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*Protecting, Maintaining and Improving the Health of Minnesotans*

Office of Health Facility Complaints Investigative Report  
PUBLIC

**Facility:**

Grand Village  
923 Hale Lake Pointe  
Grand Rapids, MN 55744  
Itasca County

Report #: H5368013

Date: September 22, 2006

Date of Visit: July 3, 2006  
Time of Visit: 3:00 AM

By: Pat Halverson, R.N.  
Special Investigator

**Nature of Visit:**

An unannounced visit was made in order to investigate the following allegation of neglect in accordance with federal regulations for long term care facilities at 42 CFR Part 483, Subpart B. In conjunction with the federal investigation, an investigation was also conducted in accordance with the Vulnerable Adults Act (VAA), Minn.Stat. 626.557.

**The allegation is:** Resident #1 had been on the sub-acute unit (The Lodge) for fifteen (15) months. Her family was "pressured" to move her to Special Care Unit 2 (SCU2) because there was more staff and she would get better care. She was only on the unit for three days before an unwitnessed fall at 2:00 AM on 5/19/06. SCU2 is insufficiently staffed to provide adequate care. The resident's family member came back to the facility after seeing the resident in the hospital on 5/19/06 to ask how this could happen. There was no staff to be found on SCU2 that night. It took 10 - 15 minutes before anyone could be found. Resident #1 had alarms when she lived in "The Lodge" and probably had them on in SCU2, but there was no staff around to respond to the alarm promptly. The resident had a history of falls and the facility was slow to implement safety measures. At the time of her fall the resident's bed was placed against the wall to give her access to only one side, she had a perimeter mattress and several alarms. The resident fractured her hip when she fell and suffered severe pain until she died on 5/24/06.

**Investigative Findings:**

All employees and persons were interviewed in private as desired and given the Tennessen Statement. During the course of the investigation the following tasks were completed.

- Obtained a list of current residents with room numbers
- Reviewed incident reports filed in May/June 2006.
- Reviewed staffing records for May 15 - 20, 2006 and for July 2 & 3, 2006.
- Reviewed internal investigation into incident.
- Reviewed policies and procedures and staff education records related to:
  - Vulnerable Adults Act, abuse/neglect identification, investigation and reporting.
  - Falls prevention, assessment, monitoring

- Admission/demission criteria for SCU2

**Observations** completed in SCU2, between 3:00 and 5:00 AM on 7/3/06, verified that two resident auditory alarms were not audible from the nurse's station or from other wings of the unit. SCU2 has three separate resident living areas, each with five (5) resident rooms on each side of a common area and a capacity for 16 residents. The three units are identified as pink wing, blue wing and green wing, and they share a central nurses station and dining room. Each wing has a door that can be closed to separate it from the nurse's station/dining room area and the corridor leading to the rest of the building.

**Medical record review:**

- The resident was admitted to "The Lodge" area of the facility on 4/28/06 with diagnoses that included Dementia, sleep disturbance and osteoporosis with compression fractures. She had a history of previous falls in the facility. Her falls prevention plan dated 5/4/06 after a fall, included staff assistance for transfers and ambulation; wheelchair for distance; bilateral 1/4 side-rails on her bed; toileting every two hours; motion sensor at the end of her bed; whisper monitor (sound monitor in her room with a speaker at nurse's station to alert staff when she got out of bed); a perimeter mattress on her bed and leaving the light on in her bathroom during the night.
- According to social service notes on 5/12/06, the resident would be moved from "The Lodge" to SCU2 on 5/15/06 for "closer observation" related to increased confusion, wandering and falls.
- Nursing notes at 2:15 AM on 5/19/06 indicated that resident #1 was found on the floor, near the door of the pink wing of Special Care Unit 2 (SCU2), having sustained a fractured right hip.
- She was provided appropriate assessment and treatment and sent to the hospital by ambulance.
- Following surgery she was agitated, confused and her pain was difficult to control. She became minimally responsive and unable to accept oral intake.
- She returned to the facility with hospice comfort care on 5/23/06 and died on 5/24/06.

**Interviews:**

Employee (C), licensed nurse, interviewed in person at 6:50 AM on 7/3/06, stated the following:

- Resident #1 was sleeping (time unknown) on 5/19/06 when last seen before her fall.
- Employee (C) was called away from the nurses station (in the center of three resident care wings) to attend residents in the blue wing.
- She was unsure how long she was away from the nurse's station and when she returned at approximately 2:15 AM she heard resident #1 calling for help.
- Resident #1 was lying on her back near the corridor door of the pink wing. She had been walking around before she fell because her wastebasket was found near the door of another resident room. The resident's motion sensor and personal alarm were sounding and the Whisper auditory monitor was functional; however, there was no one in the pink wing or at the nurse's station to hear the alarms before the resident fell.
- There were usually two nursing assistants (NA/R) s and one licensed nurse assigned for the night shift with an additional "float" NA/R to cover staff breaks in all of the units. On 5/19/06 there were two NA/Rs but no float to cover breaks. When resident #1 fell, one NA/R was out of the unit to cover staff breaks in another part of the building, leaving just one NA/R (no longer employed by the facility) and employee (C) for all three wings.

Employee (D), (NA/R), interviewed in person at 6:30 AM on 7/3/06, stated the following:

- Resident alarms are not loud enough to be heard from one unit to another. Many residents in SCU2 require two staff for incontinence care and repositioning during the night. Alarms cannot

be heard when staff are inside resident rooms with the doors closed while providing personal care.

- She was covering staff breaks on another unit when resident #1 fell on 5/19/06.

**Conclusion: Neglect did occur** when resident #1 fell and fractured her hip on 5/19/06. The resident had a history of falls and had several functional alarms to notify staff if she got up without assistance. She was moved into SCU2 because she required more supervision than was available in "The Lodge". On 5/19/06 there was no one in the area to hear the alarms that sounded while she walked around in the unit and fell.

As a result of this investigation the following federal deficiency is issued:

CFR 483.25(h)(2) F324 Accidents

The corresponding state licensing order is issued:

MN Rule 4658.0520 subpart 1

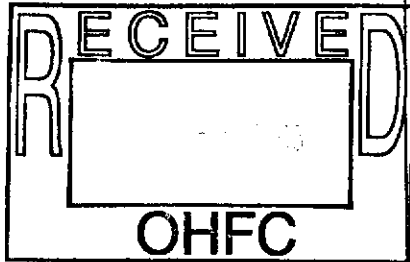
The "mitigating factors" in Minnesota Statute 626.557, Subdivision 9c (c) were considered and it was determined that the facility is responsible for the neglect. The facility will be notified of the right to request reconsideration and/or appeal the maltreatment finding.

xc: Division of Compliance Monitoring - Licensing & Certification  
Board of Nursing  
Board of Nursing Home Administrators  
Itasca County Medical Examiner  
Grand Rapids City Police Department  
Itasca County Attorney  
Grand Rapids City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245368	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/03/2006
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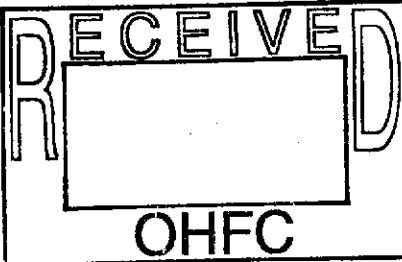
NAME OF PROVIDER OR SUPPLIER  GRAND VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>A standard abbreviated survey was conducted to investigate H5368013. The following deficiency is issued:</p>	F 000		
F 324 SS=G	<p><b>483.25(h)(2) ACCIDENTS</b></p> <p>The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review and staff interviews the facility failed to provide supervision and/or alarms loud enough to be heard in time to prevent falls for resident #1. Findings included:</p> <p>Nursing notes at 2:15 AM on 5/19/06 indicated that resident #1 was found on the floor, near the door of the Pink Wing of Special Care Unit 2 (SCU2), having sustained a fractured right hip. Her personal alarms were sounding but not loud enough to be heard from the Blue Unit where both available nursing staff were providing care for another resident. The resident was provided appropriate assessment and treatment and sent to the hospital by ambulance. She was admitted for surgical repair of a right hip fracture. Following surgery she was agitated, confused and her pain was difficult to control. She became minimally responsive and unable to accept oral intake. She returned to the facility with hospice comfort care at 5:30 PM on 5/23/06 and died at 2:42 AM on 5/24/06.</p>	F 324		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Don Engle</i> <i>in Don</i>	TITLE	(X6) DATE 9/1/06
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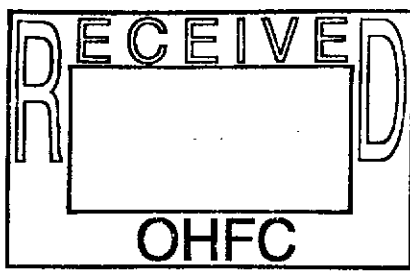
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245368	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/03/2006
NAME OF PROVIDER OR SUPPLIER  GRAND VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 823 HALE LAKE POINTE GRAND RAPIDS, MN 55744	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 324	<p>Continued From page 1 <i>4/28/05</i></p> <p>The resident was admitted to "The Lodge" area of the facility on <i>4/28/06</i> with diagnoses that included dementia, sleep disturbance and osteoporosis with compression fractures. She had a history of previous falls in the facility. According to social service notes on 5/12/06, the resident would be moved from "The Lodge" to SCU2 on 5/15/06 for "closer observation" related to increased confusion, wandering and falls. Her falls prevention plan revised on 5/4/06 after a fall in "The Lodge", included staff assistance for transfers and ambulation; wheelchair for distance; bilateral 1/4 siderails on her bed; toileting every two hours; personal alarm in bed and wheelchair; motion sensor at the end of her bed; Whisper Monitor (sound monitor in her room with a speaker at nurses station to alert staff when she got out of bed); a perimeter mattress on her bed and leaving the light on in her bathroom during the night.</p> <p>Employee (C), licensed nurse, interviewed in person at 6:50 AM on 7/3/06, stated that the resident was sleeping (time unknown) in her room on the Pink Wing on 5/19/06 when last seen prior to her fall. Employee (C) was called away from the nurses station (in the center of three resident care units) to assist with residents in the Blue Wing that required two staff for care. She was unsure how long she was away from the nurses station but when she returned at approximately 2:00 AM she heard resident #1 calling for help. Resident #1 was lying on her back near the corridor door of the Pink Wing. Employee (C) called for assistance and the resident was sent to the emergency department for care of her fractured hip.</p>	F 324	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245368	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/03/2006
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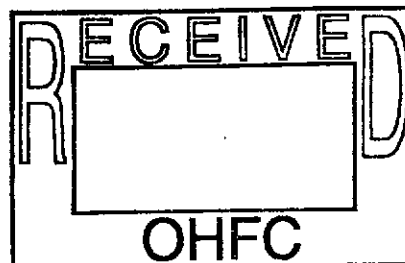
NAME OF PROVIDER OR SUPPLIER  GRAND VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 823 HALE LAKE POINTE GRAND RAPIDS, MN 55744
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F 324	<p>Continued From page 2</p> <p>Employee (C) stated that the resident's motion sensor and personal alarms were sounding and the auditory monitor at the nurse's station was functional but there were no staff at the nurse's station or in the Pink Wing to hear the alarms or the auditory monitor before the resident fell. She did not know how long resident #1 was walking around in the Pink Wing but she left her waste basket near another resident's room on the opposite side of the common area. There were usually two nursing assistants and one licensed nurse assigned for the night shift with an additional "float" nursing assistant to cover staff breaks in all of the units. On 5/19/06 there were two nursing assistants but no float to cover breaks. When resident #1 fell, one nursing assistant was out of the unit to cover a staff break in another part of the building, leaving just one nursing assistant (no longer employed by the facility) and employee (C) for all three wings (forty-eight (48) residents) of SCU2.</p> <p>SCU2 has three separate resident living areas, each with five (5) resident rooms on each side of a common area and a capacity for 16 residents. The three units are identified as Pink Wing, Blue Wing and Green Wing; and they share a central nurses station and dining room. Each wing has a door that can be closed to separate it from the nurses station/dining room area and the corridor leading to the rest of the building. During observations green wing between 3:00 and 5:00 AM on 7/3/06, it was noted that several resident personal alarms could not be heard at the nurses station. At 4:00 AM, a resident was up and dressed and walking around in his room. His personal alarm was sounding but not loud enough to be heard from the corridor door or</p>	F 324		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

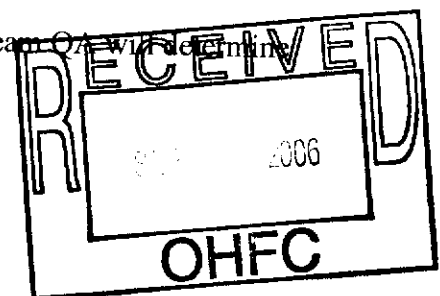
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NAME OF PROVIDER OR SUPPLIER  GRAND VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 823 HALE LAKE POINTE GRAND RAPIDS, MN 55744	
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F 324	Continued From page 3 from the nurses station. Staff passing the room to go outside for a break heard the alarm and responded. At 5:00 AM a second personal alarm was audible from the center area of the Green Unit but not at the nurses station. Interview with employee (A), director of nurses (DON), at 2:30 PM on 8/3/06, verified that resident personal alarms lost volume when the batteries were low and at times were not audible.  Employee (D), nursing assistant (NA/R), interviewed in person at 6:30 AM on 7/3/06, stated that most resident alarms are not loud enough to be heard from one unit to another. Many residents in SCU2 require two staff for incontinence care and repositioning at night. Resident personal alarms can not be heard when staff are inside resident rooms with the doors closed while providing personal care.	F 324  -7 date?		



## Plan of Correction for F 324 Accidents

This facility disputes the factual information cited in F 324. This facility is requesting an Informal Dispute Resolution regarding this deficiency. The IDR was requested via web site on 8/30/06 by Leah Erickson RN DON. However in good faith and as required by law, the following plan of correction is submitted.

1. Corrective Action
  - a. Res #1 was treated and sent to hospital for care.
  - b. The two alarms which Inspector felt she was having a difficult time hearing were changed out.
2. Corrective Action as it applies to other residents
  - a. All staff in-service on week Sept 5th reminding staff of current facility policy. Reviewed with staff supervision of residents with alarms on all shifts.
  - b. Current Fall Policy and program reviewed with Risk Management Officer and DON ~~8/5/06~~ 9/5/06 KL
  - c. Midnight time management sheets will be reviewed at the RN meeting on ~~8/5/06~~ 9/5/06 KL to ensure time management allows for supervision. Changes in treatments or duties to ensure adequate supervision.
  - d. Walkie-talkie that staff carry at night will be on same frequency to get assist as needed from other areas or supervisor.
  - e. Eve/MN Nurse Manager will continue to adjust staff as needed by each unit.
3. Date of compliance 09/18/06
4. Reoccurrence will be prevented by
  - a. Audits currently in place for three times week check for monitor compliance will continue by Eve/MN Supervisor.
  - b. Rehab Nursing will audit 10 residents per month for sound of monitor, correct application and plan of care. *each KL*
  - c. Nursing staff will check monitor for tone quality with <sup>each</sup> application. Report or change battery on weak sounding alarm. Batteries are kept in the Med carts to be available to staff.
  - d. Eve/MN Nurse Manager will audit for compliance with nursing staff being available to answer alarms and being available to hear other alarms. This audit will be weekly on each unit. *This will be done based on QA recommendations. KL*
5. The correction will be monitored by
  - a. Audits will be presented to DON for review.
  - b. DON will report findings of audits to Quality Assurance team *QA will determine* further frequency of audits. *QA meets monthly*
  - c. DON will be responsible for compliance.

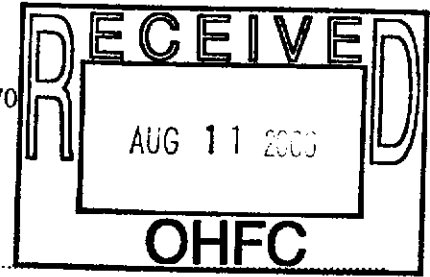


*Yrs-Spoke to Leah Erickson, DON re: PoC -  
Changes made  
Kris Spoke*

CERTIFIED MAIL #: 7005 0390 0006 1221 2710

**FROM:** Minnesota Department of Health, Division of Compliance Monitoring  
85 East Seventh Place, Suite 300, P.O. Box 64970, St. Paul, Minnesota 55164-0970  
Office of Health Facility Complaints

*Arnold Rosenthal*  
Arnold Rosenthal, Director



**TO** Jacob Goering **DATE** July 27, 2006

**PROVIDER** Grand Village **COUNTY** Itasca

**ADDRESS** 923 Hale Lake Pointe, Grand Rapids, MN 55744

On July 27, 2006 an investigator with the Office of Health Facility Complaints completed a complaint investigation, which began on May 17, 2006. The following correction orders are issued. When corrections are completed please sign and date, make a copy of the form for your records and return the original to the above address.

Signed: Jacob Goering

Date: 9 August 2006

In accordance with Minnesota Stat. section 144.653 or Minnesota Stat. section 144A.10, this correction order has been issued pursuant to a complaint investigation. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s) listed below, a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited violation. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the violation within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Office of Health Facility Complaints within 15 days of receipt of a notice of assessment for non-compliance.

#### **MN Rule 4658.1415 Subpart 7**

Based on observation, interview and record review the facility failed to ensure that hot water in resident care areas of "The Lodge" was maintained at safe temperatures. Findings included:

Facility documents indicated that the cleaning valve in the bathtub had been installed without a mixing valve to control the water temperature. Further investigation indicated that the bathtub cleaning valve and a soiled utility room sink in "The Lodge" had water temperatures as high as 155 degrees Fahrenheit. According to a "U.S. Consumer Product Safety Commission" memo dated 4/11/1975, damage to skin is instantaneous at temperatures of 150 degrees Fahrenheit and above. Observation of "The Lodge" indicated that the soiled utility room was not locked and that the sink was accessible to residents. Employee (F), Director of Risk Management, interviewed in person at 10:25 AM on 5/18/06, stated that the bathtub had been in use for approximately two (2) years since "The Lodge" opened. He stated that no one in the facility knew that hot water was plumbed into the bathtub-cleaning valve and soiled utility room sink until a resident was accidentally burned. The bathtub was taken out of service until it was re-plumbed with cold water into the cleaning valve. He stated that the hot water supply in a soiled utility room in "The Lodge" remained excessively hot; however, staff was able to adjust the water temperature to prevent scalding. He verified that the soiled utility room was unlocked and accessible to residents in "The Lodge."

**TO COMPLY:** Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to 115 degrees Fahrenheit at the fixtures.

**SUGGESTED METHOD OF CORRECTION:** The facility could review and revise policies and procedures related to water temperatures in resident care areas. They could test each water supply source to ensure that hot water temperatures were within the appropriate range. They could provide inservice for all staff regarding the risk of scalding from hot water. They could establish monitoring systems to ensure that water

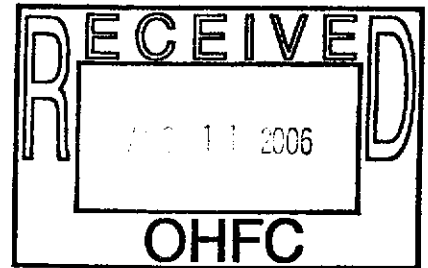
**Minnesota Department of Health, Health Policy, Information and Compliance Monitoring Division  
85 East Seventh Place, Suite 300, P.O. Box 64970, St. Paul, Minnesota 55164-0970**

Orders to Grand Village

temperatures are maintained within safe limits.

**TIME PERIOD FOR CORRECTION:** One (1) day.

xc: Division of Compliance Monitoring - Licensing & Certification  
State and County Departments of Welfare, Attn: Medical Assistance Program



**Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

<b>(Y1) Provider / Supplier / CLIA / Identification Number</b> 245368	<b>(Y2) Multiple Construction</b> A. Building _____ B. Wing _____	<b>(Y3) Date of Revisit</b> 9/26/2006
<b>Name of Facility</b> GRAND VILLAGE	<b>Street Address, City, State, Zip Code</b> 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0324</u> Reg. # <u>483.25(h)(2)</u> LSC _____	Correction Completed 09/18/2006	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
State Agency _____				
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO _____				

Followup to Survey Completed on: 8/3/2006	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right; margin-left: 20px;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		



*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7005 0390 0006 1221 3038

August 22, 2006

Mr. Jacob Goering, Administrator  
Grand Village  
923 Hale Lake Pointe  
Grand Rapids, MN 55744

RE: Project Number H5368013

Dear Mr. Goering:

On August 3, 2006, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

**No Opportunity to Correct** - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

**Remedies** - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

**Plan of Correction** - when a plan of correction will be due and the information to be contained in that document;

**Potential Consequences** - the consequences of not attaining substantial compliance 6 months after the survey date; and

**Informal Dispute Resolution** - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

## DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Sue Jackson, Assistant Director  
Office of Health Facility Complaints  
Division of Compliance Monitoring  
85 East Seventh Place, Suite 300  
P.O. Box 64970  
St. Paul, MN 55164-0970  
Telephone: (651) 201-4210 Fax: (651) 201-4202

## NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when they have deficiencies of actual harm or above cited at the current survey, and on the previous standard or intervening survey (i.e. any survey between the current survey and the last standard survey). A level G deficiency (isolated deficiencies that constituted actual harm that was not immediate jeopardy) whereby significant corrections were required was issued pursuant to a revisit completed on March 14, 2006. The current survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G). Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective August 27, 2006. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Per instance civil money penalty of \$1500.00 for the deficiency cited at F324, effective August 3, 2006, for a total penalty of \$1500.00. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

## PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

#### **PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above.

#### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the

Grand Village  
August 22, 2006  
Page 4

approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

### **FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY**

If substantial compliance with the regulations is not verified by October 27, 2006 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 27, 2007 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

### **INFORMAL DISPUTE RESOLUTION**

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process  
Minnesota Department of Health  
Division of Compliance Monitoring  
P.O. Box 64900  
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: [http://www.health.state.mn.us/divs/fpc/profinfo/lc/lc\\_idr.cfm](http://www.health.state.mn.us/divs/fpc/profinfo/lc/lc_idr.cfm)

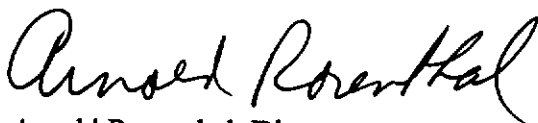
You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm>

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Grand Village  
August 22, 2006  
Page 5

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Arnold Rosenthal".

Arnold Rosenthal, Director  
Office of Health Facility Complaints  
Division of Compliance Monitoring  
85 E. 7th Place, Suite #300  
P.O. Box 64970  
St. Paul, MN 55164-0970  
Telephone: (651) 201-4221 Fax: (651) 201-4202

Enclosure

cc: Licensing and Certification File

**Certified Mail**

Certified Mail #: 7005 0390 0006 1221 3038

Facility: Grand Village

Project #: H5368013

Date mailed 8-22-06

Date faxed \_\_\_\_\_

- Cover letter
- 2567
- Correction orders
- Report
- Assessment letter
- Total notice of assessment
- Subpoena, cover letter and Tennessee

Sent to:

\_\_\_\_\_ Complainant

Facility

\_\_\_\_\_ Other

**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Jacob Goering, Administrator  
Grand Village  
923 Hale Lake Pointe  
Grand Rapids, MN 55744

OHFC      JR

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature  
X *[Signature]*  Agent  Addressee

B. Received by (Printed Name)  
MEVAN ARNAM

C. Date of Delivery  
8/24/06

D. Is delivery address different from item 1?  Yes  No  
If YES, enter delivery address below:

3. Service Type  
 Certified Mail     Express Mail  
 Registered         Return Receipt for Merchandise  
 Insured Mail        C.O.D.

4. Restricted Delivery? (Extra Fee)     Yes

2. Article Number (Transfer from service label)    7005 0390 0006 1221 3038

PS Form 3811, February 2004    Domestic Return Receipt    102595-02-M-1540

**Certified Mail**

Certified Mail #:

Facility:

Project #:

Date sent

Date faxed

- Cover letter
- 2567
- Correction orders
- Report
- Assessment letter
- Total notice of assessment
- Subpoena, cover letter and Tennessee

Sent to:

\_\_\_\_\_ Complainant

\_\_\_\_\_ Facility

\_\_\_\_\_ Other



Protecting, Maintaining and Improving the Health of Minnesotans

September 13, 2006

Mr. Jacob Goering, Administrator  
Grand Village  
923 Hale Lake Pointe  
Grand Rapids, MN 55744

RE: Project Number H5368013

Dear Mr. Goering:

On August 3, 2006, a abbreviated standard survey was completed at your facility. You have alleged that the deficiencies cited on that abbreviated standard survey by the Minnesota Department of Health (F tags) have been corrected. We are accepting your plan of correction and presume that your facility will achieve substantial compliance.

We will be conducting a revisit of your facility to verify that substantial compliance has been achieved and maintained.

Sincerely,

A handwritten signature in cursive script, appearing to read "Sue Jackson", is written over a horizontal line.

Sue Jackson, Assistant Director  
Office of Health Facility Complaints  
Division of Compliance Monitoring  
85 East Seventh Place, Suite 300  
P.O. Box 64970  
St. Paul, MN 55164-0970  
Telephone: (651) 201-4210 Fax: (651) 201-4202

POCA HEALTH

SURVEY.ORG

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General Information: (651) 201-5000 • TDD/TTY: (651) 201-5797 • Minnesota Relay Service: (800) 627-3529 •  
[www.health.state.mn.us](http://www.health.state.mn.us)

For directions to any of the MDH locations, call (651) 201-5000 • An Equal Opportunity Employer



*Protecting, Maintaining and Improving the Health of Minnesotans*

August 31, 2006

Leah Erickson  
Grand Village  
923 Hale Lake Pointe  
Grand Rapids, MN 55744

Provider Number 245368

Dear Ms. Erickson:

This letter acknowledges receipt of your request for Informal Dispute Resolution (IDR) of the deficiency issued at a recent Minnesota Department of Health survey of your facility.

It is my understanding that you are contesting the validity of the following:

F0324 - G

The item in dispute will not be entered into the OSCAR database until a final decision has been made.

I have assigned the responsibility for the IDR to Brenda Fischer of our staff. Ms. Fischer will contact you regarding the scheduling of the conference call or feel free to contact her at 320-650-1072.

Sincerely,

A handwritten signature in cursive script that reads "Mary Absolon".

Mary Absolon, Program Manager  
Division of Compliance Monitoring  
P.O. Box 64900  
St. Paul, Minnesota 55164-0900  
Telephone: (651) 201-4100 FAX: (651) 201-4101

Cc: Ombudsman for Older Minnesotans  
Arnie Rosenthal, Director  
Brenda Fischer, Unit Supervisor  
Julie Raymond  
L&C File



*Protecting, Maintaining and Improving the Health of Minnesotans*

October 6, 2006

Mr. Jacob Goering, Administrator  
Grand Village  
923 Hale Lake Pointe  
Grand Rapids, MN 55744

RE: Project Number H5368011 and H5368013

Dear Mr.. Goering:

On August 22, 2006, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective August 27, 2006. (42 CFR 488.422)

In addition, we informed you that we were recommending the following remedy to the CMS Region V Office for imposition:

- Per instance civil money penalty of \$1500.00 for the deficiency cited at F324, effective August 3, 2006, for a total penalty of \$1500.00. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard abbreviated survey completed on August 3, 2006. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On September 26, 2006, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to two standard abbreviated surveys, completed on July 27, 2006 and August 3, 2006. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 18, 2006. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our two standard abbreviated surveys, completed on July 27, 2006, and August 3, 2006, as of September 18, 2006.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 18, 2006.

In addition, this Department is recommending to the CMS Region V Office the following actions related to the imposed remedy:

- Per instance civil money penalty of \$1500.00 for the deficiency cited at F324, effective August 3, 2006, for a total penalty of \$1500.00 will remain in effect. (42 CFR 488.430 through 488.444)

Grand Village  
October 2, 2006  
Page 2

• Mandatory denial of payment for new Medicare and Medicaid admissions effective October 27, 2006 be discontinued as of September 18, 2006. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,



Arnold Rosenthal, Director  
Office of Health Facility Complaints  
Division of Compliance Monitoring  
85 E. 7th Place, Suite #220  
P.O. Box 64970  
St. Paul, MN 55164-0970  
Telephone: (651) 201-4221 Fax: (651) 201-4202

Enclosure

cc: Licensing and Certification File



*Protecting, Maintaining and Improving the Health of Minnesotans*

Post Correction Order Follow-Up/Federal Certification Review Report  
PUBLIC DATA

Facility:

Grand Village  
923 Hale Lake Pointe  
Grand Rapids, MN 55744  
Itasca County

Report #: H5368013

Date: September 18, 2006

Date of Visit: September 26, 2006

Time of Visit: 4:00p.m.

By: Pat Halverson, R.N.  
Special Investigator

Nature of Visit

An unannounced visit was made in order to follow-up one federal deficiency and one state licensing order which were issued on August 22, 2006, as the result of an investigation which had been completed on August 3, 2006.

The status of the order is as follow:

1. MN Rule 4658.1415 Subpart 7 - Corrected

See Attached 2567B for status of federal deficiency.

xc: Minnesota Department of Health -Licensing & Certification Division



*Protecting, Maintaining and Improving the Health of Minnesotans*

October 25, 2006

Leah Erickson, DON  
Grand Village  
923 Hale Lake Pointe  
Grand Rapids, MN 55744

Dear Ms. Erickson:

This is in response to your request for an informal dispute resolution (IDR) pursuant to Minnesota Department of Health compliant investigation report completed on August 3, 2006 for the federal deficiency F324 with scope and severity of G (actual harm) and state licensing order Minnesota Rule 4658.0520 subpart 1. In your request you indicated that a telephone interview was to be conducted as part of the IDR.

The telephone conference call was completed on 10-6-06 at 2:03 PM with Jake Goering, Administrator; Leah Erickson, DON; Shelly Mathis, Ecumen consultant; Vernice Berg and Brenda Fischer from the Minnesota Department of Health attending.

The additional information submitted by you, information from the telephone call on 10-6-06 at 2:03 PM, and surveyor's documentation has been carefully reviewed and the following determination has been made:

**F324CFR 483.25 (h) (2) Accidents: The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.**

**Minnesota Rule 4658.0520 Subpart 1. A resident must receive nursing care and treatment, personal and custodial care and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405.**

The deficiency was issued at a scope and severity of a "G" level which was actual harm, but not immediate jeopardy.

The Minimum Data Set for resident #1 dated 5-5-06, identified that the resident needed extensive assistance for one person physical assist in the area of transfer (G 1 b) and also needed physical assistance with ambulation. The current care plan dated May 2006 identified the problem of "impaired physical mobility r/t weakness and back discomfort." The interventions being: "transfer with assist of one and transfer belt... ambulate with restorative nursing and TB (transfer belt) with FWW (front wheeled walker). At times of increased weakness uses w/c (wheelchair)." The May 1, 2006 Restorative Charting Record identified that the resident ambulated anywhere from 100-150 feet with staff assistance.

The facility's Resident Fall/Incident Report, Weekly Interdisciplinary Team Fall Review Committee reports and Post Fall/Incident Analysis for the falls of: 1-9-06, 2-5-06, 2-28-06, and 5-3-06 were reviewed. The Post Fall/Incident Analysis from the above falls all indicated that the falls were related to: "Functional Status; impaired mobility, balance" and "Psychological: impaired cognition, judgment/safety awareness deficit..." The current care plan identified the problem of "potential for injury r/t weakness and unsteady gait," the interventions being: "Personal magnetic alarm in bed...also whisper alarm used when resident is in room...motion sensor alarm in bed at foot." The facility stated that the resident was "spry" and would only take "seconds ambulate 31 feet," on the night

of the fall. However the MDS and care plan information indicated the resident required extensive physical assistance to transfer and ambulate.

Resident #1 resided on the Pink Wing in SCU2. SCU2 has three separate resident living areas, each with five (5) resident rooms on each side of a common area and a capacity for 16 residents. The three units are identified as Pink Wing, Blue Wing and Green Wing; and they share a central nurse's station and dining room area. Each wing has a door that can be closed to separate it from the nurses station/dining room area and the corridor leading to the rest of the building. On the night of the incident on 5/19/06 resident #1 was found on the floor, near the entrance door of the Pink Wing of Special Care Unit 2 (SCU2). There were three (3) staff for 48 residents on the SCU2 unit. However, there was one staff off the floor on break during the time the resident fell and there were only two (2) staff in the area for 48 residents. Both of these staff were assisting another resident (in the Blue Unit, which was across from the Pink Unit) from the bathroom and were unable to hear resident #1 three (3) alarms sounding. Once the LPN opened the other resident door she heard resident #1 yelling and the alarms sounding. All three (3) of these alarms were functioning. During this time the resident apparently moved her garbage can from inside her room, took it across the hallway and placed it in front of another resident's door. By the time the LPN responded to the resident yelling and alarms, the resident was found lying on the floor at the entrance of the Pink Wing, indicating that the alarms had been sounding for a length of time. The two (2) staff that were caring for the other resident behind closed doors were unable to hear the alarms and as a result did not respond promptly. Resident #1 fell and sustained a hip fracture on 5-19-06 and died on 5-24-06.

The deficiency and licensing order written at F324 with scope and severity of G (actual harm) and state licensing order Minnesota Rule 4658.0520 subpart 1 will remain valid.

Sincerely,



Brenda Fischer, RN Unit Supervisor  
Division of Compliance and Monitoring  
3400 N First Street, Suite 305  
St. Cloud, MN 56303-4000  
Telephone: (320) 650-1072 Fax: (320) 255-4264

CC: Mary Absolon, Program Manger  
Arnie Rosenthal, OHFC Program Manager  
Sue Jackson, OHFC Supervisor  
Licensing and Certification file  
Ombudsman for Older Minnesotans  
Mayumi Reuvers, L&C