, at 3:42 p.m. the restorative nursing documentation was reviewed with the administrator and the director of nursing (DON). DON verified the documentation only identified R42 had been provided services twice in the month of February with two refusals documented on the Documentation Survey Report and three refusals documented on the TAR. DON confirmed they had sometimes closed the gym, but stated they tried to schedule the residents at other times in order to provide the services. The DON verified there was no documentation of restorative services provided to R42 and confirmed she would have expected services be provided or refusals by R42 be documented in the medical record. On 3/6/20, at 4:10 p.m. DON provided documentation the facility wellness gym had been closed 7 times in the month of February. The Rehabilitative Nursing Care policy revised July 2013, indicated the facility had an active program of rehabilitative nursing which was developed and coordinated through the resident's care plan and designed to assist each resident to achieve and maintain an optimal level of self-care and independence. The policy indicated rehabilitative nursing care was performed daily for those residents who required such service and included but was not limited to assisting residents to carry out prescribed therapy exercises between visits of the therapists and assisting residents with their routine range of motion exercises.
F 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 11 percent with 3 errors out of 26 opportunities for error involving 2 of 6 residents (R27, R10) who were observed during the medication pass. Findings include: R27's Admission Record (face sheet) dated 7/12/19, indicated R27 had [DIAGNOSES REDACTED]. R27's Order Summary Report (physician's orders [REDACTED]. The order directed the sliding scale [MED] to be given before meals. R27's electronic Medication Administration Record [REDACTED]. On 3/20/30, at 6:30 p.m. R27 was observed to wheel herself out of the dining room and had just finished her evening meal. Licensed practical nurse (LPN)-D informed R27 she would prepare her [MED] and bring it to her room. LPN-D stated R27's blood sugar had been 170 mg/dl before supper. LPN-D was observed to obtain a [MEDICATION NAME]pen, set it to administer 5 units of [MED] and at 6:35 p.m. administered the [MED] to R27. -At 6:41 p.m. LPN-D confirmed R27's physician orders [REDACTED]. LPN-D confirmed R27 had finished her evening meal prior to receiving the [MED]. R10's Admission Record dated 6/26/20, indicated R10 had [DIAGNOSES REDACTED]. R10's Order Summary Report dated 1/15/20, included orders for: -[MEDICATION NAME] (diuretic medication) 40 milligram (mg) by mouth two times per day. -[MEDICATION NAME] (anti-diarrhea medication) [MED] 2 mg as needed for loose stools. -[MEDICATION NAME] (diabetic medication) 500 mg by mouth one time per day. Must be given with food. -[MEDICATION NAME] (ulcer medication) 40 mg one table by mouth daily. -Potassium Chloride (supplement) 10 meq by mouth daily. -House supplement two times a day between meals. On 3/4/20, at 7:04 a.m. registered nurse (RN)-E was observed to prepare the aforementioned medications for R10. The prescription label on R10's [MEDICATION NAME] 500 mg package directed: must be given with food. The prescription label on the [MEDICATION NAME] 40 mg package directed the staff to administer the medication on an empty stomach. R10's EMAR directed the [MEDICATION NAME] to be administered with food and the [MEDICATION NAME] was to be administered 40-60 minute before breakfast on an empty stomach. -At 7:10 a.m. RN-E was observed to administer all the prepared medications to R10. -At 8:15 a.m. R10 was served the breakfast meal. -At 8:48 a.m. RN-E confirmed R10 had received all oral medications at 7:05 a.m. including the [MEDICATION NAME] and [MEDICATION NAME]. Upon review of the medication cards and EMAR, RN-E confirmed the [MEDICATION NAME] and [MEDICATION NAME] had been given at the same time and R10's stomach was not empty for 40-60 prior to administering the [MEDICATION NAME] as indicated. On 3/5/20, at 11:44 a.m. RN-A stated LPN-D and RN-E had made her aware of the medications which had not been administered per the physician's orders [REDACTED]. had been reviewed and the [MEDICATION NAME] administration time had been changed to ensure R10 received the medication on an empty stomach. On 3/6/20 at 9:19 a.m. the director of nurses stated she was aware of the aforementioned medication errors and it was an expectation

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	245368	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRAND VILLAGE	923 HALE LAKE POINTE 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.

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F 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) that staff administered the medications in accordance with the physician orders. The Medication / Treatment Administration policy dated 11/2013, directed the staff to administer medications in accordance to the physician orders.
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**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 ensure staff implemented appropriate infection control practices to prevent and control the transmission of [MEDICAL CONDITION] ([MEDICAL CONDITION], a highly infectious spore forming bacterium) when caring for 1 of 1 resident (R98) diagnosed with [REDACTED]. In addition the facility failed to implement appropriate infection control practices for 1 of 1 resident (R299) who was presumed to have the bacterium, and failed to perform appropriate hand hygiene and/or catheter care for 3 of 7 residents (R299, R200, R54) observed during personal care. Lastly, the facility failed to ensure wound care was not performed with expired normal saline solution for 1 of 1 resident (R51) who was observed to receive wound care. The Immediate Jeopardy (IJ) began on [DATE], when staff were observed providing cares for R98 who was on contact precautions related to the [MEDICAL CONDITION] infection without implementing appropriate infection control techniques. The administrator and director of nursing (DON) were notified of the IJ on [DATE], at 5:50 p.m. The IJ was removed on [DATE], at 4:39 p.m. however, non-compliance remained at the lower scope and severity of E, pattern, with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: R98's significant change Minimum Data Set ((MDS) dated [DATE], indicated R98 had severe cognitive impairment, and [DIAGNOSES REDACTED]. The assessment indicated R98 required extensive assistance with all activities of daily living (ADL) and was always incontinent of bowel and bladder. R98's Urinary Incontinence Care Area Assessment (CAA) dated [DATE], indicated R98 was always incontinent of bowel and bladder, and required staff assistance to check and change incontinence products every two hours. In addition, R98 was diagnosed with [REDACTED]. R98 was noted to have had 23 bowel movements during the reference period, and the staff were to monitor the number of bowel movements. R98 was to remain on contact transmission based precautions until the [MEDICAL CONDITION] resolved. R98's Progress Notes (PN) revealed the following: -[DATE], at 5:04 a.m. R98 had a large loose mucus stool. -[DATE], at 551 a.m. R98 had two flemmy, loose gelatinous stools.one stool had about ,[DATE] 1 cm (centimeter) long red streaks. -[DATE], at 9:45 a.m. R98 had a loose stool prior to breakfast that was yellowish brown and slimy. -[DATE], at 1:04 p.m. R98 was unresponsive, loose stools were evaluated and family member were offered to have R98 evaluated at the emergency room . Family declined evaluation and requested a Hospice consult. -[DATE], at 3:57 p.m. R98 evaluated at the emergency room (ER) per family request. -[DATE], at 8:57 p.m. R98 returned to the facility. R98 did have a bowel moment while in the ER and received orders to monitor bowel moments. -[DATE], at 5:25 a.m. R98 had mucus stools during the night shift. -[DATE], at 9:24 p.m. R98 had blood in stools. -[DATE], at 1:31 p.m. R98 had three loose yellow stools. -[DATE], at 10:28 p.m. R98 had two loose stools (no further description). -[DATE], at 5:46 a.m. R98 had three loose stools during the night shift that were of mucous like texture. -[DATE], at 12:16 p.m. the facility obtained an order to obtain a stool culture for [MEDICAL CONDITION]. The facility implemented contact precautions. -[DATE], at 4:29 p.m. R98 was diagnosed with [REDACTED]. R98's laboratory results collected on [DATE], revealed R98 was positive for the [MEDICAL CONDITION] infection. R98's Care Plan initiated [DATE], and revised on [DATE], indicated R98 had diarrhea related to [MEDICAL CONDITION] infection. R98 was always incontinent of bowel and bladder and directed the staff to check and change incontinent brief every two hours and as needed. R98 was rarely/sometimes aware of the urge to urinate/defecate and directed two staff to utilize the EX-Lift for transfers. The plan also directed the staff to monitor for signs and symptoms of dehydration and infection, to monitor R98's frequency of bowel movements every shift, and to provide peri cares after each incontinent episode. The plan did not direct the staff to ensure contact precautions were maintained. R98's electronic Medication Administration Record [REDACTED]. On [DATE], at 5:55 p.m. R98 was observed in the dining room, seated in a wheelchair. Licensed practical nurse (LPN)-D assisted R98 with his liquids as he waited for the evening meal to be served. -At 6:12 p.m. LPN-D wheeled R98 out of the dining room and into his room. -At 6:29 p.m. LPN-D stated R98 had been wheeled out of the dining room because he had a loose stool and was on contact precautions due to [MEDICAL CONDITION]. Nursing assistant (NA-A) donned a face mask, gown, and gloves and entered R98's room. On [DATE], at 8:20 a.m. NA-F and NA-D stated they were going to transfer R98 from bed into a wheelchair for breakfast. The NA's were observed to don face masks and gloves, and without gowns on, wheeled a full body mechanical lift into R98's room. The NA's proceeded to transfer R98 from the bed and into the wheelchair via the full body lift. Throughout the set-up and transfer, both NA's uniforms were observed to touch the sides of the bed, bedding and R98. Following the transfer, NA-D removed her mask and gloves, tossed them into the trash just inside of R98's room, and exited the room. However, NA-D did not wash her hands prior to leaving the room. Shortly thereafter, NA-F removed her mask and gloves, placed them in the same trash can, and wheeled R98 into the dining room. NA-F did not wash her hands prior to leaving R98's room. -At 8:29 a.m. when asked, NA-D stated she had washed her hands in the [LOC] unit's nurses' station sink which was across the unit from R98's room. NA-F confirmed she had not washed her hands after leaving R98's room. -At 8:32 a.m. NA-F was observed to enter the [LOC] kitchenette and washed her hands as dietary aide (DA)-A was at the steam table preparing resident breakfast meals. When done washing her hands, NA-F was not observed to disinfect the sink area. -At 8:33 a.m. NA-F confirmed she had washed her hands in the kitchenette while DA-A was preparing meals. NA-F stated she could have washed her hands in an alternative sink instead of in the kitchenette while the meal was being served. NA-F also verified she had not attempted to disinfect the sink or report the potential infection control breach to other staff members. -At 9:17 a.m. DA-A prepared to remove the dirty dishes from the [LOC] dining room. The State Agency (SA) informed DA-A of the potentially contaminated sink. DA-A was observed to clean the sink with a bleach based disinfectant. -At 9:28 a.m. NA-D and NA-E reported they were going to assist R98 back to bed. NA-D was observed to don a mask and gloves (no gown). NA-E donned a mask, gown, and gloves. NA-E stated she would be assisting R98 with incontinence cares so she was required to wear a gown. NA-D stated she would not be providing incontinence cares, therefore, she only had to wear a mask and gloves when in the room. -At 9:32 a.m. the NA's were observed to transfer R98 from the wheelchair to the bed via a full body mechanical lift. Once in bed, NA-E rolled R98 towards NA-D. NA-D's uniform came into contact with R98's clothing and bed while she held R98 on his side while NA-E checked R98's incontinent product. NA-E reported R98 had not been incontinent. The NA's positioned R98 onto his side and positioned R98's feet on pillows. NA-D's uniform touched R98's bedding while positioning R98 in bed. -At 9:36 a.m. NA-E offered to cover R98 with a blanket, and proceeded to cover R98 with a sheet, as he requested. NA-E held onto the bottom edge of a blanket, fanned it causing the blanket to lay flat over R98, folded it away from R98's face, and rested the bottom of the sheet on a foot cradle. NA-D was directly next to the bed while the blanket was shook/fanned in the air. NA-D removed her gloves and mask and washed her hands in R98's bathroom. NA-E removed the gown, gloves, and mask and washed hands in R98's room. -At 9:39 a.m. NA-D stated she did not have to wear a gown during cares because NA-F had completed R98's perineal cares. NA-D confirmed her uniform touched R98's clothing and bedding while assisting R98 to bed. -At 9:44 a.m. NA-E stated while providing care for R98, only one NA was required to wear full personal protective equipment (PPE/gown, gloves, mask) as only one NA would come into contact with R98's perineal area. -At 1:42 p.m. registered nurse (RN)-A confirmed [MEDICAL CONDITION] had the ability to survive on inanimate object for days, weeks, or months, and stated she would expect the staff to wear protective gowns, gloves and masks while providing care to a resident diagnosed with [REDACTED]. and not in the nurse's station or the unit's kitchenette, especially during meal service. -At 3:03 p.m. NA-N stated he had assisted R98 with bowel incontinent cares on [DATE], during the evening meal. NA-N stated R98 had had a loose bowel movement which leaked out of the incontinent product thereby not contained within the incontinent product. At 3:04 p.m. NA-N was observed to don gloves and a mask, enter R98's room carrying a blue, plastic non-disposable cup. NA-N picked up a non-disposable cup from R98's room, left the room, and entered the [LOC] living care, and placed the cup on a three tier cart stationed in the main area of the unit. NA-N returned to R98's room, removed the gloves and mask, and without performing hand hygiene, exited the room and asked RN-A what to do with the non-disposable cup that was placed on the cart. RN-A directed NA-N to place the cup in a plastic bag, identify the cup as being from R98's room, and return it to the kitchen. -At 3:07 p.m. NA-N confirmed he had exited R98's room with PPE on and had not washed his hands prior to leaving the room. NA-N proceeded to R98's room and washed his hands, exited the room, began to clean the three tier cart and the outside of R98's cup with a bleach wipe, placed the cup in a plastic bag, and wheeled the cart/cup to the kitchen. R98's PN dated [DATE], at 3:15 p.m. indicated R98's [MEDICAL CONDITION] isolation precautions were removed due to R98 having been free of symptoms. R98's PN dated [DATE], at 9:00 p.m. indicated R98 had a large incontinent bowel movement. A subsequent PN at 9:05 p.m. indicated R98's physician ordered R98 to be tested for [MEDICAL CONDITION]. A PN at 11:14 p.m. indicated R98 had a stool sample sent to the laboratory. R98's PN dated [DATE], at 9:29 a.m. indicated R98 had a large bowel movement that seeped from the incontinent brief and onto his pants and lift sling. R98 was to be kept in his room to avoid contact

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	245368	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) with others. R98's PN dated [DATE], at 10:08 a.m. indicated R98's laboratory results were positive for [MEDICAL CONDITION] therefore R98 was started on [MEDICATION NAME] (antibiotic) 125 milligrams by mouth four times per day for 14 days and contact precautions were re-started. The facility's undated, [MEDICAL CONDITION] Protocol indicated infected clients should be placed in a private room if available or cohort if possible. Contact isolation precautions should be employed as follows: -use gloves when entering residents room for: direct care contact, environmental contact. -Use gowns if soiling likely: resident or environmental soiling. -Use dedicated equipment if possible: stethoscope, thermometer, transfer belt, and lift sling etc. All staff must be diligent about hand washing for both themselves and the infected resident. The [MEDICAL CONDITION] spores is spread through oral-fecal contact-this meant anything that unwashed hands touched could become contaminated. The spores can live on a surface for a month or more. Soap, water and friction are to be used for cleansing hands. Alcohol gel is not effective against the spore. When a resident was free from signs and symptoms for three days, the room infection control precautions could be removed. The facility's undated, [MEDICAL CONDITION] policy indicated preventative measures would be taken to prevent the occurrence of [MEDICAL CONDITION] infections among residents and precautions would be taken while care for residents with [MEDICAL CONDITION] to prevent the transmission to others. [MEDICAL CONDITION] infections would be considered for a resident with an acute onset of diarrhea (three or more unformed stools within a 24 hour period) or abdominal pain. Residents considered at high risk of developing symptoms associated with [MEDICAL CONDITION] include those with previous gastrointestinal illness caused by [MEDICAL CONDITION] and antibiotic or anti-neoplastic therapy. Residents with diarrhea associated with [MEDICAL CONDITION] (resident who are colonized and symptomatic) will be placed on isolation precautions. Healthcare workers would wear gloves and gowns upon entering the room of a resident with [MEDICAL CONDITION] infection, and will remove gown and gloves prior to exiting the room. When caring for a resident with diarrhea of fecal incontinence caused by [MEDICAL CONDITION] the staff would maintain vigilant hand hygiene. Glove use and washing hands with soap and water upon exiting the room and strict hand hygiene in general was considered best practice. Enhanced infection control measures include reduced sharing of or dedicated medical equipment. The policy directed the staff to place residents with [MEDICAL CONDITION] in contact precaution and the staff providing cares to the resident to wear gowns and gloves. On [DATE], at 5:50 p.m. the administrator and director of nursing were informed of the immediate jeopardy based upon the lack of staff knowledge and implementation of contact precautions required to care for the residents in contact isolation for [MEDICAL CONDITION]. The facility's lack of implementation of contact precaution placed the other residents, staff and visitors at risk of contracting [MEDICAL CONDITION]. The IJ that began on [DATE], was removed on [DATE], at 4:39 p.m. when the facility had completed the following interventions. -The [MEDICAL CONDITION] policy and procedure was reviewed and updated. -The Isolation Transmission Based Precautions policy and procedure was reviewed and updated. -The Isolation Notices of Transmission-Based Precautions was reviewed and updated. -The Handwashing/Hand Hygiene policy and procedure was reviewed and updated. -Staff members were provided verbal and written education regarding infection control. -The staff demonstrated appropriate donning and doffing of PPE. -The facility developed guides to direct staff as to when to use each EPA approved disinfecting wipes. R299's Order Summary Report [DATE], indicated R299's [DIAGNOSES REDACTED]. R299's Medicare 5 day MDS dated [DATE], indicated R299 required extensive assist of two staff for bed mobility, transfers, dressing, and toileting. Extensive assist of on staff for hygiene, limited assist of one staff for locomotion, and was non-ambulatory. R299's Cognitive Loss/Dementia CAA dated [DATE], indicated R299 had severely impaired cognition. R299's Urinary Incontinent CAA dated [DATE], indicated R299 required assistance from two staff for transfers with mechanical standing lift, bed mobility, toileting and personal hygiene/grooming. One staff assist for dressing. He was non ambulatory. History of multiple falls prior to admission. Frequently incontinent of bowel and bladder with staff providing peri care with each incontinent episode. R299 was sometimes aware of the urge to urinate/defecate. Two staff to toilet R299 every two hours and as needed, and to not leave unattended in the bathroom. Has a history of frequent loose stools and was prescribed [MEDICATION NAME] which had not been used during the MDS reference period. No additional bowel medications ordered. R299 had three bowel movements, two of which were incontinent. R299 was admitted with a non-removable surgical wound dressing to left hip. R299's care plan printed on [DATE], indicated R299 had altered elimination due to decreased mobility, weakness, medication use, and impaired cognition. Staff were directed to encourage fluid intake, provide good peri cares, maintain record of bowel movements, observe for signs and symptoms of infection, utilize incontinent briefs, and assist to toilet every two hours and as needed. Two staff to transfer to the bathroom with gait belt and front wheeled walker for stand, pivot transfers and to not leave R299 alone in the bathroom maintain within an arm's reach away from the resident when toileting due to confusion. The care plan also indicated R299 was at risk for falls and directed the staff to place a fall mat next to the bed. R299 was not ambulating with staff at this time. R299 had long term antibiotic use due to a history of a kidney transplant. Acute pain related to a history of falls with recent lumbar fracture, [MEDICAL CONDITION] repair. Staff directed to administer [MEDICATION NAME] per physician orders, offer heat/ice, evaluate, monitor, and report changes in pain. R299's Telephone Orders form dated [DATE], included the following orders: -Test for [MEDICAL CONDITION] and if test negative, to use [MEDICATION NAME]-[MEDICATION NAME] 2XXX,[DATE].025 mg one tablet four times a day, as needed for diarrhea -[MED] 250 mg daily for chronic diarrhea. On [DATE], at 1:43 p.m. R299 was observed in the dining room, seated in a wheelchair. On [DATE], at 1:59 p.m. NA-V was observed to assist R299 to his room. R299 stated his legs were sore post physical therapy therefore NA-V assisted R299 to transfer to the bed via the mechanical standing lift. A fall mat was positioned on the floor, next to the bed. An infection control bin was not observed stationed in or near his room. On [DATE], at 7:10 a.m. during continuous observations from 7:10 a.m. until 9:13 a.m. the following was observed: -7:10 a.m. R299 was observed in his room, in bed. R299's roommate, R82 was seated at a table in the dining area. An infection control bin was stationed outside of their shared room door. Infection control signage was posted on the door which had a picture of large stop sign with the directive to please see nurse before entering patient's room. A second form read ATTENTION, turn over for information. When turned over, the back directed the following: -Gloves were indicated if touching infective materials stool -Gowns were to be worn if soiling was likely. -A private room was identified as not indicated. -hands must be washed after touching resident or potentially contaminated articles and before taking care of another resident. -Plastic bags were to be used when handling linens/garbage. -Staff were to assist with resident as needed to ensure resident followed good handwashing techniques after going to the bathroom. -Staff to wash hands with soap and water as alcohol gel is not effective. -Bleach disinfectant was to be used after each use of the toilet including the seat, grab bars, and sink which must be wiped down with bleach and paper toweling. -If a bedpan or commode was used, it must be wiped down after each use. -Housekeeping to use comet bleach on hard surfaces daily, such as toilet sink, grab bars, door handles, TV remove, bedside table, nightstand, and bed handrails. At this time, LPN-A stated R299 was under contact precautions due to being tested for [MEDICAL CONDITION]. A commode was not observed in R299's room or shared bathroom. -At 7:53 a.m. R299 remained in bed as NA-A donned a gown and gloves and pushed a mechanical standing lift into R299's room. NA-A stated R299 needed to use the bathroom. When asked if the State agency could observe the transfer, R299 declined and the surveyor exited the room. R82 remained in the dining room. -At 7:57 a.m. NA-A stepped out of the bathroom, confirmed R299 was assisted onto the toilet, and indicated R299 had been continent throughout the night. R299 remained in the bathroom. -At 8:01 a.m. LPN-A donned a gown and pair of gloves, and with wound dressing in hand, entered R299's room and went directly into the bathroom. Prior to entering the room, LPN-A stated R299 had a surgical wound which required dressing. -At 8:06 a.m. LPN-A exited the bathroom, doffed the gown and one pair of gloves. Upon removing the gloves, a purple pair of gloves were revealed on her hands. With the second pair of gloves on, LPN-A exited the room with the standing lift, positioned it up against the wall next to the infection control bin, walked across the unit, entered the nursing station, removed the gloves, and washed her hands. The standing lift was not disinfected prior to or after leaving R299's room. R82 remained in the dining area, eating breakfast. Shortly thereafter, R299 exited the bathroom seated in the wheelchair and was assisted out of the room and positioned at a dining table. R299's floor mat was noted to be upright and leaning against R299's dresser/closet area which was located on the wall near the end of R299's bed. The staff were not observed to clean or disinfect the bathroom following R299's use. -At 8:11 a.m. laundry/housekeeping (Lndry/Hskp)-A entered the unit pushing an uncovered, open faced, clean linen rack which half consisted of a bar with clean, resident clothing hanging and a column of small individual bins next to it which held clean, smaller clothing items. Lndry/Hskp-A stationed the rack next to the nurse's station. With gloved hands, Lndry/Hskp-A removed clothing on hangers from the rack, walked across the unit, and entered R229/R82's room without donning any other PPE or asked the nurse about the precautions prior to entering. Once in the room, Landry/Hskp-A picked up a corner of the floor mat, repositioned it to gain better access to the closet, and leaned it against herself

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRAND VILLAGE	923 HALE LAKE POINTE 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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 6) stabilizing it as she walked the few steps to reach the closet. Lndry/Hskp-A opened the closet door, hung the clean clothing up, and removed unused hangers while the floor mat leaned against her person. Once the clothing had been hung, and with the same gloved hands, Lndry/Hskp-A repositioned the floor mat, walked over to R82's closet, opened the door, hung his clean clothing up, removed unused hangers, exited the room, walked across the unit, and placed the hangers onto the bottom of the clean, open linen rack. With the same gloved hands, Lndry/Hskp-A grabbed a clean, brown, blanket from the clean linen rack, held the blanket against her person with both hands, and asked the nurse if she knew who the blanket belonged to. With the blanket in her arms, Lndry/Hskp-A entered the nurse's station, obtained a key, and exited the nurse's station. At this time, the State agency intervened and asked to speak with her. Lndry/Hskp-A placed the blanket on top of the hangers on the bottom of the rack, removed her gloves, and utilized hand sanitizer. -At 8:20 a.m. Lndry/Hskp-A stated the key she had obtained was for the unit's locked, clean linen closet as she was going to put the blanket in there for community use. Lndry/Hskp-A stated she worked in both housekeeping and laundry and had not noticed the infection control bin outside of R299's room yesterday. When asked what the procedure was when entering a room with posted isolation precautions, Lndry/Hskp-A stated she would use a piece/corner of the resident's clean clothing to touch/open the closets/drawers in order to avoid touching anything with her hands. Lndry/Hskp-A stated the laundry staff were informed every morning of any resident with isolation precautions in place. However, this morning she had not been informed of R299 having been placed on precautions the night before therefore she had just applied a pair of gloves to make sure she wouldn't touch anything. When asked what type of isolation precautions R299 had in place, Lndry/Hskp-A stated she did not know, and generally did not know what type of bug a resident had so she would just apply gloves because it was the biggest thing to do and she would also not touch the resident. Lndry/Hskp-A verified she had entered the room with gloves on while holding clean clothing for both R82 and R299. Lndry/Hskp-A also verified while in the room, she had handled the floor mat, stabilized it against her person, touched both closet/door handle surfaces, and touched the clean clothing that was hanging in both residents' closets with the same gloved hands. When asked if she should have applied a gown prior to entering the room, Lndry/Hskp-A stated she did not know if she should have or not. Lndry/Hskp-A confirmed she did not remove her gloves or wash her hands after touching a potentially contaminated surface, between resident room areas, nor upon exiting the room. Lndry/Hskp-A also stated the hangers that were removed from the residents' room were placed on the clothing rack to be taken back to laundry so they could be cleaned with bleach due to having been removed from an room with isolation precautions. Lndry/Hskp-A verified she had held handled the clean blanket with her gloved hands and held against her person and agreed she had potentially contaminated the blanket. Lndry/Hskp-A stated she would return the blanket to laundry so it could be washed again. -At 8:44 a.m. R82 remained at the dining table. The mechanical standing lift remained positioned up against the wall. Both the lift and R299's bathroom remained untouched. -At 8:56 a.m. R299 was assisted out of the dining room and off the unit to the therapy department. -At 9:03 a.m. R82 wheeled himself back to his room and positioned himself next to his bed. -At 9:06 a.m. R82 wheeled himself into the shared bathroom, put himself onto the toilet, and shut the door. At this time, NA-B stated he did not know why R299 was on isolation precautions. -At 9:10 a.m. both NA-B and NA-A acknowledged R299 was in contact isolation precautions and stated they had not been informed of any extra precautions to take regarding R229's roommate, R82. Both also stated they had not been directed to clean/disinfect the bathroom or any resident equipment after R299 had used it. When asked about the standing lift, NA-A and NA-B stated the standing lift positioned against the wall was ready and available to be used for any resident. NA-A and NA-B stated there were two other residents on the unit who utilized the same standing lift. At 9:13 a.m. R82 remained in the bathroom. At 9:15 a.m. RN-A stated if a resident was suspected of having [MEDICAL CONDITION], they were to be put on contact isolation precautions which involved placing an infection control bin outside of the room and stocked, isolation precaution signage taped to the room door, and if the resident shared a room, the staff would evaluate to see if the resident required a private room or if the roommate needed to be moved out. If the resident or roommate was not able to move, the staff were to try and not cross contaminate. RN-A stated R299 had recently returned from the hospital with a physician's orders [REDACTED]. The ordering physician had been contacted in order to obtain the script, however, the physician did not respond. Therefore, on [DATE], RN-A asked the rounding nurse practitioner (NP) to review the order, provide a script or to discontinue the order. The NP had asked if R299 had been having diarrhea and RN-A informed her that R299 had dumping syndrome (when food moves too quickly from your stomach which causes symptoms like cramps and diarrhea) and had been having chronic diarrhea for a couple months prior to hospitalization , and R299 had also received a multiple antibiotics while hospitalized . Due to the history of the diarrhea and recent antibiotic use (contributing factors for [MEDICAL CONDITION]), the NP requested R299 be tested in order to rule out [MEDICAL CONDITION] prior to providing a script for the [MEDICATION NAME]. RN-A stated subsequently, R299 was placed on contact isolation precautions for presumed [MEDICAL CONDITION] as he was to be considered to have it ([MEDICAL CONDITION]) until the test results returned. RN-A stated the staff should be disinfecting any equipment used by R299 including the mechanical lift after each use. RN-A verified R299 and R82 shared a room including bathrooms and stated the bathroom was to be disinfected with bleach after R299 used it. RN-A verified the lift was used for other residents on the unit, and stated it should have been disinfected immediately after R299's use. RN-A stated if the State agency had not brought the potential infection control concern to the attention of the staff, the lift would have been used on other residents prior to it having been cleaned/disinfected. -At 9:35 a.m. LPN-A stated a stool sample was ordered at 7:00 p.m. on [DATE], which was when isolation precautions were started. LPN-A stated when there was a change to resident cares such as the implementation of isolation precautions, the nurses would share this information to the oncoming nurse during shift report, but she did not know if the NAs' had also discussed it during their separate shift report. -At 11:25 a.m. RN-A stated he had spoken with the NP and since R299 had not had a bowel movement in a 48 hour period, the [MEDICAL CONDITION] testing was discontinued and the staff were informed that the isolation precautions had been discontinued. -At 12:58 p.m. the DON stated when RN-A had spoken with the NP regarding R299, she was seeking a hard copy prescription for antidiarrheal medication due to R299 having had been on [MEDICATION NAME] when hospitalized . The DON stated they were wondering if they should not have initiated isolation precautions because R299 had been asymptomatic, and the stool sample was just to rule out [MEDICAL CONDITION]. The DON stated R299 had not had any signs or symptoms of [MEDICAL CONDITION], therefore isolation precautions should not have been put into place. The DON stated the nurse manager working on [DATE], thought isolation precautions were warranted because of R299's order for a stool sample testing. The DON stated the order should have been clarified upon receipt, rather than waiting until now to seek clarification. The DON stated when a resident was suspected to have [MEDICAL CONDITION], nursing would go directly to social services so that another room could be found for that resident because residents should not cohort when they have infections requiring isolation. Additionally, the DON stated if a resident scored a seven on the bristel scale (tool used to classify the form of human feces into seven categories) it indicated the resident had had a liquid, watery stool. The DON stated R299 had more mushy, soft stools and not diarrhea consistency stools which was not an indicator of [MEDICAL CONDITION]. The DON stated she did not know when R299 had last had a bowel movement and if a resident had more than three diarrhea type stools in a 24 hour period, they would obtain an order for [REDACTED]. When asked, the DON stated she was uncertain if the staff had been educated on the colonization (the detection of the organism in the absence of symptoms) of [MEDICAL CONDITION]. The DON agreed that if a resident did have [MEDICAL CONDITION], the staff were expected to follow facility policy which included the implementation of isolation precautions. Hand Hygiene/Catheter Care R200 was observed on [DATE], at 3:05 p.m. being assisted to stand from the toilet by NA-L. R200 had had a bowel movement. With gloves on, NA-L assisted R200 to stand, cleansed R200's bottom with wet wipes, pulled up R200's incontinent brief and slacks, grabbed onto R200's transfer belt (which was located around R200's waist), and assisted R200 to sit in her wheelchair. NA-L removed her gloves, wheeled R200 out of the bathroom, positioned her next to the bed, and proceeded to transfer R200 from the wheelchair into the bed using the transfer belt. Fo