CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL TE SURVEY AGENCY	ID: 0DDK Facility ID: 00762
MEDICARE/MEDICAID PROVIDER (L1) 245579 2.STATE VENDOR OR MEDICAID NO. (L2) 030525100 5. EFFECTIVE DATE CHANGE OF OW (L9)	NO.	3. NAME AND AE (L3) ESSENTIA 1 (L4) 116 WEST S (L5) GRACEVIL 7. PROVIDER/SU 01 Hospital	DDRESS OF FACI HEALTH GRA SECOND STRE LE, MN	LITY CE HOME ET		4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 07/01 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 0 Unaccredited 1 Other 3 Other	/2019 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOW: 18 SNF 18/19 SNF 40 (L37) (L38) 16. STATE SURVEY AGENCY REMAR	19 SNF (L39)	Complian 1 B. Not in Co Requirements ICF (L42)	nce With Requirements ce Based On: Acceptable POC mpliance with Prog and/or Applied Wa IID (L43)	gram livers:	And/Or Approved Waivers Of T2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SN5. Life Safety Code * Code: A 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director
17. SURVEYOR SIGNATURE		Date :	07/08/2019	,	18. STATE SURVEY AGENCY	07/00/2010
				(L19)	Joanne Simon, Enforcem	· (L20)
19. DETERMINATION OF ELIGIBILITY X 1. Facility is Eligible to Pau 2. Facility is not Eligible	7	20. COM	APLIANCE WITH GHTS ACT:		21. 1. Statement of Fina	uncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 07/08/1991 (L24) 25. LTC EXTENSION DATE: (L27)	23. LTC AGREEN BEGINNING (L41) 27. ALTERNATI A. Suspensio B. Rescind Sur	DATE VE SANCTIONS n of Admissions:	4. LTC AGREEN ENDING DA1 (L25) (L44)		26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>0</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursen 03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	··· - ··· ··· ··· ··· ··· ···
			(L45)			
28. TERMINATION DATE:	(L28)	0. INTERMEDIARY/0 03001	UARRIER NO.	(L31)	30. REMARKS	
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION	OF APPROVAL D	DATE (L33)	DETERMINATION APPI	ROVAL



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245579

July 8, 2019

Administrator Essentia Health Grace Home 116 West Second Street Graceville, MN 56240

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 25, 2019 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered July 8, 2019

Administrator Essentia Health Grace Home 116 West Second Street Graceville, MN 56240

RE: Project Number S5579030

Dear Administrator:

On June 5, 2019, we informed you that the following enforcement remedy was being imposed:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 4, 2019.

Also on June 5, 2019, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) the following enforcement remedy:

• Civil money penalty. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on May 16, 2019. 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 July 1, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 24, 2019 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 16, 2019. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 25, 2019. We have determined, based on our visit that your facility has corrected as of June 25, 2019.

As a result of the revisit findings:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August
- 4, 2019 be rescinded as of June 25, 2019. (42 CFR 488.417 (b))

In our letter of June 5, 2019, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 4, 2019 due to denial of payment for new admissions. Since your facility attained substantial compliance on June

25, 2019, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded however, this does not apply to or affect any previously imposed NATCEP loss.

In addition, this Department recommended to the CMS Region V Office the following the remedies:

• Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, 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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 8, 2019

Administrator Essentia Health Grace Home 116 West Second Street Graceville, MN 56240

Re: Reinspection Results - Project Number S5579030

Dear Administrator:

On July 1, 2019 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 16, 2019. At this time these correction orders were found corrected.

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.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVIC	DEPARTMEN	OF HEALTH	AND HUMAN	SERVICES
---------------------------------------	-----------	-----------	-----------	----------

						AND TRANSMITTA			ID: 0DDK Facility ID: 00	762
1. MEDICARE/MEDICA (L1) 245579 2.STATE VENDOR OR M (L2) 030525100 5. EFFECTIVE DATE CF	EDICAID NO.	SHIP	 NAME AND AD (L3) ESSENTIA I (L4) 116 WEST S (L5) GRACEVILI PROVIDER/SUI 	HEALTH GRA ECOND STRE LE, MN	CE HOME ET	(L6) 5624()	 TYPE OF ACTION Initial Termination Validation On-Site Visit 	N: <u>2</u> (L8) 2. Recerti 4. CHOW 6. Compl 9. Other	1
(L9)			01 Hospital	05 HHA	09 ESRD		CLIA	8. Full Survey After (Complaint	
 DATE OF SURVEY ACCREDITATION ST 0 Unaccredited 2 AOA 	05/16/2019 ATUS: 1 TJC 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDIN 09/30	G DATE:	(L35)
 11LTC PERIOD OF CEF From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 		40 (L18) 40 (L17)	Compliand 1. 4 X B. Not in Cor	nce With Requirements ce Based On: Acceptable POC	gram	And/Or Approved Wai 2. Technical H 3. 24 Hour R1 4. 7-Day RN 5. Life Safety * Code: B *	Personnel N (Rural SNF) Code	Following Requirements: 6. Scope of Se 7. Medical Dir 8. Patient Roo 9. Beds/Room (L12)	rvices Limit rector m Size	
 LTC CERTIFIED BEI 18 SNF (L37) 	D BREAKDOWN 18/19 SNF 40 (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j		(L15)		
16. STATE SURVEY AG):					
17. SURVEYOR SIGNAT		NE II	Date :	06/25/2019		18. STATE SURVEY			Date: 06/2	6/2019

PART II - TO BE COMPLETED BY HCFA REGION	AL OFFICE OR SINGLE STATE AGENCY
--	----------------------------------

(L19)

Joanne Simon. Enforcement Specialist

 DETERMINATION OF ELIGIBIL <u>X</u> 1. Facility is Eligible to 		20. COMPLIANCE WITH CIVIL RIGHTS ACT:	 Statement of Financial Solve Ownership/Control Interest I Both of the Above : 	
2. Facility is not Eligib	le (L21)		—	
22. ORIGINAL DATE OF PARTICIPATION 07/08/1991 (L24) 25. LTC EXTENSION DATE: (L27)	 23. LTC AGREEMENT BEGINNING DATE (L41) 27. ALTERNATIVE SANCTI A. Suspension of Admission B. Rescind Suspension Data 	ons: (L44)	26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	(L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active
		(L45)		
28. TERMINATION DATE:	29. INTERM 030	EDIARY/CARRIER NO.	30. REMARKS	
	(L28)	(L31)		
31. RO RECEIPT OF CMS-1539	32. DETERMI	NATION OF APPROVAL DATE		
	(L32)	(L33)	DETERMINATION APPROVAL	

06/26/2019

(L20)



Electronically delivered June 5, 2019

Administrator Essentia Health Grace Home 116 West Second Street Graceville, MN 56240

RE: Project Number S5579030

Dear Administrator:

On May 16, 2019, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety 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 electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy(ies) and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 4, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 4, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 4, 2019.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits

approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 4, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Essentia Health Grace Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 4, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

> Maria King, RN, APM Licensing and Certification Program Health Regulation Division Minnesota Department of Health Mankato Place 12 Civic Center Plaza, Suite 2105 Mankato, Minnesota 56001-7789 Email: maria.king@state.mn.us Phone: (507) 344-2716 Fax: (507) 344-2723

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 November 16, 2019 (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.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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 Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

		AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NC	0. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245579	B. WING _	·····	05	5/16/2019
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	A HEALTH GRACE H	OME		116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
F 000	Emergency Prepare conducted on 5/13/ recertification surve with the Appendix Z Requirements. INITIAL COMMENT	iance with CMS Appendix Z edness Requirements, was 19, to 5/16/19, during a ey. The facility is in compliance Z Emergency Preparedness TS 6/19, a standard survey was	F 00	00		
	completed at your f Department of Hea was in compliance Part 483, Subpart E Term Care Facilities	acility by the Minnesota Ith to determine if your facility with requirements of 42 CFR 3, and Requirements for Long				
F 637 SS=D	as your allegation of Department's accept Upon receipt of an revisit of your facilit validate that substat regulations has been your verification.	of compliance upon the otance. acceptable POC, an on-site y may be conducted to antial compliance with the en attained in accordance with sessment After Signifcant Chg	F 63	37		6/25/19
	determines, or shou there has been a si resident's physical purpose of this sec means a major dec resident's status that itself without further implementing stand interventions, that h	Vithin 14 days after the facility uld have determined, that gnificant change in the or mental condition. (For tion, a "significant change" line or improvement in the at will not normally resolve r intervention by staff or by dard disease-related clinical has an impact on more than				
	ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 06/14/2019
	ically Signed					00/14/2019

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.

PRINTED: 06/25/2019

		& MEDICAID SERVICES			OM		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION ()		SURVEY PLETED
		245579	B. WING _			05/1	6/2019
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENTI	A HEALTH GRACE H	ОМЕ			16 WEST SECOND STREET RACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 637	Continued From pa	ge 1	F 63	37			
		dent's health status, and					
		inary review or revision of the					
	care plan, or both.)	-					
		IT is not met as evidenced					
	by:	and decument review, the			A Significant Change in Status		
		and document review, the plete a Significant Change in			A Significant Change in Status Assessment (SCSA) Minimum Data	Set	
		(SCSA) Minimum Data Set			(MDS) was initiated for the identified		
		more areas of change in			resident R8 on 5/16/19 and documer		
		e noted for 1 of 16 (R8)			in the Electronic Health Record (EHF	R).	
	residents reviewed	for decline in health status.					
					All residents with a change in status	have	
	Findings include:				the potential to be affected by this practice.		
	R8's annual MDS d	ated 8/29/18, indicated R8			The Interdisciplinary Team (IDPT)		
		leart failure, Alzheimer's			reviewed 100% of all current residen	nts	
		anxiety and depression. The			to evaluate for the presence of a		
		nad severe cognitive			significant change. Any resident iden	ntified	
		uired extensive to total			to have a change in two or more area		
		ities of daily living (ADL's),			shall have a SCSA MDS initiated and		
		quired supervision. The MDS			member of the IDPT shall complete a		
		s was frequently incontinent of s continent of bowel, did not			note in the EHR. Results of this audi be reported to the QAPI committee.	t snall	
		xygen, had no pressure ulcers			be reported to the QAFT committee.		
	and had no weight I				The "Change of Condition" policy has	s	
	Ŭ	5			been reviewed and updated. IDPT a		
		dated 2/19/19, indicated R8			nursing Staff education will be provid		
		eart failure, Alzheimer's			at least one of the following means:	1:1	
		anxiety and depression. The			meetings, standups, or scheduled		
		had severe cognitive uired extensive to total			meetings on 6/18/19 and 6/20/19 to include review of the "Change in		
		's, except eating R8 required			Condition" policy and F637.		
		The MDS further indicated R8					
		sure ulcers, no weight loss,			The Interdisciplinary Team shall revie	ew	
	always incontinent of	of bowel and bladder, utilized			100% of all current resident s week	ly x 4,	
	supplemental oxyge				then monthly x 3 months. Any reside		
	mechanically altere	d diet for meals.			identified to have a change in two or		
	Dovious of the object	e assessments indicated R8's			areas shall have a SCSA MDS initiat Results of the audit shall be reported		

Facility ID: 00762

If continuation sheet Page 2 of 41

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CON	IPLETED
		245579	B. WING		05/	16/2019
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	IOME		116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 637	Continued From pa	age 2	F 63	7		
	incontinence patter incontinent to totall totally continent to was newly coded for	rn worsened from frequently ly incontinent of bladder, and totally incontinent of bowel. R8 or supplemental oxygen use y altered diet for meals.		the QAPI committee for further recommendations.		
	Review of R8's pro 5/15/19, revealed t	gress notes from 3/20/19, to he following:				
	the buttocks which nurse planned to a absorbent dressing	noted to have an open area to measured 0.5 inches. The pply Mepilex (a foam g used to treat acute and wounds) after R8 had received				
	reviewed R8's wou identified the woun indicated treatmen ordered and Amme for minor skin irrita the area dry and to identified a ROHO pressure relief) wo wheelchair and sta	rdisciplinary Team (IDT) and to the buttocks and d as shearing. The note further t would be administered as ens powder (a powder utilized tions) would be applied to keep p prevent breakdown. The note cushion (a cushion used for uld be utilized in R8's ff would monitor the wound at at least weekly until healed.				
	R8's right buttock. to moderate amoun noted on the old dr detected. The oper (centimeters) in wir nursing staff furthe surrounded the wo measured which in	ilex dressing was changed on Nursing staff indicated a small nt of tan colored drainage was ressing and no odor was n area measured 2 cm. dth by 2.5 cm. in length. The rr indicated darker pink tissue und and the entire wound icluded the open wound and urk pink tissue 3 cm. The color				

If continuation sheet Page 3 of 41

	-	AND HUMAN SERVICES				FORM	06/25/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245579	B. WING _			05/	16/2019
NAME OF I	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME			SWEST SECOND STREET RACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 637	Continued From pa	ige 3	F 63	37			
	in color and the pro had a 0.25 cm. dark	oximal area of the open wound k red-brown area.					
	Further review of R the following:	8's progress notes revealed					
	significant weight lo lbs.(pounds) (10% had variable intakes identified staff were	entation indicated R8 had a bass in the past 180 days of 21 loss). The note indicated R8 s from 25% - 100%. The note to continue to encourage onitor weights and plan of care nt changes.					
	which was a loss of in 180 days. The n have varying intake The note identified monitor and refer to (RD)-D at the next s	reight was noted to be 185 lbs. f 3.6 % in 30 days and 10.1% note indicated R8 continued to as at meals from 25% to 100%. staff were to continue to b the registered dietician site visit. The note lacked any a pressure ulcer or wound					
	indicated a loss of The note indicated intakes at mealtime were to provide cue need more assistar note indicated staff and refer to the RD	ight was 181.6 lbs. which 19 lbs. in the past 180 days. R8 continued with varying es. The note identified staff eing at mealtimes and R8 may nce with eating. Further, the were to continue to monitor 0-D at the next site visit. The cumentation of a pressure sent on R8.					
	development of pre indicated R8's weig	was notified of weight loss and essure ulcer. The note Jht was 180.4 lbs. which was a %) in 30 days, nine lbs. in 90					

Facility ID: 00762

If continuation sheet Page 4 of 41

	-	AND HUMAN SERVICES			FORM	06/25/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245579	B. WING		05/	16/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	ОМЕ		16 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 637	identified R8 had vare commendation work of ensure at dinner/ additional protein, of were to encourage when able. The RD visit with R8 at the result of the common for all residents and been completed with areas of decline we was unsure whether more areas. NM-A in the electronic head 4/10/19, and confir R8 had a significan confirmed R8 had a significan confirmed R8 had a significan confirmed R8 had a SC (DON) stated a SC (DON) stated a SC completed on R8 work decline had been not experienced weight criteria to complete a pressum which had slough pexperienced weight criteria to complete a information as approximation as approximatin as approximat	 180 days (9%). The note ariable meal intakes and a as made to trial four ounces (supper meals to provide calories and fluid. The staff protein rich foods and fluids -D planned to follow-up and next RD-D site visit. 2 p.m. nurse manager (NM)-A pleted the MDS assessments d a SCSA MDS should have thin 14 days when two or more are noted. NM-A explained she or R8 had a decline in two or reviewed R8's progress note alth record (EHR) from med the progress note stated t weight loss. Further, NM-A a wound present on her right offirmed SCSA MDS had not R8. p.m. the director of nursing SA MDS should have been then two or more areas of oted. DON confirmed R8 had are ulcer to her right buttocks resent and additionally R8 had a loss which would meet a SCSA MDS. 1/19 policy Change in d the care plan and MDS as required with any pertinent 	F 637			

If continuation sheet Page 5 of 41

		AND HUMAN SERVICES			FORM	: 06/25/2019 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245579	B. WING		05/	16/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET		
ESSENT	IA HEALTH GRACE H	IOME		GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 637 F 686 SS=G	10/2018, indicated change as a declin- resident's status of "1. Will not normal intervention by staf disease-related clir is not considered s 2. Impacts more th health status; and 3. Requires interdi- revision of the care The manual further interdisciplinary tea significant change have documented to significant change regarding what con- status must be bas IDT. Further, the massessments are not temporary variation Treatment/Svcs to CFR(s): 483.25(b)(1) \$483.25(b) Skin Int §483.25(b)(1) Pres Based on the comp- resident, the facility (i) A resident receive professional standar pressure ulcers and ulcers unless the in- demonstrates that find (ii) A resident with p	0 User's Manual dated the definition of a significant e or improvement in a which: ly resolve itself without f or by implementing standard nical interventions, the decline elf-limiting, nan one area of the resident's sciplinary review and/or plan." r directed when the im (IDT) determined that a occurred, the facility should the initial identification of the in the EHR. The final decision stituted a significant change in ed upon the judgement of the nanual clarified that MDS ot required for minor or is in the resident status. Prevent/Heal Pressure Ulcer 1)(i)(ii) egrity sure ulcers. orehensive assessment of a	F 6			6/25/19

Facility ID: 00762

If continuation sheet Page 6 of 41

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED	
ND FLAN C	of connection	IDENTIFICATION NONIBER.	A. BUILD	NG		COM		
		245579	B. WING			05/16/2019		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	E		
ESSENT	IA HEALTH GRACE H	OME			16 WEST SECOND STREET GRACEVILLE, MN 56240			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 686	Continued From pa	ige 6	Fe	686				
	promote healing, pr new ulcers from de This REQUIREMEI by: Based on observat review, the facility f identify and monito ulcers for 2 of 2 res observed for press practice resulted in initially had an oper (occurs when layer other or when the s underlying tissue m underlying capillarie tissue damage) ide which worsened to (observed full-thick which the extent of confirmed due to the slough or eschar). Findings include: R8's quarterly Minin 2/19/19, indicated F failure, Alzheimer's and depression. The severe cognitive im extensive to total as living (ADL's) which transfers, dressing, bathing and limited	andards of practice, to revent infection and prevent veloping. NT is not met as evidenced tion, interview and document ailed to accurately assess, r facility acquired pressure sidents (R8, R27) who were ure ulcer care. This deficient actual harm for R8 who n area caused by shearing s of skin rubs against each kin remains stationary and the loves and stretches and tears es and blood vessel causing ntified to the right buttocks an unstageable pressure ulcer ness skin and tissue loss in the damage cannot be ne wound bed obscured with num Data Set (MDS) dated R8 had diagnoses of heart disease, dementia, anxiety ne MDS identified R8 had pairment and required ssistance with activities of daily n included bed mobility, toileting, personal hygiene, assistance with eating. The ted R8 was at risk for			All residents with identified risk for Pressure Ulcers and/or residents w current pressure ulcers have the po- to be affected by this practice. A Braden Scale was completed for of all residents to evaluate pressure risk. Care plans were reviewed and updated, as appropriate for 100% of residents with known risk and/or his skin breakdown. Results of this aud be reported to the QAPI Committee The IDPT will review 100% of all re with pressure ulcers. Any resident identified pressure ulcer was asses and documentation completed in the to include: location, stage, size, exu odor, pain, wound bed, description wound edges and surrounding tissu present pressure ulcers. The revie also include evaluation of nutritional status, notification of the Registered Dietitian (RD) appropriateness of co treatment and interventions. The resident s care plan reviewed and revised as appropriate. Results of audit shall be reported to the QAPI Committee.	tential 100% ulcer f f all story of dit shall story of dit shall e. sidents with an sed te EHR udate, of ue of w will t d urrent		
	pressure ulcers ide following intervention	e ulcers and had no current ntified. The MDS revealed the ons were in place to prevent ich included pressure reducing			Developing a skin care manageme policy and procedure with a defined wound care team.			

Facility ID: 00762

If continuation sheet Page 7 of 41

STATEMENT	OF DEFICIENCIES	KOMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
				ING		
		245579	B. WING			6/2019
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 116 WEST SECOND STREET)E	
ESSENT	IA HEALTH GRACE H	IOME		GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETIC DATE
F 686	Continued From pa	age 7	Fe	86		
	device for chair an program. The MDS loss and received a	d a turning and repositioning 6 identified R8 had no weight a mechanically altered diet for		Facility standing orders wound have been reviewed and update	ated.	
meals. The MDS further identified R8 was frequently incontinent of bladder and always incontinent of bowel.		ent of bladder and always el.		The Nutritional Care and Doci policy has been reviewed and The Certified Dietary Manage enter a note in the EHR when	revised. er(CDM) will	
	9/5/18, indicated R ADL's due to progr	Area Assessment (CAA) dated 8 required assistance with ressing Alzheimer's disease e CAA revealed R8 was at risk		consulting RD has been inforr pressure ulcers. The CDM, or will audit EHR to ensure appr notification to RD and comple	designee opriate	
	for developing pres and the need to be CAA identified R8 the time of the ass	e repositioned by staff. The had no current skin issues at essment. The CAA further at risk for weight and fluid		assessment/review of nutrition RD in EHR monthly x 3 then of Results shall be reported to th committee.	nal status by quarterly X 3.	
	changes due to int CAA further identif due to heart diseas kidney failure, dem	ake and abnormal labs. The ied R8 was at nutritional risk se with heart failure, acute nentia and atrial fibrillation		Staff will receive education by means: 1:1 meetings, standur scheduled meetings on 6/18/1 6/20/19 to review skin, wound	os, 19 and and	
	indicated R8 was t on the commode u transfer, provide th	Ilar heartbeat). The CAA o be toileted three times a day Itilizing the mechanical lift to he bedpan as needed and to ce care as needed.		nutrition policies, F686, and th Pressure Ulcer and Preventio (NPUAP). Education will inclu utilization of EHR for document requirements in accordance w and facility policy.	n Guidelines ude ntation	
	required extensive which included bec	sed 5/14/19, revealed R8 to total assistance with ADL's d mobility, transfers, ng, toileting, personal hygiene		Essentia Health Medical staff education on 6/19/19 related t documentation upon notificati	to need for	
	and bathing. The of supervision with se plan identified R8 I buttock as a result instructed staff to a	care plan indicated R8 required et-up for eating tasks. The care had an open area to her right of shearing. The care plan apply a Mepilex dressing to the		changes in resident status, ar pertinent health information.		
	plan identified R8 I buttock as a result instructed staff to a open area and to c days or more often further instructed s	nad an open area to her right of shearing. The care plan				

If continuation sheet Page 8 of 41

		AND HUMAN SERVICES				FORM	06/25/2019 APPROVED
STATEMENT	TOF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY IPLETED
		245579	B. WING			05/ ⁻	16/2019
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME			16 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	and every three hou care plan indicated breakdown and rep occurred. The care encourage R8 to co as well as consume times. The care pla to use a geo matt (a to aid in prevention ulcers) placed on th cushion (a cushion prevention) with an used in R8's wheeld instructed staff to to the commode utilizi transfer, provide the provide incontinence On 5/14/19, at 1:00 and occupational the placed sling for a m back and looped it seated in the wheel down in bed. Once been applied to the operated the lift to tw wheelchair and low OTA-C guided R8 in and OTA-C turned removed an inconti dressing was noted area and was intact dark brown drainag cleansed perineal a new brief to R8. NA on the left side and right side to keep R provided call light to	urs when laying in bed. The staff would monitor for skin port to the nurse if breakdown e plan instructed staff to onsume a well balanced diet e all fluids offered at meal an identified the resident was a therapeutic overlay mattress and treatment of pressure he bed and a Vicair Liberty prescribed for pressure ulcer antishear cushion cover to be chair. R8's care plan bilet R8 three times a day on ing the mechanical lift to e bedpan as needed and to	F	586			

Facility ID: 00762

If continuation sheet Page 9 of 41

	-	AND HUMAN SERVICES			FOR	D: 06/25/2019 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) D/	ATE SURVEY OMPLETED
		245579	B. WING _		0	5/16/2019
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE	
ESSENT	IA HEALTH GRACE H	OME		116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Continued From pathygiene after remove On 5/14/19, at 1:58 assessed Mepilex of lower buttocks and sized area of dark by the dressing that was soaked through. RN just been changed she would not be changed she would not be changed she would not be changed on 5/14/19, at 3:30 seated on a pressu wheelchair in the data activity. On 5/15/19, at 7:47 laying in bed on her provided morning c NA-C removed the proceeded to clean NA-C and NA-A post and removed the br perineal cares to her dressing to right low intact with the quart drainage present. A new brief under R8 NA-A, applied the by to side in the bed. N	SC IDENTIFYING INFORMATION) age 9 ving gloves. 3 p.m. registered nurse (RN)-A dressing noted on R8's right noted there was a quarter prown drainage in the center of as visible however had not N-A stated the dressing had the day before and indicated hanging it at that time. 9 p.m. R8 was noted to be re reducing cushion in a ayroom attending a music 7 a.m. R8 was noted to be r back as NA-A and NA-C cares to R8. At 7:50 a.m. front of the soiled brief and use R8's front perineal area. sitioned R8 on the right side rief completely and provided er back side. A Mepilex wer buttocks was noted to be ter sized area of dark brown At 7:56 p.m. NA-C placed a and with assistance from prief while turning R8 from side NA-A and NA-C applied pants		CROSS-REFERENCED TO THE A DEFICIENCY)		DATE
	while turning R8 fro NA-A operated the the wheelchair on to NA-A and NA-C ren R8 in an upright pro wheelchair. NA-A p nightgown, cleanse	r the mechanical lift under R8 om side to side. At 8:01 a.m. lift and NA-C guided R8 into op of the wheelchair cushion. moved the sling and positioned operly aligned position in the roceeded to remove R8's ed chest and applied deodorant At 8:04 a.m. NA-A applied bra				

Facility ID: 00762

If continuation sheet Page 10 of 41

		AND HUMAN SERVICES				FORM	06/25/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245579	B. WING			05/ [.]	16/2019
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME			16 WEST SECOND STREET RACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	elbow which resulte immediately provide bleeding and asked staff. At 8:08 a.m. F assessed the skin t obtain dressings to return. At 8:10 a.m. entered the room al shortly with supplies a.m. NA-A proceed glasses. At 8:16 a.r supplies, applied gli washcloth to the sk DON indicated the r were 5 cm long and proceeded to clean saline and applied t tear after using a co the skin together. D the skin tear and wi wrap. At 8:21 a.m. R8 and brushed he completed hand hy brought R8 to the d On 5/15/19, at 1:21 Control Coordinator R8's room during a buttocks area. RN- the left side. RN-A r from right buttocks had a little bit of dar RN-A stated most of slough present and dark brown area to wound bed. RN-A r indicated the width	nge 10 ratched right arm near R8's ed in a skin tear. NA-A ed pressure to stop the d for assistance from nursing RN-A entered R8's room and tear and stated she would treat the skin tear and would d treat the skin tear and would d director of nursing (DON) nd stated she would return s to treat the skin tear. At 8:14 ed to apply R8's shirt and m. DON returned to room with oves and placed a cold in tear that had bled slightly. measurements of the skin tear d 0.7 cm in width. DON se the wound with normal three steri strips to the skin otton-tip applicator to realign DON placed a dressing over rapped the arm with kling NA-A provided oral cares to r hair. DON and NA-A giene after cares and NA-A lining room for breakfast. p.m. RN-A and Infection r (ICC)-F were both present in dressing change to her right -A and ICC-F positioned R8 on removed old Mepilex dressing and indicated the dressing rk brown drainage present. of the wound bed had yellow additionally had a 0.25 cm the proximal area of the measured the wound and of the wound was 2 cm and bound was 2.5 cm. RN-A	F 6	86			

Facility ID: 00762

If continuation sheet Page 11 of 41

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/25/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245579	B. WING			05 / [.]	16/2019
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	ОМЕ			16 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	wound. RN-A confi worsened since she been no yellow slou when she'd last ass not able to recall the wound. RN-A state wound as a stage to depth of the wound applied clean glove normal saline and a dressing. RN-A ren completed hand hyp had been caused b result staff identified Review of R8's Brad determine risk for p dated 11/19/18, ind developing pressur risk factors: slightly moisture, chairfast, and had a potential shearing. The Brad additional risk facto cardiovascular dise diabetes, and thyro further indicated R8 assistance with bed a mechanical lift for incontinent of bowe Review of R8's Brad indicated R8 was at pressure ulcers due slightly limited sens moist, chairfast, slig problem with friction	bout 0.1 cm depth to the rmed the wound had had seen it last as there had igh present in the wound bed sessed the wound. RN-A was e date she had last seen the d she would classify the wo pressure ulcer due to the and ICC-F concurred. RN-A s, cleansed the wound with upplied a new Mepilex noved her gloves and giene. RN-A stated the wound y friction from a sling and as a d it as an abrasion. den scale (tool used to ressure ulcer development) icated R8 was at risk for e ulcers due to the following limited sensory perception, slightly limited with mobility problem with friction and den scale revealed R8 had the rs which included ase, chronic incontinence, id disease. The Braden 8 required extensive I mobility, required the use of transfers and was always	F	586			

If continuation sheet Page 12 of 41

	-	AND HUMAN SERVICES			FORM	06/25/2019 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245579	B. WING		05/	16/2019
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME		16 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	which included carc incontinence and co Braden scale furthe extensive assistant the use of a mecha incontinent of bowe The medical record scale assessments Review of R8's Skir revealed the followi -R8 developed a sk that was noted to be centimeters (cm.). amount of bleeding edges. It was unkn developed. The wo and water and a Me it after R8's bath. T physician and famil Review of the intero from the electronic 5/16/19, revealed th - 4/8/19, R8 was no her buttocks that m planned to apply Me dressing used to the and wounds) after F - 4/9/19, Interdiscip R8's wound to the b wound as shearing, treatment would be Ammens powder (a	diovascular disease, chronic ognitive impairment. The er indicated R8 required ce with bed mobility, required inical lift and was always el. I lacked any additional Braden completed after 2/16/19. In Integrity Event for 4/8/19, ing: sin tear to her right buttocks e shallow and measured 0.5 The wound had a small and had smooth wound bound was cleansed with soap epilex dressing was applied to The event indicated the by had been notified. disciplinary progress notes health record (EHR) from 4/8-	F 686			

Facility ID: 00762

If continuation sheet Page 13 of 41

	-	AND HUMAN SERVICES				FORM	06/25/2019 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245579	B. WING			05/	16/2019
NAME OF	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME			I6 WEST SECOND STREET RACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	and to prevent brea ROHO cushion (a c relief) would be utili staff would monitor document at least w - 4/13/19, 0.5 cm ra buttock as well as a laterally to the initia foul-smelling bowel medications were m Nursing staff applie the right buttock are -4/14/19, R8 had a and dressing had b result. The note inc measured 1 x 1 cm measured 0.8 x 0.8 -4/20/19, R8's dress and nursing staff cl new dressing. Nurs appeared to be incr the director of nursi - 4/23/19, R8's dress 4/22/19, and 4/23/1 The lower open are superficial and near area had been note diameter with four s of the wound barely superficial. -4/27/19, dressing o after R8 had a large be 2 x 2 cm and the	akdown. The note identified a cushion used for pressure ized in R8's wheelchair and the wound daily and weekly until healed. aw area noted to R8's right another 0.5 cm. located 1 cm I area. R8 had a large loose I movement (BM) and bowel not administered as a result. ed a new Mepilex dressing to ea. large loose foul-smelling BM been changed again as a dicated the inferior (older) area and the superior (new) area	F 6	.86			

If continuation sheet Page 14 of 41

		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES		(X2) MUI	TIF	PLE CONSTRUCTION		. 0938-0391 E SURVEY
-	OF CORRECTION	IDENTIFICATION NUMBER:			G		IPLETED
		245579	B. WING	i		05/	16/2019
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	03/	10/2013
FREENT					116 WEST SECOND STREET		
ESSENII	IA HEALTH GRACE H	OME			GRACEVILLE, MN 56240		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETION DATE
					DEFICIENCY)		
		 	Γ			_	
F 686		-	F6	386	6		
	is applied and remo	oved).					
	-5/1/19, R8's dressi	ing to her right buttock was					
	noted to be all curle	ed up. Nursing staff removed					
		d applied a new Mepilex					
		a had no drainage, had clean ed to be dark red in color.					
		sing was noted to be coming					
		lex dressing was applied. No ns of change had been noted					
	to the wound.	ns of change had been noted					
		bted to continue to have a 2 cm					
		hat was dressed with a The wound had no drainage					
		rea had clean edges. R8 was					
		recurrent incontinent BM's.					
	5/6/10 OT (000UR	votional thorany) staff					
		bational therapy) staff positioning needs and instructed					
	staff to position R8	on the left side. The note					
		e ROHO cushion (pressure					
		vas not holding air and OT with vendors for other					
	cushion options.						
		ressing completed to R8's right					
	buttock due to solle more shallow and li	ed. Area noted to be slightly					
		rovided education to nursing					
		of the hygiene sling. The					
		er indicated the DM (dietary re of the skin concern and					
	nutrition had been a						
		hange completed to R8's right ed. Area noted to have had					

If continuation sheet Page 15 of 41

PRINTED: 06/25/2019

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES		TID			. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		045570	B. WING				
	PROVIDER OR SUPPLIER	245579	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	05/	16/2019
	NOVIDEN ON SOLIT EIEN				116 WEST SECOND STREET		
ESSENT	A HEALTH GRACE H	OME			GRACEVILLE, MN 56240		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLETION DATE
		,			DEFICIENCY)		
E 000							
F 686	Continued From pa	ge 15	F	686			
	slow healing.						
	- 5/10/19, dressing	change completed to R8's					
		oted to have a round area that					
		n the center and superficial sing in 1 cm border of the					
		area had been noted to be					
	pink in color.						
	- 5/11/19 R8's old a	dressing had been removed					
		e soiled and difficult to					
		vas noted to be 3.0 cm. x 3.0					
	cm, had an odor an	d was noted to be moist.					
	-5/12/19, the dressi	ng to R8's right buttock					
	shearing area was	removed and a new Mepilex					
	dressing had been	applied.					
	-5/15/19, Mepilex d	ressing changed to R8's right					
		aff indicated a small to					
		of tan colored drainage was essing and no odor had been					
		area measured 2 cm in width					
		The nursing staff further					
		nk tissue surrounded the					
		re wound measured, which					
		vound and the surrounding m. The color of the majority of					
		light yellow in color and the					
		e open wound had a 0.25 cm					
	dark red-brown are	а.					
	The progress notes	a lacked documentation of					
	staging of the press	sure ulcer or the presence of					
	yellow slough in R8	's pressure ulcer.					
	During interview on	5/14/19, at 1:25 p.m. NA-B					
		extensive to total assist with					
		r eating which she required					

If continuation sheet Page 16 of 41

PRINTED: 06/25/2019

		AND HUMAN SERVICES			FORM	06/25/2019 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245579	B. WING		05/	16/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME		116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	limited assistance v shearing to her righ sling and OTA-C as positioning practice use of the hygiene s further shearing. N were notified by NA and skin was check morning cares. On 5/15/19, at 11:2 occupational therap evaluate and make pressure relieving c as suggesting posit confirmed R8 had b sling to prevent furt OTA-C stated OT s nursing staff on pro proper positioning f On 5/15/19, at 11:4 required extensive assistance with eat had been changed hygiene sling due to to her skin. NA-C fur ight buttocks devel sling. Review of R8's curr 5/15/19, which inclu - 4/8/19, general nu dressing weekly on document the cond	with. NA-B stated R8 had a at buttocks from her old lift asisted with determining best as as well as suggesting the sling in an attempt to prevent IA-B stated licensed nurses 's when skin issues develop ked every day by NAs during 1 a.m. OTA-C stated by staff received an order to recommendations for devices for R8 to use as well tioning strategies. OTA-C been changed to a hygiene ther shearing from occurring. taff provided education to oper use of slings as well as for R8. 6 a.m. NA-C stated R8 assist with ADL's and minimal ing tasks. NA-C indicated R8 from the old lift sling to a the old one causing irritation urther stated the sore on her loped from the use of the old	F 686			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP		OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	à	COM	PLETED
		245579	B. WING			05/ [.]	16/2019
NAME OF I	PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	ОМЕ			116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETION DATE
F 686	Continued From no						
F 000	Continued From pa	ge 17 tment administration record	F6	586	>		
		, revealed the following:					
	- an order on 4/8/19), Ammens Powder- apply					
		nens Powder to bottom to aide and prevent breakdown.					
		19, to change the dressing n day and as needed.					
	Additionally, the nur	rsing staff were to document					
		dressing under result in the and chart under event at least					
	weekly on Sundays						
	Review of R8's phy 3/19- 5/15/19, revea	sician progress notes from aled the following:					
		cian progress note indicated					
		nts except for feeling tired and e plan was indicated. The					
	progress note lacke skin issues.	ed any documentation of any					
		ess note indicated R8 had no					
		or feeling tired. The progress crease of lisinopril to 5					
		escribed for high blood					
	draw. The progress	eck labs with the next lab s note lacked any					
		ny pressure ulcers or wounds.					
	- 5/14/19, the progr						
		reight loss or a plan to address er, there was an addendum					
	note indicating nurs	ing staff had informed the					
		MD)-E of R8's gluteal ulcer ne progress toward healing.					
	According to the no	te, the physician indicated the					
	ulcer had developed	d due to shear or maceration					

Facility ID: 00762

If continuation sheet Page 18 of 41

PRINTED: 06/25/2019

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE SURVEY COMPLETED	
		245579	B. WING			05/ [.]	16/2019
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	ОМЕ			116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	due to friction, seat urine. -5/15/19, an addend note indicated MD-I determined the ulce and had shallow pa However, the note of assessment of the weight loss, or any loss. The note ind believed the ulcer of maceration due to f exposure to urine. Further review of R revealed the reside significant weight lo 11/13/18, 200.5 pot 12/13/18, 196 lbs. 1/13/19, 193 lbs. 2/13/19, 188.3 lbs. 3/12/19, 188.8 lbs. 4/15/19, 183.9 lbs. 5/13/19, 180.4 lbs. 5/15/19, RD-D doct R8 had an open wo measured 2 cm by cm. RD-D also ider pounds which equa loss in 30 days, 5% 9% weight loss in 1 indicated R8's mea variable, and indica had the best intake supper meals range	position and exposure to dum to the 5/14/19, progress E had assessed the ulcer and er was the size of a quarter le superficial slough. did not include any physician resident's nutritional status, plans to address the weight icated the nursing staff leveloped from shear or friction, seat position and 8's progress notes of the EHR nt had experienced a	F	\$86			

Facility ID: 00762

If continuation sheet Page 19 of 41

PRINTED: 06/25/2019

		AND HUMAN SERVICES				FORM	06/25/2019 APPROVED 0938-0391
				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245579	B. WING			05/ [.]	16/2019
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
ESSENT	IA HEALTH GRACE H	OME			16 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	lunch and supper m protein, calories and were to offer protein favorite foods to im identified goals of s integrity, supplement intakes to be equal the RD-D planned to visit. Review of R8's med (MAR) for May 2019 nutritional supplement Review of R8's treat (TAR) for May 2019 nutritional supplement On 5/15/19, at 1:46 manager (RN)-A correceiving any supplement On 5/15/19, at 2:35 were reviewed on a had not been eating unwanted weight lo would be one of the implement. DD-B a supplements would who had pressure u healing. DD-B confi during her last site confirmed he was r ulcer. DD-B further receiving nutritional On 5/16/19, at 10:0 interview with RD-D	heals to provide additional d fluids. Additionally, staff n-rich food/fluids and offer prove intakes. The note stabilizing weight, improve skin nt acceptance, improve meal to or greater than 75% and to follow-up at the next site dication administration record 9, indicated there had been no ents ordered/initiated for R8. atment administration record 0, also failed to indicate any ent order or implementation. 6 p.m. registered nurse onfirmed R8 had not been lements. 6 p.m. DD-B stated weights a weekly basis and if a resident g well or experienced an ess, offering high caloric foods e first interventions to lso stated high protein I be implemented for residents ulcers or wounds to promote firmed RD-D had not seen R8 visit on 4/24/19 and further not aware R8 had a pressure r confirmed R8 had not been	F	586			

If continuation sheet Page 20 of 41

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/25/2019 APPROVED 0938-0391
				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245579	B. WING			05 / [.]	16/2019
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENTIA HEALTH GRACE HOME					16 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	and further stated s monthly basis. RD-I developed inbetwee email or call her on she would expect to any resident develo significant weight lo first been notified by and significant weigh have expected to ha both. RD-D stated s 5:56 p.m. on 5/15/1 weight loss had occ had experienced a past six months. For recommendations f and supper meals, foods to promote w further weight loss. evaluating R8 in per visit which she plan couple of weeks. On 5/15/19, at 1:46 stated the process f nurses assessing th wounds and determ blanchable or not. pressure ulcer had caused by friction o as an abrasion. NM ulcer had been caus incontinence brief. I aware R8's pressur present and would I to determine that. N was for nursing staf	the made onsite visits on a D explained for any needs that en her visits, DD-B would the telephone. RD-D stated b be notified within 48 hours if ped a pressure ulcer or had a ss. RD-D confirmed she had y DD-B of R8's pressure ulcer ght loss on 5/15/19, and would ave been notified earlier for she'd reviewed R8's EHR at 9, to determine intakes and curred. RD-D confirmed R8 significant weight loss in the	F	\$86			

If continuation sheet Page 21 of 41

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	06/25/2019 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245579	B. WING		05/	16/2019
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENTIA HEALTH GRACE HOME				16 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	of the EHR. NM-A s staff would commen- ulcer was improving Review of R8's E-Z Worksheet dated 5 wound to the "Butt- worksheet indicated 3.0 cm and a depth indicated the prese eschar/slough pres hand drawn diagrar with an inner circle "yellow". To the righ was the handwritten The worksheet prov wound base, draina periwound appeara present, and wound were left blank. No Assessment Works On 5/16/19, at 12:5 (MD)-E indicated he normally, would cor when a wound or p resident. MD-E con pressure ulcer on 5 ulcer to her right low unstageable due to slough. MD-E state current treatment a the pressure ulcer v On 5/16/19, at 2:02 (DON) stated R8 ha identified in R8's Ef- implemented new in	stated it was expected nursing ont on whether the pressure g or not at least weekly. Graph Wound Assessment 5/11/19, indicated R8 had a - R [right] side." The d a length of 3.0 cm, width of n of 0.5 cm. The worksheet ence of an odor and sent. The worksheet had a m of an irregular shaped circle with a line from it indicating nt of the hand drawn diagram n words "Soft" and "Moist". vided space to document age amount, drainage type, ance, age of wound, pain d status however, these areas further E-Z Graph Wound sheet were provided for R8. 55 p.m. primary physician e expected, and the facility ntact him immediately via fax pressure ulcer developed on a afirmed he assessed R8's 5/15/19, and R8 had a pressure wer buttocks that was o the wound bed covered in ed he planned to continue and interventions and expected	F 686			

If continuation sheet Page 22 of 41

		AND HUMAN SERVICES				FORM	06/25/2019 APPROVED 0938-0391
				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245579	B. WING			05/ [.]	16/2019
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENTIA HEALTH GRACE HOME					16 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	monitoring and treat involved the nursing form, updating the of the appearance of the least weekly. The D pressure ulcer docu- location of the wour wound, if there was signs or symptoms present and a thoro The DON explained as a shearing abras or sling utilized with verified the pressur unstageable pressur slough present. The staff recently watch regarding pressure repositioning require R27's quarterly MD moderate cognitive heart failure, hypert disease, Diabetes M MDS indicated R27 from 2 staff with act including bed mobil dressing and perso R27's annual care at 1/25/19, revealed F and indicated at rish no skin issues. In a R27 required staff at dressing the lower f was at risk for skin	Atting a pressure ulcer or wound g staff completing an event care plan, and documenting the pressure ulcer or wound at DON stated it was expected the umentation would include the nd, the measurements of the s drainage or odor present, any of infection, if there was pain bugh description of the wound. d R8's pressure ulcer started sion from the incontinent brief on the mechanical lift and re ulcer had worsened to an ure ulcer which had yellow e DON stated licensed nursing ned a webinar in March 2019, ulcer prevention and rements.	F 6	86			

If continuation sheet Page 23 of 41

DEPART		APPROVED						
CENTER	<u> IS FOR MEDICARE</u>	& MEDICAID SERVICES			(. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
245579		B. WING	i		05/	/16/2019		
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
ECCENT	IA HEALTH GRACE H	OME		1	116 WEST SECOND STREET			
ESSENT	A REALIN GRACE N	OME		C	GRACEVILLE, MN 56240			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	NC	(X5)	
PRÉFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETION DATE	
TAG	REGOLATORT OR E		TAG		DEFICIENCY)			
			 					
F 686	Continued From pa	uge 23	F	686				
	thin fragile skin.	<u>.</u> ge 20		000)			
	unin nagile skin.							
	R27's current care	plan described various						
		structions for self care						
		ed assistance with all ADLs. In						
		lan addressed R27's risk for						
		her feet related to structural						
		assist with ADL's, diagnoses						
		s with peripheral vascular						
		vanced age, and history of						
	easily bruising relat	ed to thin fragile skin.						
	During an interview	on 5/13/19, at 1:47 p.m. R27						
		bre toe and indicated staff						
		d been applying salve to the						
	area, but indicated							
l								
	A review of R27's a							
		rd (MAR) orders on 5/15/19,						
		e to apply topical animal						
		n right foot at bedtime, and						
l		ut on TED stockings and leg orning and remove at bedtime.						
		Sinning and remove at bedtime.						
	Review of R27's pro	ogress notes reviewed from						
		any documentation of skin						
		ons utilized. In addition, a						
	nursing progress no	ote dated 3/16/19, at 7:00 p.m.						
		a reddened area on second						
		t and indicated she also had						
	5	noes on her left foot, that she						
		nd indicated staff would make						
	sure sne was weari	ing the toe sleeves.						
	R27's electronic me	edication administration record						
		onic treatment administration						
		e reviewed and lacked						
		mentation of the redness						
		toe, use of the toe sleeve, or						

If continuation sheet Page 24 of 41

PRINTED: 06/25/2019

		AND HUMAN SERVICES			FORM	06/25/2019 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245579	B. WING		05/	16/2019
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENTIA HEALTH GRACE HOME				16 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	address any reports feet/toes or use of t friction or rubbing d skin concerns were On 5/14/19, 2:41 p. room with her feet of R27 was wearing b tan compression so extremities with tan sleeves) on both low On 5/15/19, at 7:16	-	F 686			
	head to toe with mo NA-C stated if she issues with a reside nurse right away. N on the left second t new for R27 and st sleeve on R27's toe prevent rubbing in H On 5/16/19, at 8:39 checked the reside morning and evenir bath aide complete assessment on eac would report any co stated NAs do not of report them to the r assessment/docum NA-D stated if there interventions they w the eTAR so nursin	orning and bedtime cares. observed any changes or ent's skin she would notify the IA-C stated R27 had redness oe and indicated it was not aff were putting a foam toe e to separate the toes and her shoes. a.m. NA-D stated she nt's skin every day with ng cares, and indicated the d a head to toe skin ch resident's bath day and oncerns to the nurse. NA-D document the skin issues, but				

Facility ID: 00762

If continuation sheet Page 25 of 41
		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	06/25/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		245579	B. WING		05/16/2019	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	ОМЕ		116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	cared for R27 and c which she had mad said nursing was m applying padding to morning cares. On 5/16/19, at 8:52 look at the resident cares in the mornin them over head to t any issues such as different she would stated the process to complete a Stop if a resident had Dia she would pay close stated the nurse wo and complete the d resolved. NA-E stat and stated staff loo cares. NA-E also ex stockings and remo- indicated they look NA-E stated she ha left second toe and the nurse several m apply toe cushion w stated R27's toes d they had for the las On 5/16/19, at 10:3 (RN)-A stated the p monitoring was to c data collection (LNI the residents which skin condition. RN-, NAs looked at the r cares and notify nu	a.m. NA-E stated she would 's skin when she is providing g and evenings, checking 'oe. NA-E stated if there are bruising, redness, or anything report it to the nurse. NA-E for reporting a skin issue was N Watch (alert). NA-E stated abetes or other skin issues e attention to their feet. NA-E build then assess the skin issue ocumenting and tracking until ted she had worked with R27 k at her skin and feet with kplained staff help R27 apply by them every day and at feet and legs at that time. Id observed redness on R27's had reported the concern to nonths ago. NA-E stated they yraps as an intervention, and id not look any different than	F 686			

Facility ID: 00762

If continuation sheet Page 26 of 41

		AND HUMAN SERVICES			FORM	06/25/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE	E SURVEY IPLETED
		245579	B. WING		05/	16/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME		116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	resident's skin head LNDC and indicated facility policy. RN-A skin breakdown dua and stated they get there was no monit place. In addition, F of any current skin the most current ten resident's chart and redness on her toes plan. RN-A stated th monitor any change nursing, but indicate anything specific at toes, or effectivenes sleeves. RN-A verif of redness on R27's staff to notify her of On 5/16/19, at 1:13 Registered Nurse (I look at R27's toes a toes were reported provider today and to look at them. IC provider discontinue Ted stockings, stati pressure on her toe feet, causing her to multiple reddened area verbalized her toes	d to toe each week for the d she thought that was the a stated R27 was at risk for e to history of hammer toes, red and sore. RN-A verified coring for this issue currently in RN-A stated she was not aware issues with R27, and reviewed mporary care plan in the d verified monitoring of the s was not in temporary care he care plan instructed staff to es in skin and report to ed the care plan lacked pout monitoring R27's feet or ss of the use of R27's toe fied she had not been notified s toes, and would expect NA any skin concerns. B p.m. Infection Control ICRN)- F stated she would again, and stated R27's red to the resident's medical he came over from the clinic RN-F stated the medical ed use of the toe sleeves, and ing they were actually putting pes related to deformities in her bes to rub together. The areas measured were as st knuckle 0.4 cm x 0.5 cm a 100% blanchable, R27 hurt.				

If continuation sheet Page 27 of 41

	FORM	APPROVED					
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING .		CON	MPLETED
		245579	B. WING			05	/16/2019
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		10/2010
ESSENT	IA HEALTH GRACE H	ОМЕ			16 WEST SECOND STREET RACEVILLE, MN 56240		
	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	G	PROVIDER'S PLAN OF CORRECT		(X5)
(X4) ID PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION DATE
TAG	NEGOLATONT ON E		TAG		DEFICIENCY)		
F 000							
F 686	Continued From pa	ge 27	F6	86			
		toe top of knuckle calloused					
	area with 100% blanchable reddened area measured 0.5 cm X 0.4 cm.						
	- Right top of foot so dry with no drainage	cabbed area measured 0.5 cm					
	ory with no urainage	Э.					
	- Left foot second toe first knuckle 100% red blanchable area which measured 0.5 cm X 0.5						
	cm.	ICh measured 0.5 Cm A 0.5					
		nuckle 0.7 cm X 0.6 cm discomfort with palpation,					
	center of the redder	ned area which measured 0.3					
	cm X 0.2 cm red ar	ea not blanchable.					
		100% red blanchable area					
	which measured 0.4	4 cm x 0.5 cm.					
		on the side of the third toe					
	which measured 1.	5 cm long.					
		p.m. ICRN-F verified "today					
		she had been notified of the R27's toes. ICRN-F stated					
		taff to report issues with skin					
	integrity to nursing	staff for monitoring. In					
	2	ated the toe socks, Ted checks should be completed					
	by licensed staff we	ekly and any issues added to					
		TAR for monitoring until					
		verified that R27 was at high on her feet related to her					
	advanced age, histo	ory of Diabetes Mellitus, and					
	edema. She indicat monitored and docu	ed she should have her feet umented on daily.					
		-					
	1 On 5/16/19, at 3:00	p.m. the DON stated she had					

If continuation sheet Page 28 of 41

PRINTED: 06/25/2019

		AND HUMAN SERVICES				FORM	06/25/2019 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245579	B. WING _			05/	16/2019
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	TA HEALTH GRACE H	OME			6 WEST SECOND STREET RACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	not been aware of I her toes, and stated observe alterations charge nurse and in monitoring and doc DON stated license assessed and docu foot tenderness with this had not been d nursing staff should head to toe skin as the weekly LNDC, a done for R27. Review of facility's I Non-Surgical Wour Management revise provide the followin ulcers and wounds location, stage, dep of drainage, tissue condition of skin su present, and approp The policy further in review nutritional st make recommenda policy identified the when the stage incu licensed staff would documentation was Review of facility's I 3/19, indicated licer weekly head to toe undressing the port pressure ulcer or w identified licensed r	R27's sore reddened areas on d she would expect staff who in skin condition to notify the mplement the process to begin cumentation until resolved. The ed nursing staff should have umented on R27's redness and h daily monitoring, but verified lone. The DON stated the d be completing a thorough sessment when completing and verified this had not been policy Pressure Ulcer and hd Documentation and ed 1/19, instructed staff to ig documentation of pressure at least weekly: wound type, oth, measurement, description description, signs of infection, irrounding the ulcer, if pain priate care and treatment. hstructed the dietician to tatus of the resident and to ations to promote healing. The physician would be notified reases. The policy indicated	F 68	86			

Facility ID: 00762

If continuation sheet Page 29 of 41

		AND HUMAN SERVICES			FORM	06/25/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245579	B. WING		05/ [.]	16/2019
NAME OF F	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ESSENT	IA HEALTH GRACE H	OME		16 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	Continued From pa	ige 29	F 686			
		nitoring, documentation and kin alteration was completed ded.				
	The Centers for Me Long-Term Care Fa Instrument (RAI) 3. 10/2018, identified be completed to ide appearance and ch ulcers/injures. The ulcer/injury as a loc underlying tissue, u prominence, as a re prolonged pressure pressure ulcer/injur an open ulcer and r further identified it w the etiology of all w would determine ar and management of - The manual define ulcer/injury as "an of alteration of intact s compared to an adj body, may include of following parameter or coolness), tissue sensation (pain, itch persistent redness	edicare and Medicaid (CMS) acility Resident Assessment 0 User's Manual dated Section M: Skin Conditions to entify the risk, presence, hange of pressure manual defines a pressure calized injury to the skin and/or usually over a bony esult of intense and/or in combination of shear. The ry can present as intact skin or may be painful. The manual was imperative to determine ounds and lesions as that and direct the proper treatment				
	appear with persiste - The manual define ulcer/injury as "part presenting as a sha	ent red, blue or purple hues." es a stage two pressure ial thickness loss of dermis allow open crater with a d, without slough or bruising."				

If continuation sheet Page 30 of 41

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245579	B. WING _		05/ ⁻	16/2019
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	ОМЕ		116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686 F 692 SS=G	 The manual define ulcer/injury as "Full Subcutaneous fat n tendon or muscle is present but does no loss." The manual define ulcer/injury as "Full exposed bone, tend eschar may be pres wound bed." The manual stated with slough and/or e cannot be visualized unstageable becaus soft tissue damage be determined." Nutrition/Hydration CFR(s): 483.25(g)(1) §483.25(g) Assisted (Includes naso-gas) both percutaneous percutaneous endo enteral fluids). Bas comprehensive asss ensure that a reside §483.25(g)(1) Main of nutritional status, desirable body weig balance, unless the demonstrates that t preferences indicated 	es a stage three pressure thickness tissue loss. hay be visible but bone, s exposed. Slough may be of obscure the depth of tissue es a stage four pressure thickness tissue loss with don or muscle. Slough or sent on some parts of the d " pressure ulcers covered eschar, and the wound bed d, should be coded as se the true anatomic depth of (and therefore stage) cannot Status Maintenance 1)-(3) d nutrition and hydration. tric and gastrostomy tubes, endoscopic gastrostomy and scopic jejunostomy, and ed on a resident's sessment, the facility must ent- tains acceptable parameters , such as usual body weight or ght range and electrolyte resident's clinical condition his is not possible or resident	F 68			6/25/19

Facility ID: 00762

If continuation sheet Page 31 of 41

PRINTED: 06/25/2019

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	(X3) DATE SURVEY COMPLETED	
		245579	B. WING _		05/	16/2019	
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-		
ESSENT	IA HEALTH GRACE H	OME		116 WEST SECOND STREET GRACEVILLE, MN 56240			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 692	maintain proper hyd	dration and health;	F 69	02			
	there is a nutritiona provider orders a th This REQUIREMEN by: Based on observat review, the facility for ongoing nutritional residents (R8) revies sustained harm who accurately and time address risk factors status, and implem acceptable nutrition experienced a clinic 10% in six months. Findings include: R8's quarterly Minin 2/19/19, indicated F	NT is not met as evidenced tion, interview and document ailed to complete accurate and assessment for 1 of 2 ewed for nutrition. R8 en the facility failed to ely assess nutritional status, s for impaired nutritional ent approaches to maintain nal parameters for R8 who cally severe weight loss of over		The Registered Dietician (RD) notified by the Certified Dietary (CDM) of the identified resident additional weight loss and chan condition on 5/15/19, since pre- notifying the RD of a significant loss on 3/20/19 and documenta "may benefit from a gradual wei reduce stress on organs and joi 5/15/19 RD made recommenda nutritional interventions "trial of Ensure at Dinner/ Supper meal additional protein, calories, and Encourage protein rich foods ar when able. Offer favorite foods improve intake."	Manager R8 ge in skin viously, weight tion noted ght loss to nts." On tion for 4oz. to provide fluids. d fluids		
	included anemia, heart failure, high blood pressure, Alzheimer's, Dementia, anxiety and depression. The MDS identified R8 had severe cognitive impairment and required extensive to total assistance with activities of daily living (ADL's) which included bed mobility, transfers, dressing, toileting, personal hygiene, bathing and limited assistance with eating tasks. The MDS indicated R8 was at risk for developing pressure ulcers and had no current pressure ulcers identified. The MDS revealed the following interventions were in place to prevent pressure ulcers which included pressure reducing device for chair and a turning and repositioning program. The MDS identified R8 had no weight loss and received a mechanically altered diet for meals.			On 5/24/19 CDM added addition nutritional supplement of Plus 2 Shakes TID between meals. Ri plan updated to reflect changes The nutritional/ hydration status residents was reviewed by IDPT those at risk have been referred monthly onsite assessment, nut interventions put in place care p reviewed and updated, as appro Results of this audit shall be rep the QAPI committee.	Protein D and care of current and to RD for ritional lans opriate.		

Facility ID: 00762

If continuation sheet Page 32 of 41

		AND HUMAN SERVICES				FORM	06/25/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245579	B. WING			05/ ⁻	16/2019
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	IOME			16 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	Continued From pa	age 32	F6	92			
	 9/5/18, indicated Ri ADL's due to progra The CAA revealed pressure ulcers due be repositioned by had no current skin assessment. The of for weight and fluid abnormal labs. The was at nutritional ris heart failure, acute atrial fibrillation (qu R8's care plan revis required extensive which included bed locomotion, dressir and bathing. The care supervision with se were to monitor the assistance. The care open area to her rig shearing. The care encourage R8 to co as well as consume times. The care plan regular diet with ne be seated at the su occasionally require eating tasks from s instructed staff to n to report any signifi and family. On 5/14/19, at 12:2 seated in her whee 	Area Assessment (CAA) dated 8 required assistance with essing Alzheimer's Dementia. R8 was at risk for developing e to immobility and the need to staff. The CAA identified R8 n issues at the time of the CAA indicated R8 was at risk changes due to intake and e CAA further identified R8 sk due to heart disease with kidney failure, dementia and ivering or irregular heartbeat). sed 5/14/19, revealed R8 to total assistance with ADL's mobility, transfers, ng, toileting, personal hygiene care plan indicated R8 required t-up for eating tasks and staff e resident's need for increased re plan identified R8 had an ght buttock as a result of plan instructed staff to onsume a well balanced diet e all fluids offered at meal an identified R8 was on a ctar thin liquids and R8 was to ipervision table due to ed increased assistance with taff. The care plan further nonitor and record intake and cant changes to the physician			The "Nutritional Care and Documer policy has been reviewed and revis Staff will receive education regardir updated policy and F692 by one of following means: 1:1 meetings, stat or scheduled meetings on 6/18/19 a 6/20/19. The IDPT will review all residents w current impaired nutritional status w x4, then monthly thereafter. CDM v notify RD per "Nutritional Care and Documentation" policy & procedure Results of the audit will be reported QAPI Committee for further recommendations.	ed. ng the the ndups, and rith veekly vill	

If continuation sheet Page 33 of 41

	-	AND HUMAN SERVICES			FORM	06/25/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY PLETED
		245579	B. WING		05/	16/2019
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME		I16 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 692	her lunch. R8 cons and one fourth of he apple juice. On 5/15/19, at 8:42 dining room and pla table. R8 was prov consisting of a bana and yogurt as well a was noted to be lea wheelchair. R8 was attempted to feed h difficulty. At 8:46 a and attempted to pe position in her whee herself her breakfas occasional assistan food on her fork and 9:20 a.m. R8 contin was no longer eatin consumed all of her and a couple bites of On 5/15/19, at 11:1 wheelchair at the di lunch to be served. brought back to her nausea. R8 had no the nausea. Review of R8's weig	sumed one half of her sherbet er hotdish. R8 drank all of her e a.m. NA-A wheeled R8 to the aced her at the dining room rided her breakfast tray ana, toast, scrambled eggs as two glasses of juice. R8 aning to her left in her s provided a fork by NA-A and herself bites of her banana with .m. NA-A sat down next to R8 osition R8 in a more upright elchair. R8 proceeded to feed st slowly with cueing and nee from NA-A with placing d guiding it to R8's mouth. At nued to drink her juices and ng anymore of her food. R8 r banana, half a slice of toast of the yogurt and eggs. 4 a.m. R8 was seated in her ining room table waiting for At 12:15 p.m. R8 was r room due to complaints of t eaten her lunch as a result of ght record from the electronic to were reviewed from 9 and included:	F 692			

Facility ID: 00762

If continuation sheet Page 34 of 41

		AND HUMAN SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		CON	IPLETED
		245579	B. WING			05/	/16/2019
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET		
ESSENTI	IA HEALTH GRACE H	OME			GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	Continued From pa 4/15/19, 183.9 lbs. 5/13/19, 180.4 lbs. Review of R8's 2/19 revealed R8's weigh this compared to 19 201.5 lbs. 180 days indicated R8's usual lbs. The screening swallowing problem equipment. The sc intake was 51%- 75 consumed under 10 The screening furth intact, and indicated current plan of care Review of progress revealed the followi 3/20/19, registered weight was 188.3 lb significant weight lo days. The note ind gradual weight loss and joints. The note intakes varied from identified R8 require indicated staff woul- intakes and plan of 4/10/19, dietary dire was 185 pounds wh	age 34 9/19, nutritional screening ht was noted to be 190.2 lbs., 92.9 lbs. 30 days prior and s prior. The screening al body weight was 190- 200 further indicated R8 had hs and utilized adaptive screening identified R8's usual 5% and she typically 000 milliliters (ml.) of fluids. her identified R8's skin as d the team should continue the s.	Fe	592	DEFICIENCY)	PRIATE	DATE
	days. The note ide from 25% to 100%	ntified R8's intakes varied per meal. The note indicated to monitor and to refer to					

Facility ID: 00762

If continuation sheet Page 35 of 41

PRINTED: 06/25/2019

	-	AND HUMAN SERVICES			FORM	06/25/2019 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245579	B. WING		05/	16/2019
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	ОМЕ		116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 692	5/2/19, DD-B noted pounds which equa 180 days. The note by meal. Further, th cueing to dine as no require more assist indicated staff woul RD-D would see R8 5/15/19, RD-D state had an open wound measured 2 cm by cm. RD-D also iden pounds which equa loss in 30 days, 5% 9% weight loss in 1 meal intakes contin indicated breakfast intake 76-100%, w ranged from 25% to trial of 4 ounces of meals to provide ac fluids. Additionally, food/fluids and offe intakes. The note i weight, improve ski acceptance, improv or greater than 75% follow-up at the nex Review of the physi electronic health re- from 2/22-5/15/19, 2/22/19, the progrea- regarding R8's weig weight loss. 3/15/19, the progrea-	R8's weight was 181.6 led a 19 pound weight loss in indicated R8's intake varied he note indicated R8 required eeded, and indicated R8 may cance with eating. The note d continue to monitor and the 8 at next site visit. ed she had been notified R8 d to her right buttocks that 2.5 cm with a total width of 3 ntified R8's weight of 180.4 led an additional 2% weight weight loss in 90 days and 80 days. RD-D indicated R8's ued to be variable, and was where R8 had the best hile lunch and supper meals 0 75%. RD-D recommended a ensure at lunch and supper dditional protein, calories and staff were to offer protein-rich r favorite foods to improve dentified goals of stabilizing n integrity, supplement ve meal intakes to be equal to 6 and the RD-D planned to	F 692			

Facility ID: 00762

If continuation sheet Page 36 of 41

	-	AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES				<u>OMB NO. 0938-0391</u>	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245579	B. WING			05/	16/2019
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FSSENT	IA HEALTH GRACE H	OME			116 WEST SECOND STREET		
LOOLINI				(GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
TAG F 692	Continued From pa weight loss. 4/24/19, the progres regarding R8's weig weight loss. 5/14/19, the progres of weight loss or a p However, there was nursing staff had int (MD)-E of R8's glut progress toward he the physician indica due to shear or mad position and expost 5/15/19, an addend note indicated MD-I determined the ulce and had shallow pa However, the note of assessment of the f weight loss, or any loss. Review of R8's sign 5/16/19, indicated F nectar thickened flu weights. Additionall dated 6/28/17, rega per RD-D or DD-B t	ge 36 ss note lacked documentation ght loss or a plan to address ss note lacked documentation olan to address weight loss. s an addendum note indicating formed the primary physician eal ulcer being treated and the aling. According to the note, ated the ulcer had developed ceration due to friction, seat ure to urine. lum to the 5/14/19, progress E had assessed the ulcer and er was the size of a quarter le superficial slough. did not include any physician resident's nutritional status, plans to address the weight hed physician orders dated R8 was on a regular diet with hids and required weekly y, there were general orders arding nutritional supplement recommendation, noted.	F 6	92	DEFICIENCY)	RIATE	DATE
	(MAR) for May 2019 nutritional suppleme Review of R8's trea (TAR) for May 2019	dication administration record 9, indicated there had been no ents ordered/initiated for R8. ttment administration record 0, also failed to indicate any					
	On 5/15/19, at 8:36	ent order or implementation. a.m. NA-A stated R8 could leing but did occasionally					

If continuation sheet Page 37 of 41

PRINTED: 06/25/2019

		AND HUMAN SERVICES				FORM	06/25/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245579	B. WING			05 / [.]	16/2019
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	ОМЕ			16 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 692	require assistance i further indicated R8 experienced weight much weight R8 ha On 5/15/19, at 11:4 required assistance often refused meals had experienced a nutritional suppleme much weight R8 ha On 5/15/19, at 1:46 manager (RN)-A sta weights for all resid nutritional interventi due to weight loss. R8 had experience reviewed the weigh a weight loss had o records, RN-A conf significant weight lo and RD-D, manage residents. RN-A als receiving any suppl On 5/15/19, at 2:35 were reviewed on a had not been eating unwanted weight lo supplement. DD-B a supplements would stabilization of weig referral to RD-D wo see the resident in visits. DD-B stated significant weight lo	from staff with eating. NA-A B had a fair appetite but had t loss. NA-A wasn't sure how d lost. 6 a.m. NA-C stated R8 with eating at times, and s at noontime. NA-C stated R8 weight loss but did not receive ents. NA-C wasn't sure how	F	592			

If continuation sheet Page 38 of 41

		AND HUMAN SERVICES				FORM	06/25/2019 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245579	B. WING			05/ ⁻	16/2019
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME			16 WEST SECOND STREET RACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	notified via phone of the monthly visit. Di supplements would who had pressure u healing. DD-B cont during her last site confirmed he was r ulcer. DD-B further receiving nutritional On 5/16/19, at 10:0 interview with RD-D closely with DD-B to and further stated s monthly basis. RD- developed inbetwee email or call her on she would expect to any resident develo significant weight lo first been notified b and significant weigh have expected to h both. RD-D stated s 5:56 p.m. on 5/15/1 weight loss had occ had experienced a past six months. Fi recommendations f and supper meals, foods to promote w further weight loss. evaluating R8 in pe visit which she plan couple of weeks.	 ar email instead of waiting for D-B also stated high protein I be implemented for residents alcers or wounds to promote firmed RD-D had not seen R8 visit on 4/24/19 and further not aware R8 had a pressure r confirmed R8 had not been I supplements. 7 a.m. during a phone D, RD-D stated she worked o monitor nutritional concerns she made onsite visits on a D explained for any needs that en her visits, DD-B would the telephone. RD-D stated the telephone. RD-D stelephone. RD-D stated the te	F 6	\$92			

If continuation sheet Page 39 of 41

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	06/25/2019 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245579	B. WING		05/	16/2019
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	IOME		116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 692	recommendations f weight stabilization stated it was expec 5% or more in 30 d days would be addr which included sup stated R8 had a sig identified in R8's Ef- implemented new in Review of facility's indicated RD-D word during a monthly in least annually, or w significant change in needs changed. Th assessments would resident's condition identified DD-B word labs and recommen needed. Further, th refer high nutritionan nutritional assessmineeded. The policy changes in the prog and the changes we care plan. The Centers for Ma Long-Term Care Fa Instrument (RAI) 3. 10/2018, identified Swallowing/Nutrition with an intent to ass cold affect the reside	for interventions to promote and/or weight gain. The DON eted a significant weight loss of lays, or 10% or more in 180 ressed with new interventions plements. The DON also gnificant weight loss as HR and verified RD-D had nterventions on 5/15/19. 5/18 policy, Nutritional Care, uld initially assess residents house visit to facility, and at then there had been a in condition or as nutritional he policy further indicated d cover dietary needs of recommended changes as a n changed. The policy uld monitor weights, intakes, nded changes to diet plans as he policy identified DD-B would al risk residents to RD-D for nent and recommendations as y instructed staff to document gress notes and/or screening ould also be addressed in the edicare and Medicaid (CMS) acility Resident Assessment .0 User's Manual dated Section K: nal Status to be completed sess the many conditions that dent's ability to maintain and hydration. Under K0300:	F 69:			

If continuation sheet Page 40 of 41

		AND HUMAN SERVICES				FORM	06/25/2019 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245579	B. WING			05/ ⁻	16/2019
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	ОМЕ			6 WEST SECOND STREET RACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	Continued From pa	ge 40	F 6	92			
		be an important indicator of a ent's health status or					
	causes of changed change in medication fluid volume status.	m should review for possible intake, changed caloric need, on (e.g. diuretics), or changed					
	and care planned a	eight loss should be assessed t the time of detection and not ext MDS assessment."					

Facility ID: 00762

If continuation sheet Page 41 of 41

DEPARTMENT OF HEALTH AND HUMAN SERVICES

F	5	5	7	9	0	30	
- 1		-		/	-	-	_

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

	ENTERS FOR MEDICARE & MEDICAID SERVICES		(X2) MULT	IPLE CONST	RUCTION		(X3) DATE	
	F CORRECTION	IDENTIFICATION NUMBER:	A BUILDIN	NG 01 - MAIN	N BUILDING 01		COMF	PLETED
		245579	B. WING				05/1	5/2019
	PROVIDER OR SUPPLIER		2	116 WEST	DDRESS, CITY, STATI I SECOND STREET /ILLE, MN 56240			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(() CR	PROVIDER'S PLAN EACH CORRECTIVE / OSS-REFERENCED DEFICI	ACTION SHOULD	BE	(X5) COMPLETIC DATE
K 000	INITIAL COMMEN	TS	K 00	00				
	FIRE SAFETY							
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT T	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS F COMPLIANCE.						
	UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.							
	Minnesota Departu Fire Marshal Divis Essentia Health - (compliance with th in Medicare/Medic 483.70(a), Life Sar edition of National	e Survey was conducted by the ment of Public Safety, State ion. At the time of this survey, Grace Home was found not in he requirements for participation aid at 42 CFR, Subpart fety from Fire, and the 2012 Fire Protection Association 101, Life Safety Code (LSC), ng Health Care.						
		the E-POC process, a paper f correction is not required."	- - - -		EP	OC		
	PLEASE RETURN CORRECTION FO DEFICIENCIES (P							
	Health Care Fire I							
	State Fire Marsha	Division	1					1

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.

		AND HUMAN SERVICES			0		APPROVED 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY IPLETED
		245579	B, WING			05/	15/2019
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME			116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	Continued From pa 445 Minnesota Stre St. Paul, MN 55101	eet, Suite 145	К 0	000)		
	Or by email to: FM.HC.Inspections	@state.mn.us					
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:			ž		
	1. A description of to correct the defic	what has been, or will be, done iency.					
	2. The actual, or pr	oposed, completion date.					
	responsible for cor	r title of the person rection and monitoring to ence of the deficiency.					
	building with no ba constructed at 2 dir building was constr determined to be of 1998, 3 additions w northeast and north be of Type II(111)c original building an construction types	Grace Home is a 1-story sement. The building was fferent times. The original ructed in 1976 and was f Type II(111) construction. In vere added to the southeast, hwest that were determined to onstruction. Because the d the addition meet the allowed for existing buildings, veyed as one building.					
	sprinkler system. T system with smoke barrier doors and s is monitored for au notification. The fa	tected by a complete fire The facility has a fire alarm a detection by the smoke spaces open to the corridor that tomatic fire department cility has a licensed capacity of census of 33 at the time of the					

Facility ID: 00762

If continuation sheet Page 2 of 7

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING 01		SURVEY
		0.45570				- 10040
		245579	B. WING		· · · · · · · · · · · · · · · · · · ·	5/2019
AME OF F	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET		
SSENTI	A HEALTH GRACE H	OME		RACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
K 000	Continued From pa survey.	ige 2	K 000			
	The requirement at 42 CFR Subpart 483.70(a) is NOT MET.					
	Cooking Facilities CFR(s): NFPA 101		K 324			6/7/ 19
	with NFPA 96, Star and Fire Protection Operations, unless * residential cookin appliances such as toasters) are used cooking in accorda * cooking facilities compartments with with the conditions or * cooking facilities 30 or fewer patient 18.3.2.5.4, 19.3.2.5 Cooking facilities p per 9.2.3 are not re hazardous areas, b corridor.	g equipment (i.e., small s microwaves, hot plates, for food warming or limited nce with 18.3.2.5.2, 19.3.2.5.2 open to the corridor in smoke 30 or fewer patients comply under 18.3.2.5.3, 19.3.2.5.3, in smoke compartments with s comply with conditions under 5.4. rotected according to NFPA 96 equired to be enclosed as but shall not be open to the 18.3.2.5.4, 19.3.2.5.1 through				22
	by: Based on docume interview the facilit	NT is not met as evidenced entation review and staff y failed to inspect the cooking six months, as stated in the Life		The kitchen hood and cooking will be inspected semi-annual qualified contractor. The next	y by a	

ATEMENT	OF DEFICIENCIES F CORRECTION	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01		E SURVEY PLETED	
		245579	B. WING	05/)5/15/2019		
	PROVIDER OR SUPPLIER	IOME	STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
K 372	 9.2.3 & NFPA 96 sepractice could allow hood suppression properly, affecting residents, staff and Findings include: On the facility tour on 05/15/2019 door there was record or inspection in the lat This deficient cond Maintenance Super Subdivision of Buil CFR(s): NFPA 101 Subdivision of Buil Construction 2012 EXISTING Smoke barriers sh fire resistance ratio be permitted to ter Smoke dampers a penetrations in full an approved sprint smoke compartmet barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanismo in the second second	A 101) 2012 edition section ection 11.2. This deficient w for the spread of fire if the system did not operate an isolated amount of t visitors. between 8:00 am to 11:30 am umentation review revealed f only one semi annual hood st 12 months. lition was confirmed by the ervisor. ding Spaces - Smoke Barrie ding Spaces - Smoke Barrier all be constructed to a 1/2-hour ng per 8.5. Smoke barriers shall minate at an atrium wall. re not required in duct y ducted HVAC systems where kler system is installed for ents adjacent to the smoke	К 32	 has been scheduled for 10-02-2019 Tom Montonye, Maintenance will be responsible to see that completed. The inspection report will be a the Safety committee and the Assurance Committee for rev 	t work is submitted to Quality	6/20/19	
	Based on observation facility failed to ma	ation and staff interview the intain one smoke barrier as 12 Life Safety Code (NFPA		All smoke penetrations will b above the ceiling along the le smoke barrier by the adminis	ength of the		

Facility ID: 00762

If continuation sheet Page 4 of 7

		& MEDICAID SERVICES			OMB NO.	SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3 01 - Main Building 01		PLETED
		245579	B. WING		05/*	15/2019
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SSENT	A HEALTH GRACE H	OME		116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX T A G	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
K 372	practice could allow smoke compartme exiting of 12 of the	ige 4 .3, 8.5.6.2. This deficient v smoke to transfer from one nt to another affecting the 40 residents and an unt of staff and visitors.	K 372	2 offices. A qualified contractor w completing the work. Work is sc to start 6-13-19 and scheduled t complete 6-17-19	heduled	
	on 05/15/2019 obs barrier by the admi	between 8:00 am to 11:30 am ervations revealed the smoke nistration offices contained d penetrations above the gth.		Tom Montonye, Maintenance Su will be responsible to see that w completed. The repair work information will	ork is	
	This deficient cond Maintenance Supe Evacuation and Re CFR(s): NFPA 101		K 71	submitted to the Safety committed to the Safety committee for a submittee for	ee and the	6/1/19
	patients and for the an emergency. Employees are per informed with their copy of the plan is operator or with se basic response rec and provides for al components per 18 18.7.1.1 through 18 18.7.2.3, 19.7.1.1 th 19.7.2.2, 19.7.2.3 This REQUIREME by: Based on docume	blan for the protection of all bir evacuation in the event of iodically instructed and kept duties under the plan, and a readily available with telephone curity. The plan addresses the juired of staff per 18/19.7.2.1.2 of the fire safety plan 8/19.2.2. 3.7.1.3, 18.7.2.1.2, 18.7.2.2, hrough 19.7.1.3, 19.7.2.1.2, NT is not met as evidenced intation review and staff y failed to maintain a Fire		The Fire Safety Plan has been include items: 7, 8 & 9 listed in The updated Fire Safety Plan w	NFPA101.	

Event ID: 0DDK21

Facility ID: 00762

If continuation sheet Page 5 of 7

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE SU COMPLE	
		245579	B. WING		05/15/2019	
	PROVIDER OR SUPPLIER		· · · · ·	STREET ADDRESS, CITY, STATE, ZIP CODE		
				116 WEST SECOND STREET		
ESSENT	IA HEALTH GRACE H	OME		GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
K 711	deficient practice c	section 19.7.2.2. This ould cause confusion in an	K 71 [,]	1 reviewed and approved by the s committee on 6/12/19.	afety	
		ect all 40 residents and an unt of staff and visitors.				
	on 05/15/2019 doc the fire safety plan	between 8:00 am to 11:30 am umentation review revealed did not clearly address all nine A 101. (Items 7, 8 & 9 were not		Tom Montonye, Maintenance Su will be responsible to see that w completed. The revised Fire Safety Plan wil submitted to the Safety committe Quality Assurance Committee for	ork is l be ee and the	
	This deficient cond Maintenance Supe Portable Space He CFR(s): NFPA 101		K 78	1		5/21/19
	prohibited in all hea unless used in non areas where the he 212 degrees Fahre 18.7.8, 19.7.8 This REQUIREME by:	ating devices shall be alth care occupancies, except, sleeping staff and employee eating elements do not exceed enheit (100 degrees Celsius). NT is not met as evidenced		The encode bester in the front le	hhu has	
	and staff interview, a portable space h on file as stated in Code" 2012 edition deficient practice c	ntation review, observation the facility allowed the use of eater without having a policy NFPA 101 "The Life Safety (LSC) section 19.7.8. This ould affect an undetermined s, staff, and visitors.		The space heater in the front lo been removed. Tom Montonye, Maintenance S		
	Findings include:			will be responsible to see that w completed.		

Event ID: 0DDK21

Facility ID: 00762

If continuation sheet Page 6 of 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE									
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0		0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		SURVEY PLETED		
		245579	B, WING			05/1	5/2019		
NAME OF F	PROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE				
ESSENT	A HEALTH GRACE H	OME			6 WEST SECOND STREET RACEVILLE, MN 56240				
LOOLINI				G					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
K 781	on 05/15/2019 docu observations revea address the portabl main entry sitting a	between 8:00 am to 11:30 am umentation review & led there was no policy to le space heater located in the rea.	K 7	781	The information on the removal of space heater will be submitted to the Safety com and the Quality Assurance Commit review.	mittee			

PRINTED: 06/17/2019

ł.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 5, 2019

Administrator Essentia Health Grace Home 116 West Second Street Graceville, MN 56240

Re: State Nursing Home Licensing Orders - Project Number S5579030

Dear Administrator:

The above facility was surveyed on May 13, 2019 through May 16, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. 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 and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> 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 order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

Essentia Health Grace Home June 5, 2019 Page 2

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Maria King, RN, APM Licensing and Certification Program Health Regulation Division Minnesota Department of Health Mankato Place 12 Civic Center Plaza, Suite 2105 Mankato, Minnesota 56001-7789 Email: maria.king@state.mn.us Phone: (507) 344-2716 Fax: (507) 344-2723

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 Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00762	B. WING		05/1	6/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME	SECOND S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf elicensing orders are				
	epartment of Health Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE
	ically Signed					06/14/19

STATE FORM

If continuation sheet 1 of 45

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00762	B. WING		05/16/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	·	
ESSENT	IA HEALTH GRACE H		ST SECOND ST /ILLE, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th corrected prior to e Minnesota Departm On 5/13/19, to 5/16 Department's staff the following correct Please indicate in y correction that you and identify the dat Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag r column entitled " II statute/rule out of contents.	alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rrected" in the box available for indicate in the electronic cess, under the heading he date your orders will be electronically submitting to the nent of Health. 6/19, surveyors of this visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, te when they will be completed nent of Health is documenting g Correction Orders using ag numbers have been sota state statutes/rules for humber appears in the far left D Prefix Tag." The state compliance is listed in the				
	"Summary Stateme and replaces the "T correction order. The findings which are after the statement evidence by." Follo	ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute t, "This Rule is not met as wing the surveyors findings Method of Correction and				
	FOURTH COLUM "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. AR ON EACH PAGE.				

Minnesc	ta Department of He	alth		I	ORM APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE SURVEY COMPLETED
		00762	B. WING		05/16/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
ESSENT	IA HEALTH GRACE H		F SECOND SILLE, MN 50		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 000	Continued From pa	ige 2	2 000		
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.			
2 545	MN Rule 4658.040 Resident Assessme	0 Subp. 3 A-C Comprehensive ent; Frequency	2 545		6/25/19
	assessments must A. within 14 day B. within 14 day the resident's physi	cy. Comprehensive resident be conducted: vs after the date of admission; vs after a significant change in ical or mental condition; and e every 12 months.			
	by: Based on interview facility failed to con Status Assessment (MDS) when two or resident status wer	ent is not met as evidenced and document review, the pplete a Significant Change in t (SCSA) Minimum Data Set more areas of change in e noted for 1 of 16 (R8) for decline in health status.		A Significant Change in Status Assessment (SCSA) Minimum Data S (MDS) was initiated for the identified resident R8 on 5/16/19 and document the Electronic Health Record (EHR).	ed in
	had diagnoses of H disease, dementia, MDS identified R8 impairment and rec assistance for activ except eating R8 re further identified R8 bladder, was alway	lated 8/29/18, indicated R8 neart failure, Alzheimer's anxiety and depression. The had severe cognitive quired extensive to total rities of daily living (ADL's), equired supervision. The MDS 8 was frequently incontinent of s continent of bowel, did not pxygen, had no pressure ulcers loss or gain.		All residents with a change in status h the potential to be affected by this practice. The Interdisciplinary Team (IDPT) reviewed 100% of all current residents evaluate for the presence of a signific change. Any resident identified to hav change in two or more areas shall hav SCSA MDS initiated and a member of IDPT shall complete a note in the EHI Results of this audit shall be reported the QAPI committee. The "Change of Condition" policy has been reviewed and updated. IDPT ar	s to ant e a /e a the R. to

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		:		LETED
		00762	B. WING		05/1	6/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H		T SECOND			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETI DATE
2 545	Continued From pa	age 3	2 545			
2 343	R8's quarterly MDS had diagnoses of h disease, dementia, MDS identified R8 impairment and rec assistance with AD limited assistance. had no current pre- always incontinent supplemental oxyg mechanically altered Review of the above incontinence patter incontinent to totall totally continent to was newly coded for and a mechanically Review of R8's pro 5/15/19, revealed t On 4/8/19, R8 was the buttocks which nurse planned to a absorbent dressing chronic ulcers and a morning bath. On 4/9/19, the Inter reviewed R8's wou identified the woun indicated treatment ordered and Amme for minor skin irrita the area dry and to identified a ROHO	S dated 2/19/19, indicated R8 heart failure, Alzheimer's , anxiety and depression. The had severe cognitive quired extensive to total 'L's, except eating R8 required The MDS further indicated R8 ssure ulcers, no weight loss, of bowel and bladder, utilized en, and received a ed diet for meals. We assessments indicated R8's rn worsened from frequently y incontinent of bladder, and totally incontinent of bowel. R8 or supplemental oxygen use y altered diet for meals.		nursing Staff education will be p at least one of the following me meetings, standups, or schedul meetings on 6/18/19 and 6/20/1 include review of the "Change i Condition" policy and F637. The Interdisciplinary Team shal 100% of all current residents we then monthly x 3 months. Any identified to have a change in tw areas shall have a SCSA MDS Results of the audit shall be rep the QAPI committee for further recommendations.	ans: 1:1 ed I9 to n I review eekly x 4, resident vo or more initiated.	
		ff would monitor the wound t at least weekly until healed.				
nocota D	epartment of Health	ה מו ופמטו שפפרוץ טוונוו וופמופט.				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00762	B. WING		05/	16/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE	-	
SSENT	IA HEALTH GRACE H		T SECOND ST ILLE, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 545	Continued From pa	ige 4	2 545			
	R8's right buttock. I to moderate amour noted on the old dra detected. The oper (centimeters) in wid nursing staff further surrounded the woo measured which in the surrounding da of the majority of th in color and the pro- had a 0.25 cm. dar Further review of R the following: On 3/20/19, docum significant weight to Ibs.(pounds) (10% had variable intake identified staff were food/fluid intake, m closely for significa On 4/10/19, R8's w which was a loss of in 180 days. The n have varying intake The note identified monitor and refer to (RD)-D at the next	8's progress notes revealed entation indicated R8 had a oss in the past 180 days of 21 loss). The note indicated R8 s from 25% - 100%. The note to continue to encourage onitor weights and plan of care				
	indicated a loss of The note indicated	ight was 181.6 lbs. which 19 lbs. in the past 180 days. R8 continued with varying es. The note identified staff				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00762	B. WING		05/	16/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
ESSENT	IA HEALTH GRACE H	IOME	ST SECOND ST VILLE, MN 562			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 545	Continued From pa	ige 5	2 545			
	need more assistar note indicated staff and refer to the RD note lacked any do ulcer or wound press On 5/15/19, RD-D development of pre- indicated R8's weig loss of three lbs. (2 days and 18 lbs. in identified R8 had va recommendation w of ensure at dinner, additional protein, of were to encourage when able. The RD	eing at mealtimes and R8 may nee with eating. Further, the were to continue to monitor I-D at the next site visit. The cumentation of a pressure sent on R8. was notified of weight loss and essure ulcer. The note lyht was 180.4 lbs. which was a %) in 30 days, nine lbs. in 90 180 days (9%). The note ariable meal intakes and a 'as made to trial four ounces /supper meals to provide calories and fluid. The staff protein rich foods and fluids I-D planned to follow-up and next RD-D site visit.	Ŀ			
	confirmed she com for all residents and been completed wir areas of decline we was unsure whethe more areas. NM-A in the electronic he 4/10/19, and confir R8 had a significan confirmed R8 had a buttocks. NM-A cor been completed on		9			
	(DON) stated a SC completed on R8 w decline had been n developed a pressu	p.m. the director of nursing SA MDS should have been when two or more areas of oted. DON confirmed R8 had ure ulcer to her right buttocks present and additionally R8 had	d			

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00762	B. WING		05/	05/16/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE			
ESSENT	IA HEALTH GRACE H	IOME	ST SECOND ST /ILLE, MN 562				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 545	Continued From pa	age 6	2 545				
	experienced weigh criteria to complete	t loss which would meet a SCSA MDS.					
	Condition, indicated	1/19 policy Change in d the care plan and MDS as required with any pertinent ropriate.					
	Long-Term Care Facility Re Instrument (RAI) 3.0 User's	the definition of a significant e or improvement in a					
	intervention by staf disease-related clir is not considered s 2. Impacts more th health status; and	nan one area of the resident's sciplinary review and/or					
	significant change have documented significant change regarding what con status must be bas IDT. Further, the n assessments are n	r directed when the am (IDT) determined that a occurred, the facility should the initial identification of the in the EHR. The final decision astituted a significant change in sed upon the judgement of the nanual clarified that MDS not required for minor or as in the resident status.	ו 🗌				
	administrator, direct designee could rev procedures for con	THOD OF CORRECTION: The ctor of nursing (DON) or riew and revise policies and nprehensive significant change sing staff could be educated as	9				

Minneso	ta Department of He	alth		FOI	RM APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
		00762	B. WING	c	5/16/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
ESSENT	IA HEALTH GRACE H	OME	SECOND S		
		GRACEVI	LLE, MN 56		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 545	Continued From pa	ge 7	2 545		
	comprehensive ass	portance of significant change essments. The DON or nduct audits on a regular basis ce.			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one			
2 900	MN Rule 4658.0525 Ulcers	5 Subp. 3 Rehab - Pressure	2 900		6/25/19
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which			
	without pressure so pressure sores unle condition demonstra	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and			
	receives necessary	ho has pressure sores / treatment and services to event infection, and prevent reloping.			
	by: Based on observati review, the facility fa identify and monitor ulcers for 2 of 2 res observed for pressu practice resulted in initially had an oper	ent is not met as evidenced on, interview and document ailed to accurately assess, facility acquired pressure idents (R8, R27) who were ure ulcer care. This deficient actual harm for R8 who a rea caused by shearing s of skin rubs against each		All residents with identified risk for Pressure Ulcers and/or residents with current pressure ulcers have the potenti to be affected by this practice. A Braden Scale was completed for 1009 of all residents to evaluate pressure ulcor risk. Care plans were reviewed and	%

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y
		00762	B. WING		05/16/201	9
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME	SECOND S			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMP	(5) PLET ATE
2 900	other or when the s underlying tissue m underlying capillarie tissue damage) ide	kin remains stationary and the loves and stretches and tears es and blood vessel causing ntified to the right buttocks	2 900	updated, as appropriate for 100% residents with known risk and/or h skin breakdown. Results of this at be reported to the QAPI Committe	nistory of udit shall	
	(observed full-thick which the extent of	an unstageable pressure ulcer ness skin and tissue loss in the damage cannot be le wound bed obscured with		The IDPT will review 100% of all r with pressure ulcers. Any residen identified pressure ulcer was asse and documentation completed in to include: location, stage, size, ex	it with an essed the EHR	
	2/19/19, indicated F failure, Alzheimer's and depression. Th severe cognitive im extensive to total as living (ADL's) which transfers, dressing, bathing and limited	total assistance with activities of daily) which included bed mobility, essing, toileting, personal hygiene,		odor, pain, wound bed, description wound edges and surrounding tiss present pressure ulcers. The revi also include evaluation of nutrition status, notification of the Register Dietitian (RD) appropriateness of treatment and interventions. The resident s care plan reviewed an as appropriate. Results of this au be reported to the QAPI Committee	n of sue of ew will ed current d revised dit shall ee.	
	developing pressur pressure ulcers ide following intervention pressure ulcers whit device for chair and program. The MDS loss and received a meals. The MDS fur	ted R8 was at risk for e ulcers and had no current ntified. The MDS revealed the ons were in place to prevent ich included pressure reducing d a turning and repositioning i dentified R8 had no weight a mechanically altered diet for orther identified R8 was ent of bladder and always el.		Developing a skin care managem policy and procedure with a define care team. Facility standing orders wounds/ s have been reviewed and updated. The Nutritional Care and Docume policy has been reviewed and rev Certified Dietary Manager(CDM) a note in the EHR when the const	ed wound skin care ntation ised. The will enter ulting RD	
	9/5/18, indicated R& ADL's due to progreand dementia. The for developing presand the need to be	area Assessment (CAA) dated 8 required assistance with essing Alzheimer's disease e CAA revealed R8 was at risk sure ulcers due to immobility repositioned by staff. The had no current skin issues at		has been informed of any pressur The CDM, or designee will audit E ensure appropriate notification to completion of assessment/review nutritional status by RD in EHR m 3 then quarterly X 3. Results shall reported to the QAPI committee.	EHR to RD and of onthly x	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00762	B. WING		05/1	6/2019
IAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		0/2010
SSENT	IA HEALTH GRACE H		T SECOND S			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORF	RECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLET DATE
2 900	Continued From pa	age 9	2 900			
	the time of the asse indicated R8 was a changes due to inta CAA further identifie due to heart diseas kidney failure, dem (quivering or irregu indicated R8 was to on the commode ut transfer, provide the provide incontinent R8's care plan revis required extensive which included bed locomotion, dressin and bathing. The of supervision with se plan identified R8 h buttock as a result instructed staff to a open area and to of days or more often further instructed st with every two hour and every three hou care plan indicated breakdown and rep occurred. The care encourage R8 to co as well as consume times. The care plat to use a geo matt (to o aid in prevention ulcers) placed on th cushion (a cushion prevention) with an used in R8's wheele	essment. The CAA further t risk for weight and fluid ake and abnormal labs. The ed R8 was at nutritional risk with heart failure, acute entia and atrial fibrillation lar heartbeat). The CAA to be toileted three times a day tilizing the mechanical lift to be bedpan as needed and to be care as needed. Sed 5/14/19, revealed R8 to total assistance with ADL's		Staff will receive education b means: 1:1 meetings, standu scheduled meetings on 6/18/ 6/20/19 to review skin, wound nutrition policies, F686, and th Pressure Ulcer and Preventic (NPUAP). Education will inclu of EHR for documentation red accordance with F686 and fa Essentia Health Medical staff education on 6/19/19 related documentation upon notificati changes in resident status, an pertinent health information.	ps, 19 and 4 and he National on Guidelines ude utilization quirements in cility policy. shall receive to need for ion of	

	OVIDER OR SUPPLIER	00762	B. WING			
(X4) ID PREFIX		STREET AF			05/16/20	
(X4) ID PREFIX	HEALTH GRACE H	OTTLET	DRESS, CITY, ST	ATE, ZIP CODE		
PRÉFIX		OME	T SECOND ST ILLE, MN 562			
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLET DATE
2 900 C	Continued From pa	ge 10	2 900			
	ransfer, provide the provide incontinenc	e bedpan as needed and to e care as needed.				
a pt sobo v O a r o a o o r o r pt f O a k s ti s ji s O	and occupational the blaced sling for a m back and looped it is seated in the wheel down in bed. Once been applied to the operated the lift to the wheelchair and low OTA-C guided R8 in and OTA-C turned la removed an inconti- dressing was noted area and was intact dark brown drainag cleansed perineal a new brief to R8. NA on the left side and right side to keep R provided call light to blankets. NA-B and hygiene after remov On 5/14/19, at 1:58 assessed Mepilex of ower buttocks and sized area of dark be he dressing that was soaked through. RN ust been changed is she would not be ch On 5/14/19, at 3:30	p.m. nursing assistant (NA)-B herapy assistant (OTA)-C hechanical lift behind R8's under her legs while she was lchair with plans to lay R8 the loops of the sling had mechanical lift, NA-B transfer R8 out of the ered her into her bed while in the sling. At 1:09 p.m. NA-B R8 to the left side in bed and nent brief. A square Mepilex to R8's right lower buttocks t with a quarter sized area of e noted on the dressing. NA-B placed a pillow behind the t8 on the left side. NA-B o R8 and covered her up with I OTA-C completed hand ving gloves. p.m. registered nurse (RN)-A dressing noted on R8's right noted there was a quarter prown drainage in the center of as visible however had not N-A stated the dressing had the day before and indicated hanging it at that time. p.m. R8 was noted to be re reducing cushion in a				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
---------------	-------------------------------------	--	-------------------------------	--	-------------------------------	-----------------
			. Doilbirta.			
		00762	B. WING		05/16/2019	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
SSENT	IA HEALTH GRACE H	IOME	ST SECOND ST VILLE, MN 562			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	age 11	2 900			
		7 a.m. R8 was noted to be				
		r back as NA-A and NA-C cares to R8. At 7:50 a.m.				
		front of the soiled brief and				
	proceeded to clear	nse R8's front perineal area.				
		sitioned R8 on the right side				
		rief completely and provided er back side. A Mepilex				
		wer buttocks was noted to be				
		ter sized area of dark brown				
		At 7:56 p.m. NA-C placed a				
		and with assistance from				
		brief while turning R8 from side NA-A and NA-C applied pants				
		or the mechanical lift under R8				
		om side to side. At 8:01 a.m.				
	•	lift and NA-C guided R8 into				
		top of the wheelchair cushion. moved the sling and positioned	4			
		operly aligned position in the				
		proceeded to remove R8's				
		ed chest and applied deodoran				
		. At 8:04 a.m. NA-A applied bra	a			
		ratched right arm near R8's ed in a skin tear. NA-A				
		led pressure to stop the				
		d for assistance from nursing				
		RN-A entered R8's room and				
		tear and stated she would				
		treat the skin tear and would . director of nursing (DON)				
		and stated she would return				
		es to treat the skin tear. At 8:14	L I			
		led to apply R8's shirt and				
		m. DON returned to room with				
		loves and placed a cold kin tear that had bled slightly.				
		measurements of the skin tea	r			
	were 5 cm long and	d 0.7 cm in width. DON				
		nse the wound with normal				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00762	B. WING	B. WING		16/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	ADDRESS, CITY, STATE, ZIP CODE				
SSENTI	A HEALTH GRACE H		T SECOND ST ILLE, MN 562				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
	tear after using a co the skin together. If the skin tear and w wrap. At 8:21 a.m. R8 and brushed he completed hand hy brought R8 to the co On 5/15/19, at 1:21 Control Coordinato R8's room during a buttocks area. RN- the left side. RN-A from right buttocks had a little bit of da RN-A stated most of slough present and dark brown area to wound bed. RN-A indicated the width	three steri strips to the skin otton-tip applicator to realign DON placed a dressing over rapped the arm with kling NA-A provided oral cares to er hair. DON and NA-A giene after cares and NA-A lining room for breakfast. p.m. RN-A and Infection r (ICC)-F were both present in a dressing change to her right -A and ICC-F positioned R8 on removed old Mepilex dressing and indicated the dressing rk brown drainage present. of the wound bed had yellow I additionally had a 0.25 cm the proximal area of the measured the wound and of the wound was 2 cm and bund was 2.5 cm. RN-A					
	statedd there was a wound. RN-A conf worsened since she been no yellow slou when she'd last ass not able to recall th wound. RN-A state wound as a stage t depth of the wound applied clean glove normal saline and a dressing. RN-A rer completed hand hy	about 0.1 cm depth to the irmed the wound had e had seen it last as there had ugh present in the wound bed sessed the wound. RN-A was ie date she had last seen the ed she would classify the wo pressure ulcer due to the I and ICC-F concurred. RN-A es, cleansed the wound with applied a new Mepilex moved her gloves and rgiene. RN-A stated the wound by friction from a sling and as a					
		den scale (tool used to pressure ulcer development)					

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	CONSTRUCTION		E SURVEY PLETED
		00762	B. WING	NG		16/2019
NAME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	TATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H		ST SECOND ST VILLE, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	dated 11/19/18, ind developing pressur risk factors: slightly moisture, chairfast and had a potentia shearing. The Bray additional risk facto cardiovascular dise diabetes, and thyro further indicated R8 assistance with beg a mechanical lift fo incontinent of bowe Review of R8's Bra indicated R8 was a pressure ulcers duy slightly limited sens moist, chairfast, slip problem with frictio scale revealed R8 which included carre incontinence and c Braden scale furthe extensive assistant the use of a mecha incontinent of bowe The medical record scale assessments Review of R8's Ski revealed the follow -R8 developed a sk that was noted to b centimeters (cm.), amount of bleeding	licated R8 was at risk for re ulcers due to the following r limited sensory perception, slightly limited with mobility l problem with friction and den scale revealed R8 had the ors which included ease, chronic incontinence, bid disease. The Braden 8 required extensive d mobility, required the use of r transfers and was always el. den scale dated 2/16/19, t moderate risk for developing e to the following risk factors: sory perception, was often ghtly limited mobility and a n and shearing. The Braden had additional risk factors diovascular disease, chronic ognitive impairment. The er indicated R8 required ce with bed mobility, required anical lift and was always el. d lacked any additional Brader is completed after 2/16/19. n Integrity Event for 4/8/19,	· · · · · · · · · · · · · · · · · · ·	DEFICIEN	57)	

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00762	B. WING		05/16/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME	T SECOND ST ILLE, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	ge 14	2 900			
	it after R8's bath. 1	epilex dressing was applied to The event indicated the y had been notified.				
		disciplinary progress notes health record (EHR) from 4/8- ne following:				
	her buttocks that m planned to apply M dressing used to tre	oted to have an open area to easured 0.5 [cm]. Nurse epilex (a foam absorbent eat acute and chronic ulcers R8 had received morning bath.				
	R8's wound to the t wound as shearing treatment would be Ammens powder (a irritations) would be and to prevent brea ROHO cushion (a c relief) would be utili	linary Team (IDT) reviewed buttocks and identified the . The note further indicated administered as ordered and a powder utilized for minor skin e applied to keep the area dry akdown. The note identified a cushion used for pressure ized in R8's wheelchair and the wound daily and weekly until healed.				
	buttock as well as a laterally to the initia foul-smelling bowel medications were r	aw area noted to R8's right another 0.5 cm. located 1 cm I area. R8 had a large loose movement (BM) and bowel not administered as a result. Ind a new Mepilex dressing to ea.				
	and dressing had b result. The note inc	large loose foul-smelling BM een changed again as a dicated the inferior (older) area and the superior (new) area cm.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00762	B. WING	B. WING		16/2019	
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
SSENT	IA HEALTH GRACE H	IOME	ST SECOND ST VILLE, MN 562				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	age 15 sing had been soiled again	2 900				
	and nursing staff cl new dressing. Nurs appeared to be incl	eansed the area and applied sing staff noted the area reasing in size and would ask ing (DON) to assess the area					
	4/22/19, and 4/23/1 The lower open are superficial and nea area had been note diameter with four s	ssing had been changed on 9, due to large loose BM's. a had been noted to be very rly healed. The upper open ed to be approximately 2 cm in spots covering and about 1/3 y through the skin and					
	after R8 had a large be 2 x 2 cm and the	changed to R8's right buttock e BM. The area was noted to e area was 100% blanchable rmal skin color when pressure oved).					
	noted to be all curle the old dressing an dressing. R8's area	ing to her right buttock was ed up. Nursing staff removed d applied a new Mepilex a had no drainage, had clean ed to be dark red in color.					
	off and a new Mepi	sing was noted to be coming lex dressing was applied. No ns of change had been noted					
	x 2 cm open area t Mepilex dressing. T and the dark red ar	oted to continue to have a 2 c hat was dressed with a The wound had no drainage rea had clean edges. R8 was recurrent incontinent BM's.	m				
		pational therapy) staff psitioning needs and instructe	d				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00762	B. WING		05/	16/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H		ST SECOND ST VILLE, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 16	2 900			
	further indicated th relieving cushion) v	on the left side. The note e ROHO cushion (pressure vas not holding air and OT g with vendors for other				
		ressing completed to R8's rigl ed. Area noted to be slightly ighter pink in color.	ht			
	staff on proper use progress note furth	rovided education to nursing of the hygiene sling. The per indicated the DM (dietary are of the skin concern and addressed.				
		change completed to R8's righed. Area noted to have had	nt			
	right buttock and n measured 1.5 cm i skin noted to be mi	change completed to R8's oted to have a round area tha n the center and superficial issing in 1 cm border of the area had been noted to be	t			
	and was noted to b remove. The area	dressing had been removed be soiled and difficult to was noted to be 3.0 cm. x 3.0 nd was noted to be moist.				
		ing to R8's right buttock removed and a new Mepilex applied.				
	buttock. Nursing st moderate amount of	Iressing changed to R8's right aff indicated a small to of tan colored drainage was essing and no odor had been				

TATEMEN	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00762	B. WING		05/16/2019		
IAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
SSENT	IA HEALTH GRACE H		ST SECOND ST /ILLE, MN 562				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	-	2 900				
	by 2.5 cm in length indicated darker pin wound and the entri included the open dark pink tissue 3 of the wound bed was	n area measured 2 cm in width . The nursing staff further nk tissue surrounded the ire wound measured, which wound and the surrounding cm. The color of the majority o s light yellow in color and the e open wound had a 0.25 cm ea.					
		s lacked documentation of sure ulcer or the presence of 3's pressure ulcer.					
	stated R8 required all ADL's except for limited assistance shearing to her righ sling and OTA-C as positioning practice use of the hygiene further shearing. No were notified by NA	a 5/14/19, at 1:25 p.m. NA-B extensive to total assist with or eating which she required with. NA-B stated R8 had a at buttocks from her old lift ssisted with determining best as well as suggesting the sling in an attempt to prevent IA-B stated licensed nurses A's when skin issues develop ked every day by NAs during					
	occupational therap evaluate and make pressure relieving of as suggesting posi confirmed R8 had sling to prevent fur OTA-C stated OT s	21 a.m. OTA-C stated by staff received an order to a recommendations for devices for R8 to use as well tioning strategies. OTA-C been changed to a hygiene ther shearing from occurring. staff provided education to oper use of slings as well as for R8.					
		6 a.m. NA-C stated R8 assist with ADL's and minimal					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00762	B. WING		05/	16/2019
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
SSENT	IA HEALTH GRACE H		ST SECOND ST /ILLE, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 18	2 900			
	had been changed hygiene sling due to to her skin. NA-C fu	ing tasks. NA-C indicated R8 from the old lift sling to a o the old one causing irritation urther stated the sore on her loped from the use of the old				
	Review of R8's cur 5/15/19, which inclu	rent physician orders as of uded the following:				
	dressing weekly on	ursing order to change I bath day and as needed and lition of dressing under results				
	- 5/15/19, Vicair cu	shion for wheelchair.				
		atment administration record 9, revealed the following:				
	light dusting of Am	9, Ammens Powder- apply mens Powder to bottom to aide and prevent breakdown.	e			
	weekly on R8's bat Additionally, the nu the condition of the	(19, to change the dressing h day and as needed. rsing staff were to document dressing under result in the and chart under event at leas and as needed.	st			
	Review of R8's phy 3/19- 5/15/19, reve	vsician progress notes from aled the following:				
	R8 had no complai no changes with th	ician progress note indicated nts except for feeling tired and e plan was indicated. The ed any documentation of any				
	- 4/24/19, the progr	ress note indicated R8 had no				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED	
		00762	B. WING		05/	05/16/2019	
	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
		116 WES	T SECOND S				
ESSENT	IA HEALTH GRACE H		/ILLE, MN 562				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	age 19	2 900				
	note identified an in milligrams (mg) (pr pressure) and to ch draw. The progress documentation of a - 5/14/19, the progress documentation of v weight loss. Howev note indicating nurse primary physician (being treated and the According to the neu- ulcer had developed	any pressure ulcers or wounds.	5				
	note indicated MD- determined the ulc and had shallow pa However, the note assessment of the weight loss, or any loss. The note inc believed the ulcer of	dum to the 5/14/19, progress E had assessed the ulcer and er was the size of a quarter ale superficial slough. did not include any physician resident's nutritional status, plans to address the weight licated the nursing staff developed from shear or friction, seat position and					
		8's progress notes of the EHR ent had experienced a oss:					
	11/13/18, 200.5 po 12/13/18, 196 lbs. 1/13/19, 193 lbs. 2/13/19, 188.3 lbs. 3/12/19, 188.8 lbs. 4/15/19, 183.9 lbs.	unds (lbs.)					

STATE FORM

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00762	B. WING	B. WING		16/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	TATE, ZIP CODE	•	
ESSENT	IA HEALTH GRACE H		ST SECOND ST VILLE, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 20	2 900			
	5/13/19, 180.4 lbs.					
	R8 had an open we measured 2 cm by cm. RD-D also ider pounds which equa loss in 30 days, 5% 9% weight loss in 1 indicated R8's mea variable, and indica had the best intake supper meals rang recommended a tri lunch and supper n protein, calories an were to offer protei favorite foods to im identified goals of s integrity, suppleme intakes to be equal the RD-D planned to visit.	umented she had been notifie bund to her right buttocks that 2.5 cm with a total width of 3 ntified R8's weight of 180.4 aled an additional 2% weight weight loss in 90 days and 80 days. The RD-D note 1 intakes continued to be ated breakfast was where R8 76-100%, while lunch and ed from 25% to 75%. RD-D al of 4 ounces of ensure at neals to provide additional d fluids. Additionally, staff n-rich food/fluids and offer prove intakes. The note stabilizing weight, improve skir nt acceptance, improve meal to or greater than 75% and to follow-up at the next site	1			
	(MAR) for May 201 nutritional supplem	dication administration record 9, indicated there had been no ents ordered/initiated for R8.				
	(TAR) for May 2019	atment administration record 9, also failed to indicate any ent order or implementation.				
		p.m. registered nurse onfirmed R8 had not been lements.				
	were reviewed on a had not been eating	p.m. DD-B stated weights a weekly basis and if a residen g well or experienced an uss, offering high caloric foods				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
	OF CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _			FLETED	
		00762	B. WING			05/16/2019	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
SSENT	IA HEALTH GRACE H		T SECOND ST /ILLE, MN 562				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 900	Continued From pa	age 21	2 900				
	implement. DD-B a supplements would who had pressure healing. DD-B con during her last site confirmed he was n ulcer. DD-B furthe receiving nutritiona						
	interview with RD-I closely with DD-B t and further stated s monthly basis. RD- developed inbetwe email or call her or she would expect t any resident develo significant weight lo first been notified b and significant weigh have expected to h both. RD-D stated 5:56 p.m. on 5/15/7 weight loss had oc had experienced a past six months. F recommendations and supper meals, foods to promote w further weight loss.	07 a.m. during a phone D, RD-D stated she worked o monitor nutritional concerns she made onsite visits on a -D explained for any needs tha en her visits, DD-B would the telephone. RD-D stated o be notified within 48 hours if oped a pressure ulcer or had a bass. RD-D confirmed she had by DD-B of R8's pressure ulcer ght loss on 5/15/19, and would have been notified earlier for she'd reviewed R8's EHR at 19, to determine intakes and curred. RD-D confirmed R8 significant weight loss in the further, RD-D made for a supplement at the lunch and encouraging high caloric vound healing and to prevent RD-D stated she planned on erson during her next onsite aned to do within the next					
	stated the process nurses assessing t	5 p.m. nurse manager (NM)-A for skin care involved the he pressure ulcers and nining if the pressure ulcer was					

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00762	B. WING		05/	05/16/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
ESSENT	IA HEALTH GRACE H	OME	F SECOND ST LLE, MN 562				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 900	blanchable or not. pressure ulcer had caused by friction of as an abrasion. NM ulcer had been cau incontinence brief. aware R8's pressur present and would to determine that. N was for nursing sta Wound Assessmer and document in th of the EHR. NM-As staff would comme ulcer was improving Review of R8's E-Z Worksheet dated 5 wound to the "Butt worksheet indicated 3.0 cm and a depth indicated the prese eschar/slough pres hand drawn diagran with an inner circle "yellow". To the righ was the handwritte The worksheet pro- wound base, draina periwound appeara present, and wound were left blank. No Assessment Works On 5/16/19, at 12:5 (MD)-E indicated he normally, would con-	NM-A further stated if the been determined to be or shearing the staff identified it A-A indicated R8's pressure used by shearing from her NM-A stated she was not re ulcer had yellow slough have had to assess it herself NM-A stated the expectation ff to utilize the E-Z Graph nt Worksheet at least weekly be events and progress notes stated it was expected nursing nt on whether the pressure g or not at least weekly. C Graph Wound Assessment M11/19, indicated R8 had a - R [right] side." The d a length of 3.0 cm, width of n of 0.5 cm. The worksheet	2 900	DEFICIENC	ΥΥ)		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00762	B. WING	B. WING		16/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME	T SECOND ST ILLE, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	ulcer to her right low unstageable due to slough. MD-E state current treatment a the pressure ulcer v On 5/16/19, at 2:02 (DON) stated R8 ha identified in R8's EF implemented new in DON also stated th monitoring and treat involved the nursing form, updating the of the appearance of t least weekly. The D pressure ulcer docu location of the wour wound, if there was signs or symptoms present and a thoro The DON explained as a shearing abras or sling utilized with verified the pressur unstageable pressu slough present. The staff recently watch regarding pressure repositioning requir R27's quarterly MD moderate cognitive heart failure, hypert disease, Diabetes M MDS indicated R27 from 2 staff with action	wer buttocks that was the wound bed covered in ed he planned to continue nd interventions and expected would heal. p.m. the director of nursing ad a significant weight loss as IR and verified RD-D had nterventions on 5/15/19. The e expectation for identifying, ting a pressure ulcer or wound g staff completing an event care plan, and documenting the pressure ulcer or wound at 0ON stated it was expected the umentation would include the nd, the measurements of the drainage or odor present, any of infection, if there was pain bugh description of the wound. d R8's pressure ulcer started sion from the incontinent brief the mechanical lift and e ulcer had worsened to an ure ulcer which had yellow e DON stated licensed nursing ed a webinar in March 2019, ulcer prevention and ements. S dated 4/17/19, indicated impairment and diagnoses of ension, peripheral vascular Mellitus, and dementia. The required extensive assistance tivities of daily living (ADL)s ity, transferring, toileting,				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00762	B. WING				
NAME OF I	PROVIDER OR SUPPLIER	STREET #	ADDRESS, CITY, STATE, ZIP CODE				
ESSENT	IA HEALTH GRACE H	IOME	ST SECOND ST VILLE, MN 562				
(X4) ID	SUMMARY ST		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE	
2 900	Continued From pa	age 24	2 900				
	 1/25/19, revealed F and indicated at ris no skin issues. In R27 required staff dressing the lower was at risk for skin advanced aging, pot thin fragile skin. R27's current care interventions and in deficits, and require addition, the care p skin breakdown on problems, needing of Diabetes Mellitus disease (PVD), adve easily bruising relat During an interview stated she had a se were aware and ha area, but indicated A review of R27's at administration reconstructed staff to p protectors in the m Review of R27's pr 3/5-5/14/19, lacked issues or interventi 		9 d n				
	indicated R27 had toe on the right foo rubbing from her sl	a reddened area on second t and indicated she also had hoes on her left foot, that she nd indicated staff would make					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00762	B. WING		05/16/2019	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			10/2010
		116 WES				
SSENTI	A HEALTH GRACE H	IOME GRACE\	/ILLE, MN 562	240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 900	Continued From pa	age 25	2 900			
	sure she was wearing the toe sleeves.					
	(EMAR) and electror record (ETAR) were monitoring or docu	edication administration record onic treatment administration e reviewed and lacked mentation of the redness toe, use of the toe sleeve, or s toes or feet.				
	address any report feet/toes or use of friction or rubbing of	ry consult on 3/5/19, did not s of redness or irritation of her the toe sleeve to reduce during the visit and indicated no e noted at the time of the visit.				
	room with her feet R27 was wearing b tan compression so extremities with tar	m. R27 was seated in her elevated in a recliner chair. lack diabetic shoes and had ocks on bilateral lower of Geri sleeves (protective wer legs under her pants.				
	(NA)-C stated she head to toe with me NA-C stated if she issues with a reside nurse right away. N on the left second to new for R27 and st	S a.m. Nursing Assistant looked at all residents' skin orning and bedtime cares. observed any changes or ent's skin she would notify the IA-C stated R27 had redness toe and indicated it was not aff were putting a foam toe e to separate the toes and her shoes.				
	checked the reside morning and evenin bath aide complete assessment on eac would report any co	a.m. NA-D stated she ont's skin every day with ng cares, and indicated the od a head to toe skin ch resident's bath day and oncerns to the nurse. NA-D document the skin issues, but				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MI II TIPI F	CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00762	B. WING		05/16/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
SSENT	IA HEALTH GRACE H		ST SECOND ST /ILLE, MN 562			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	ige 26	2 900			
	NA-D stated if there interventions they w the eTAR so nursin document on the au cared for R27 and o which she had mac said nursing was m applying padding to morning cares.	nentation could be completed. e were any skin issues or vould be care planned and on g staff could monitor and rea. NA-D stated she had observed redness on her toes de nursing staff aware of. NA-I ionitoring the areas and were o the reddened toes with				
	look at the resident cares in the mornin them over head to any issues such as different she would stated the process to complete a Stop if a resident had Dia she would pay clos stated the nurse wo and complete the d resolved. NA-E state and stated staff loo cares. NA-E also et stockings and remo indicated they look NA-E stated she ha left second toe and the nurse several m apply toe cushion w stated R27's toes d	a.m. NA-E stated she would 's skin when she is providing g and evenings, checking toe. NA-E stated if there are bruising, redness, or anything report it to the nurse. NA-E for reporting a skin issue was N Watch (alert). NA-E stated abetes or other skin issues e attention to their feet. NA-E buld then assess the skin issue locumenting and tracking until ted she had worked with R27 k at her skin and feet with xplained staff help R27 apply by them every day and at feet and legs at that time. ad observed redness on R27's had reported the concern to nonths ago. NA-E stated they wraps as an intervention, and lid not look any different than t couple of months.	9			
	(RN)-A stated the p monitoring was to c	0 a.m. registered nurse process for routine skin complete the licensed nurse DC) weekly assessment for al				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00762	B. WING		05/	16/2019
AME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE. ZIP CODE	00/	10/2013
	A HEALTH GRACE H	IOME 116 WES	T SECOND ST	TREET		
		GRACEV	/ILLE, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLE DATE
2 900	Continued From pa	age 27	2 900			
	skin condition. RN- NAs looked at the r cares and notify nu in skin integrity. RI resident's skin head LNDC and indicate facility policy. RN-A skin breakdown du and stated they get there was no monit place. In addition, F of any current skin the most current te resident's chart and redness on her toe plan. RN-A stated t monitor any change nursing, but indicat anything specific at toes, or effectivene sleeves. RN-A verif of redness on R27' staff to notify her of On 5/16/19, at 1:13 Registered Nurse (look at R27's toes a toes were reported provider today and to look at them. IC provider discontinu Ted stockings, stati pressure on her toe feet, causing her to multiple reddened a follows:	a included questions regarding A stated the bath aide and residents' skin during daily rsing if there are any changes V-A stated she looked at the d to toe each week for the d she thought that was the a stated R27 was at risk for e to history of hammer toes, a red and sore. RN-A verified coring for this issue currently in RN-A stated she was not aware issues with R27, and reviewed mporary care plan in the d verified monitoring of the s was not in temporary care he care plan instructed staff to es in skin and report to ed the care plan lacked pout monitoring R27's feet or ss of the use of R27's toe fied she had not been notified s toes, and would expect NA f any skin concerns. B p.m. Infection Control ICRN)- F stated she would again, and stated R27's red to the resident's medical he came over from the clinic RN-F stated the medical ed use of the toe sleeves, and ing they were actually putting es related to deformities in her heres to rub together. The areas measured were as				
		a 100% blanchable, R27				

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00762	B. WING		05/16/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME	T SECOND ST VILLE, MN 562			
	SUMMARY STA			PROVIDER'S PLAN OF		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	ge 28	2 900			
	verbalized her toes	hurt.				
	- Right foot second measuring 0.5 cm	toe red 100% blanchable area X 0.3 cm.	ı			
		toe top of knuckle calloused nchable reddened area (0.4 cm.				
	- Right top of foot s dry with no drainag	cabbed area measured 0.5 cm e.	ı			
		be first knuckle 100% red nich measured 0.5 cm X 0.5				
	resident expressed	nuckle 0.7 cm X 0.6 cm discomfort with palpation, ned area which measured 0.3 rea not blanchable.				
	- Left foot third toe which measured 0.	100% red blanchable area 4 cm x 0.5 cm.				
	- Left foot redness which measured 1.	on the side of the third toe 5 cm long.				
	was the first time" s reddened areas on she would expect s integrity to nursing	p.m. ICRN-F verified "today she had been notified of the R27's toes. ICRN-F stated taff to report issues with skin staff for monitoring. In ated the toe socks, Ted				
	stockings, and skin by licensed staff we the care plan and e resolved. ICRN-F	checks should be completed eekly and any issues added to TAR for monitoring until verified that R27 was at high				
	advanced age, histe	on her feet related to her ory of Diabetes Mellitus, and red she should have her feet				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00762	B. WING		05/	05/16/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
ESSENT	IA HEALTH GRACE H	IOME	T SECOND ST ILLE, MN 562				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	age 29	2 900				
	monitored and doc	umented on daily.					
	not been aware of l her toes, and stated observe alterations charge nurse and in monitoring and door DON stated license assessed and door foot tenderness wit this had not been d nursing staff should head to toe skin as	p.m. the DON stated she had R27's sore reddened areas on d she would expect staff who in skin condition to notify the mplement the process to begin cumentation until resolved. The ed nursing staff should have umented on R27's redness and h daily monitoring, but verified lone. The DON stated the d be completing a thorough sessment when completing and verified this had not been					
	Non-Surgical Wour Management revise provide the followin ulcers and wounds location, stage, dep of drainage, tissue condition of skin su present, and appro The policy further in review nutritional st make recommenda policy identified the when the stage incl licensed staff would	policy Pressure Ulcer and nd Documentation and ed 1/19, instructed staff to ng documentation of pressure at least weekly: wound type, oth, measurement, description description, signs of infection, irrounding the ulcer, if pain priate care and treatment. Instructed the dietician to tatus of the resident and to ations to promote healing. The physician would be notified reases. The policy indicated d verify weekly that a accurate and appropriate.					
	3/19, indicated licer weekly head to toe undressing the port pressure ulcer or w	policy Skin Inspection revised nsed staff would complete a skin inspection which included tion of the body with a round present. The policy nurses would manage any					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00762	B. WING		05/16/2019	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
SSENT	IA HEALTH GRACE F		ST SECOND ST /ILLE, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 900	Continued From pa	age 30	2 900			
	policy indicated lice event to ensure mo	ons in skin noted. Further, the ensed staff would create a skin phitoring, documentation and kin alteration was completed ded.				
	Long-Term Care Fa Instrument (RAI) 3. 10/2018, identified be completed to ide appearance and ch ulcers/injures. The ulcer/injury as a loc underlying tissue, u prominence, as a r prolonged pressure pressure ulcer/injur an open ulcer and further identified it w the etiology of all w	e manual defines a pressure calized injury to the skin and/or usually over a bony esult of intense and/or e in combination of shear. The ry can present as intact skin or may be painful. The manual was imperative to determine younds and lesions as that nd direct the proper treatment	,			
	ulcer/injury as "an of alteration of intact s compared to an ad body, may include following paramete or coolness), tissue sensation (pain, itc persistent redness whereas in darker s	tes a stage one pressure observable, pressure-related skin whose indicators, as ljacent or opposite area of the changes in one or more of the ers: skin temperature (warmth e consistency (firm or boggy), hing); and/or a defined area of in lightly pigmented skin, skin tones, the injury may tent red, blue or purple hues."				
	ulcer/injury as "part presenting as a sha	les a stage two pressure tial thickness loss of dermis allow open crater with a d, without slough or bruising."				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00762	B. WING	B. WING		16/2019
AME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, S	TATE, ZIP CODE	00,	10/2013
SSENTI	A HEALTH GRACE H		ST SECOND ST VILLE, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 31	2 900			
	- The manual defines a stage three pressure ulcer/injury as "Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is exposed. Slough may be present but does not obscure the depth of tissue loss."					
	ulcer/injury as "Full exposed bone, ten	es a stage four pressure I thickness tissue loss with don or muscle. Slough or sent on some parts of the				
	with slough and/or cannot be visualize unstageable becau	ed " pressure ulcers covered eschar, and the wound bed ed, should be coded as use the true anatomic depth of e (and therefore stage) cannot				
	The administrator of review, and/or revision ensure identified quip pressure ulcer treat reviewed by the quip assurance committed to address the con- designee could eduit the policies and pro-	THOD OF CORRECTION: or designee could develop, se policies and procedures to uality of care concerns with tment and prevention and are ality assessment and tee and action plans develope cerns. The administrator or ucate all appropriate staff on ocedures. The administrator of velop monitoring systems to mpliance.	d			
	TIME PERIOD FO (21) Days	R CORRECTION: Twenty-on	e			
2 965	MN Rule 4658.060 -Nutritional Status	0 Subp. 2 Dietary Service	2 965			6/25/19

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/16/2019	
		00762	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	IOME	T SECOND S			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLET DATE
2 965	Continued From pa	age 32	2 965			
	must ensure that a which supplies the determined by the assessment. Subs	onal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident stitutes of similar nutritive value residents who refuse food				
	by: Based on observat review, the facility f ongoing nutritional residents (R8) revie sustained harm wh accurately and time address risk factor status, and implem acceptable nutrition experienced a clini 10% in six months. Findings include: R8's quarterly Mini 2/19/19, indicated I included anemia, h pressure, Alzheime depression. The M cognitive impairme total assistance wit	mum Data Set (MDS) dated R8 had diagnoses which eart failure, high blood er's, Dementia, anxiety and IDS identified R8 had severe nt and required extensive to h activities of daily living		The Registered Dietician (RD) by the Certified Dietary Manage the identified resident R8 add weight loss and change in skin on 5/15/19, since previously, n RD of a significant weight loss and documentation noted "may from a gradual weight loss to re stress on organs and joints." C RD made recommendation for interventions "trial of 4oz. Ensu Dinner/ Supper meal to provide protein, calories, and fluids. Er protein rich foods and fluids wh Offer favorite foods to improve On 5/24/19 CDM added addition nutritional supplement of Plus 2 Shakes TID between meals. R plan updated to reflect changes	er (CDM) of itional condition otifying the on 3/20/19 benefit educe on 5/15/19 nutritional re at additional ncourage ien able. intake."	
	dressing, toileting, limited assistance	ided bed mobility, transfers, personal hygiene, bathing and with eating tasks. The MDS it risk for developing pressure		The nutritional/ hydration status residents was reviewed by IDP at risk have been referred to RI monthly onsite assessment, nu	T and those D for	

0DDK11

If continuation sheet 33 of 45

	ta Department of He	ealth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00762	B. WING		05/16/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
		116 WES	T SECOND	STREET		
ESSENT	IA HEALTH GRACE H	GRACEV	ILLE, MN 5	6240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 965	Continued From pa	age 33	2 965			
	identified. The MDS revealed the following interventions were in place to prevent pressure ulcers which included pressure reducing device for chair and a turning and repositioning program. The MDS identified R8 had no weight loss and received a mechanically altered diet for meals.			interventions put in place car reviewed and updated, as ap Results of this audit shall be the QAPI committee.	propriate. reported to	
	9/5/18, indicated R ADL's due to progra The CAA revealed pressure ulcers due be repositioned by	Area Assessment (CAA) dated 8 required assistance with essing Alzheimer's Dementia. R8 was at risk for developing e to immobility and the need to staff. The CAA identified R8 n issues at the time of the		The "Nutritional Care and Do policy has been reviewed and Staff will receive education re updated policy and F692 by o following means: 1:1 meeting or scheduled meetings on 6/ 6/20/19.	d revised. egarding the one of the gs, standups,	
	for weight and fluid abnormal labs. Th was at nutritional ri heart failure, acute	CAA indicated R8 was at risk changes due to intake and e CAA further identified R8 sk due to heart disease with kidney failure, dementia and ivering or irregular heartbeat).		The IDPT will review all resid current impaired nutritional si x4, then monthly thereafter. notify RD per "Nutritional Car Documentation" policy & proo Results of the audit will be re QAPI Committee for further	atus weekly CDM will e and cedure.	
	required extensive which included bed locomotion, dressir and bathing. The c supervision with se were to monitor the assistance. The ca open area to her rig	sed 5/14/19, revealed R8 to total assistance with ADL's I mobility, transfers, ng, toileting, personal hygiene care plan indicated R8 required t-up for eating tasks and staff e resident's need for increased re plan identified R8 had an ght buttock as a result of plan instructed staff to		recommendations.		
	encourage R8 to co as well as consume times. The care play regular diet with ne be seated at the su occasionally require eating tasks from so instructed staff to no	onsume a well balanced diet e all fluids offered at meal an identified R8 was on a ctar thin liquids and R8 was to pervision table due to ed increased assistance with staff. The care plan further nonitor and record intake and icant changes to the physician				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			E SURVEY PLETED		
		00762	B. WING	B. WING		16/2019		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE					
ESSENT	A HEALTH GRACE H		ST SECOND ST VILLE, MN 562					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE		
2 965	Continued From pa	age 34	2 965					
	and family.							
	seated in her whee being assisted by r her lunch. R8 com and one fourth of h apple juice. On 5/15/19, at 8:42 dining room and pl table. R8 was prov consisting of a ban and yogurt as well was noted to be lea wheelchair. R8 wa attempted to feed h difficulty. At 8:46 a and attempted to p position in her whe herself her breakfa occasional assistan food on her fork ar 9:20 a.m. R8 contin was no longer eatin consumed all of her	20 p.m. R8 was observed to be elchair at the dining room table hursing assistant (NA)-B to eat asumed one half of her sherbe her hotdish. R8 drank all of he 2 a.m. NA-A wheeled R8 to the aced her at the dining room vided her breakfast tray hana, toast, scrambled eggs as two glasses of juice. R8 aning to her left in her as provided a fork by NA-A and herself bites of her banana wit a.m. NA-A sat down next to R8 bosition R8 in a more upright elchair. R8 proceeded to feed ast slowly with cueing and nce from NA-A with placing and guiding it to R8's mouth. At nued to drink her juices and ng anymore of her food. R8 er banana, half a slice of toast of the yogurt and eggs.	t r e					
	wheelchair at the d lunch to be served brought back to he nausea. R8 had no the nausea. Review of R8's we	4 a.m. R8 was seated in her lining room table waiting for . At 12:15 p.m. R8 was r room due to complaints of ot eaten her lunch as a result o ight record from the electronic						
	health record (EHF 11/13/18, to 5/13/1	R) were reviewed from 9 and included:						

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
		00762	B. WING		05/	16/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	IOME	ST SECOND ST /ILLE, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From pa	age 35	2 965			
	revealed R8's weig this compared to 1 201.5 lbs. 180 days indicated R8's usual lbs. The screening swallowing problem equipment. The sc intake was 51%-75 consumed under 1 The screening furth	9/19, nutritional screening ht was noted to be 190.2 lbs., 92.9 lbs. 30 days prior and s prior. The screening al body weight was 190- 200 further indicated R8 had hs and utilized adaptive creening identified R8's usual 5% and she typically 000 milliliters (ml.) of fluids. her identified R8's skin as d the team should continue the	Ð			
	Review of progress revealed the follow	s notes from 3/20-5/15/19, ing:				
	weight was 188.3 II significant weight lo days. The note inc gradual weight loss and joints. The note intakes varied from identified R8 requir indicated staff wou	dietician (RD)-D noted R8's bs. and R8 had experienced a oss of 21 lbs. (10%) in 180 licated R8 may benefit from a s to reduce stress on organs e further indicated R8's meal o 25% to 100%. The note red encouragement and ld continue to monitor weights, f care for significant changes.				
	was 185 pounds w loss in 30 days and days. The note ide	ector (DD)-B noted R8's weigh hich equaled a 3.6% weight d a 10.1% weight loss in 180 entified R8's intakes varied per meal. The note indicated	t			

Minneso	ta Department of H	ealth			FURIM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA				E SURVEY PLETED
		00762	B. WING		05/16/2019	
NAME OF I	PROVIDER OR SUPPLIER		DRESS. CITY. S	STATE, ZIP CODE		10/2013
	IA HEALTH GRACE H	116 WES	T SECOND S			
ESSENT		GRACEV	ILLE, MN 56	240		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 965	Continued From pa	age 36	2 965			
	the plan to continu RD-D at the next s	e to monitor and to refer to ite visit.				
linnesota D	pounds which equa 180 days. The note by meal. Further, it cueing to dine as r require more assis indicated staff wou RD-D would see R 5/15/19, RD-D stat had an open woun measured 2 cm by cm. RD-D also ide pounds which equa loss in 30 days, 5% 9% weight loss in meal intakes contin indicated breakfass intake 76-100%, w ranged from 25% t trial of 4 ounces of meals to provide a fluids. Additionally food/fluids and offe intakes. The note weight, improve sk acceptance, impro or greater than 75% follow-up at the net Review of the phys electronic health re from 2/22-5/15/19, 2/22/19, the progre	ed she had been notified R8 d to her right buttocks that 2.5 cm with a total width of 3 ntified R8's weight of 180.4 aled an additional 2% weight 6 weight loss in 90 days and 180 days. RD-D indicated R8's nued to be variable, and t was where R8 had the best while lunch and supper meals o 75%. RD-D recommended a ensure at lunch and supper dditional protein, calories and , staff were to offer protein-rich er favorite foods to improve identified goals of stabilizing in integrity, supplement ve meal intakes to be equal to % and the RD-D planned to				
TATE FOR	-		⁶⁸⁹⁹ C	DDK11	If continuati	on sheet 37 of 4

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			SURVEY PLETED
		00762	B. WING		05/-	16/2019
AME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
SSENTI	A HEALTH GRACE H	IOME	T SECOND ST ILLE, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 965	Continued From pa	ige 37	2 965			
	regarding R8's weig weight loss. 4/24/19, the progree regarding R8's weig weight loss. 5/14/19, the progree of weight loss or a However, there was nursing staff had in (MD)-E of R8's glut progress toward he the physician indica due to shear or ma position and expos 5/15/19, an addeno note indicated MD- determined the ulor and had shallow pa However, the note assessment of the weight loss, or any loss.	ss note lacked documentation ght loss or a plan to address ss note lacked documentation ght loss or a plan to address ss note lacked documentation plan to address weight loss. s an addendum note indicating formed the primary physician real ulcer being treated and the paling. According to the note, ated the ulcer had developed ceration due to friction, seat ure to urine. Jum to the 5/14/19, progress E had assessed the ulcer and er was the size of a quarter the superficial slough. did not include any physician resident's nutritional status, plans to address the weight				
	5/16/19, indicated I nectar thickened flu weights. Additional dated 6/28/17, rega	ned physician orders dated R8 was on a regular diet with uids and required weekly y, there were general orders arding nutritional supplement recommendation, noted.				
	(MAR) for May 201	dication administration record 9, indicated there had been no ents ordered/initiated for R8.				
	(TAR) for May 2019	atment administration record 9, also failed to indicate any ent order or implementation.				
	On 5/15/19 at 8:36	a.m. NA-A stated R8 could				

	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	CONSTRUCTION		E SURVEY PLETED
		00762	B. WING		05/	16/2019
IAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
		116 WF	EST SECOND ST			
SSENT	IA HEALTH GRACE H	OME	EVILLE, MN 562			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO		COMPLET DATE
ma		,	inte	DEFICIEN		
2 965	Continued From pa	ae 38	2 965			
	-	-				
		leing but did occasionally				
		from staff with eating. NA-A				
		3 had a fair appetite but had t loss. NA-A wasn't sure how				
	much weight R8 ha		/			
	muon weigni no na					
	On 5/15/19, at 11:4	6 a.m. NA-C stated R8				
		e with eating at times, and				
	often refused meals	s at noontime. NA-C stated F	88			
		weight loss but did not receiv				
		ents. NA-C wasn't sure how				
	much weight R8 ha	d lost.				
	Op 5/15/10 + 1:46	p.m. registered nurse				
		ated DD-B monitored the				
		lents, and would start new				
		ions if a resident required it				
		RN-A stated she wasn't sure	if			
		d a weight loss or not, and				
	reviewed the weigh	ts in R8's EHR to determine	if			
		ccurred. Upon review of R8's				
		irmed R8 had experienced a				
		ss. RN-A again stated DD-B				
		ed weight loss concerns for a				
		o confirmed R8 had not been ements for the weight loss.	n			
	receiving any suppl	ements for the weight loss.				
	On 5/15/19. at 2:35	p.m. DD-B stated weights				
		weekly basis and if a reside	nt			
	had not been eating	g well or experienced an				
		ss, offering high caloric food	s			
		e first interventions to				
		lso stated nutritional				
		be offered to promote				
		pht or weight gain. Further, a buld be initiated, and she wou				
		person during her monthly				
		when a resident triggered a				
		oss of 5% or more in 30 days	.			
	or 10% or more in ⁻		· .			1

	ta Department of He	ealth	•			APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BOILDING			
		00762	B. WING		05/	16/2019
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
SSENT	IA HEALTH GRACE H		T SECOND ST ILLE, MN 562			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
2 965	Continued From pa	age 39	2 965			
	the monthly visit. D supplements would who had pressure in healing. DD-B con- during her last site confirmed he was in ulcer. DD-B further receiving nutritional On 5/16/19, at 10:0 interview with RD-E closely with DD-B t and further stated as monthly basis. RD- developed inbetwe email or call her or she would expect t any resident develop significant weight los first been notified b and significant weigh have expected to h both. RD-D stated 5:56 p.m. on 5/15/- weight loss had och had experienced a past six months. F recommendations and supper meals, foods to promote w further weight loss. evaluating R8 in per- visit which she plan couple of weeks.	D7 a.m. during a phone D, RD-D stated she worked to monitor nutritional concerns she made onsite visits on a -D explained for any needs that en her visits, DD-B would in the telephone. RD-D stated o be notified within 48 hours if oped a pressure ulcer or had a oss. RD-D confirmed she had by DD-B of R8's pressure ulcer ght loss on 5/15/19, and would have been notified earlier for she'd reviewed R8's EHR at 19, to determine intakes and curred. RD-D confirmed R8 significant weight loss in the further, RD-D made for a supplement at the lunch and encouraging high caloric wound healing and to prevent . RD-D stated she planned on erson during her next onsite nned to do within the next				
	(DON) stated DD-E residents for weigh	2 p.m. the director of nursing 3 and RD-D monitor all at loss and provided for interventions to promote				
nesota De	epartment of Health		6899 OF)DK11	If continuati	

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
116 WEST SECOND STREET GRACEVILLE, NN 56240 OWNID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULTORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OP DEFICIENCY 2 965 Continued From page 40 2 965 2 965 veight stabilization and/or weight gain. The DON stated it was expected a significant weight loss of 5% or more in 30 days, or 10% or more in 180 days would be addressed with new interventions which included supplements. The DON also stated RB had a significant weight loss as identified in R8's EHR and verified RD-D had implemented new interventions on 51/51/9. Review of facility's 5/18 policy, Nutritional Care, indicated RD-D would initially assess residents during a monthly in house wisit to facility, and at least annually, or when there had been a significant change in condition or as nutritional needs changed. The policy further indicated assessments would cover dietary needs of residents condition changes. The policy identified DD-B would refer high nutritional assess ment and recommended changes as a needed. Further, the policy identified DD-B would refer high nutritional assess and/or screening and the changes would also be addressed in the care plan. The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment instrument (RAI) 30 User's Manual dated 10/2018, identified Section K: Swallowing/Nutritional Status to be completed with an intert to assess the many conditions that			00762	B. WING		05/	16/2019
ESSENTIA HEALTH GHACE HOME GRACEVILLE, MN 56240 (X4) ID PRETX TAG ESUMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECATO BYFORVOW UST ENTRYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECATO BYFORVOW UST ENTRYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY) ID PROVIDER'S PLAN OF CORRECTIVE ACTION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY) ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY) ID PROVIDER'S PLAN OF CORRECTIVE ACTION (EACH DEFICIENCY) ID PROVIDER'S PLAN OF CORRECTIVE ACTION (EACH DEFICIENCY) ID PROVIDER'S PLAN OF CORRECTIVE (EACH DEFICIENCY) <t< th=""><th>NAME OF F</th><th>PROVIDER OR SUPPLIER</th><th>STREET AI</th><th>DDRESS, CITY, S</th><th>TATE, ZIP CODE</th><th></th><th></th></t<>	NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
Image: Continued Figure 1 and the properties of the process of the proces of the process of the process of the proces of the	SSENTI	A HEALTH GRACE H	1C)N/IE				
 weight stabilization and/or weight gain. The DON stated it was expected a significant weight loss of 5% or more in 30 days, or 10% or more in 180 days would be addressed with new interventions which included supplements. The DON also stated R8 had a significant weight loss as identified in R8's EHR and verified RD-D had implemented new interventions on 5/15/19. Review of facility's 5/18 policy, Nutritional Care, indicated RD-D would initially assess residents during a monthly in house visit to facility, and at least annually, or when there had been a significant change in condition or as nutritional needs changed. The policy further indicated RD-B would monitor weights, intakes, labs and recommended changes as a resident's condition changes to diet plans as needed. Further, the policy identified DD-B would refer high nutritional risk residents to RD-D for nutritional assessment and recommendations as needed. The policy instructed staff to document changes in the progress notes and/or screening and the changes would also be addressed in the care plan. The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RA) 3.0 User's Manual dated 10/2018, identified Status to be completed with an intent to assess the many conditions that 	PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE	(X5) COMPLET DATE
adequate nutrition and hydration. Under K0300: Weight Loss Planning for Care:	2 965	weight stabilization stated it was expect 5% or more in 30 of days would be add which included sup stated R8 had a sig identified in R8's El implemented new i Review of facility's indicated RD-D wo during a monthly in least annually, or w significant change needs changed. T assessments would resident's condition identified DD-B wo labs and recomme needed. Further, the refer high nutritional nutritional assessments would refer high nutritional nutritional assessments needed. The policy changes in the pro- and the changes w care plan.	and/or weight gain. The DON cted a significant weight loss of lays, or 10% or more in 180 ressed with new interventions oplements. The DON also gnificant weight loss as HR and verified RD-D had interventions on 5/15/19. 5/18 policy, Nutritional Care, uld initially assess residents a house visit to facility, and at <i>v</i> hen there had been a in condition or as nutritional he policy further indicated d cover dietary needs of recommended changes as a n changed. The policy uld monitor weights, intakes, nded changes to diet plans as he policy identified DD-B would al risk residents to RD-D for nent and recommendations as y instructed staff to document gress notes and/or screening rould also be addressed in the dedicare and Medicaid (CMS) acility Resident Assessment .0 User's Manual dated Section K: mal Status to be completed sess the many conditions that dent's ability to maintain and hydration. Under K0300:				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00762	B. WING		05/	16/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME	SECOND ST LLE, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 965	Continued From pa	ge 41	2 965			
	change in the resid environment.	ent's health status or				
	causes of changed	m should review for possible intake, changed caloric need, on (e.g. diuretics), or changed				
	continuing basis; wand care planned a	d be monitored on a eight loss should be assessed t the time of detection and not ext MDS assessment."				
	The Director of Nu develop and implem to ensure residents appropriate interven determined necess assessment. The D educate all appropri procedures. The D	THOD FOR CORRECTION: rsing (DON) or designee could nent policies and procedures at nutritonal risk received ntions to maintain nutrition as ary by their individualized OON or her designee could iate staff on the policies and ON could develop monitoring ongoing compliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				
21942	MN St. Statute 144 Resident and Fami	A.10 Subd. 8b Establish ly Councils	21942			6/25/19
	boarding care home advisory council an fewer than three pe participating. If one function, the nursin home shall docume	council. Each nursing home or e shall establish a resident d a family council, unless ersons express an interest in or both councils do not g home or boarding care ent its attempts to establish the at least once each calendar				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE SURVEY COMPLETED
		00762	B. WING		05/16/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY,	STATE, ZIP CODE	
ESSENT	IA HEALTH GRACE H		T SECOND		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLET
21942	Continued From pa	age 42	21942		
		ion does not alter the rights of ies provided by section on 27.			
	by: Based on interview facility failed to atter council after four re- shown interest, as potential to affect a Findings include: On 5/13/19, at 12:5 entrance conference (DON) confirmed th have a family council On 5/13/19, at 5:29 (SSD)-A indicated to annually to establis indicated she had I forms regarding a f representatives in a the form had three family council established on it if asked. SSD included a contact SSD-A indicated 29 were returned. SS answered yes that council established indicated they woul three had indicated	ent is not met as evidenced and document review, the mpt to establish a family esident representatives had required. This had the II 33 residents in the facility. 88 p.m. during the survey be the director of nursing ne facility did not currently cil. 9 p.m. social service designee the facility made attempts h a family council. SSD-A ast sent out questionnaire family council to the resident's January 2019. SSD-A indicated questions; would you want a plished, are you willing to be ar ctive in maintaining the council d, and lastly would you serve D-A indicated the form also name and phone number. D forms were sent out and 18 D-A indicated four had they would want a family . SSD-A indicated none had d want to organize it and only I they would want to serve on the facility did not establish a	1	The four family members interested in developing a family council have been contacted by phone and a letter with agreed upon date and time of meeting develop a family council. If had been agreed to meet 6/12/19, but then three the four were not able to attend this day and time. Meeting is now re-schedule 6/19/19. SSD or designee will continue to assiss residents and families on establishing family council. SSD or designee will continue to document at least yearly the attempts establish a family council if these interested parties determine not to establish a family council. The facility will continue to promote fac council during facility gatherings/ ever like "family picnic" periodically in Fam newsletter and all new admits. Policy "Family Council" was developee Staff will be educated by one of the means: : 1:1 meetings, standups, scheduled meetings on 6/18/19 and 6/20/19 on this policy. Results will be reported to the QAPI	n g to e of ate d for st a to to mily nts ily

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00762	B. WING		05/	16/2019
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
EGGENT		OME 116 WES	ST SECOND	STREET		
ESSENT	IA HEALTH GRACE H	GRACE	/ILLE, MN 50	6240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE	(X5) COMPLET DATE
21942	Continued From pa	ge 43	21942			
	interest because no to organize it. SSD assist them if they of family members to no formal response interest in having a been completed. On 5/15/19, at 9:06 facility had sent out the questionnaire re indicated 22 had be the reason the facil council after four re shown interest was responded that they SSD-A confirmed s four who had show and indicated she v	a though four had shown one of the respondents agreed -A indicated the facility would could, but felt it was up to the facilitate it. SSD-A indicated to those who had shown family council established had a.m. SSD-A indicated the 30 mailings, which included egarding family council. SSD-A een returned. SSD-A indicated ity had not established a famil sident representatives had because they had not y would organize or maintain it he had not responded to the n interest in a family council would include the results of the tionnaire in the facility June	1 A Y	committee.		
	aware there was so establishing a famil none of those who or maintain it. DON established a family The facility forms til Important Informati Receipt, included th script; Family Coun below to each ques forms provided by t by resident represe answered yes to the	a.m. DON confirmed she was ome interest in the facility y council, but understood responded wanted to organize I confirmed the facility had not y council. tled Annual Reminder of on-Acknowledgement of ne section identified in bold cil-Please answer yes or no tion. Review of the twenty he facility that were returned ntatives identified four had e question "Would you want a ablished at Grace Home?".				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		B. WING		05/	16/2019	
IAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
SSENT	IA HEALTH GRACE H		T SECOND ST ILLE, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
21942	Continued From pa and 1/30/19.	age 44	21942			
	reviewed the Famil survey results cond letter included direc not they would like established at the f were willing to com in organizing and m attending meetings developing and org scheduled meeting family council was self-determining gra- residents. The forr complete and return their response was the State of Minnes facility was making residents aware of Council if they wish the letter had a que three questions; Do council established willing to be an org- maintaining a famil council were estably you serve on it if as A facility policy for f and not provided. O SSD-A confirmed th for Family Council.	y council? , and If a family lished at Grace Home would				