DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0DDK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00762

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245579**

2.STATE VENDOR OR MEDICAID NO.
(L2) **030525100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH GRACE HOME**
(L4) **116 WEST SECOND STREET**
(L5) **GRACEVILLE, MN** (L6) **56240**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/01/2019** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **40** (L18)
13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
LeAnn Huseth, HFE - NE II 07/08/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 07/08/2019 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
07/08/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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

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

DEPARTMENT OF HEALTH

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 SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0DDK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00762

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245579**

2.STATE VENDOR OR MEDICAID NO.
(L2) **030525100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH GRACE HOME**
(L4) **116 WEST SECOND STREET**
(L5) **GRACEVILLE, MN** (L6) **56240**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/16/2019** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **40** (L18)
13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Susan Bachleitner, HFE - NE II 06/25/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 06/26/2019 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
07/08/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245579	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH GRACE HOME	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 5/13/19, to 5/16/19, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 5/13/19, to 5/16/19, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than	F 637		6/25/19

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

Electronically Signed | 06/14/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245579	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH GRACE HOME	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 1 one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS) when two or more areas of change in resident status were noted for 1 of 16 (R8) residents reviewed for decline in health status. Findings include: R8's annual MDS dated 8/29/18, indicated R8 had diagnoses of heart failure, Alzheimer's disease, dementia, anxiety and depression. The MDS identified R8 had severe cognitive impairment and required extensive to total assistance for activities of daily living (ADL's), except eating R8 required supervision. The MDS further identified R8 was frequently incontinent of bladder, was always continent of bowel, did not use supplemental oxygen, had no pressure ulcers and had no weight loss or gain. R8's quarterly MDS dated 2/19/19, indicated R8 had diagnoses of heart failure, Alzheimer's disease, dementia, anxiety and depression. The MDS identified R8 had severe cognitive impairment and required extensive to total assistance with ADL's, except eating R8 required limited assistance. The MDS further indicated R8 had no current pressure ulcers, no weight loss, always incontinent of bowel and bladder, utilized supplemental oxygen, and received a mechanically altered diet for meals. Review of the above assessments indicated R8's	F 637	A Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS) was initiated for the identified resident R8 on 5/16/19 and documented in the Electronic Health Record (EHR). All residents with a change in status have the potential to be affected by this practice. The Interdisciplinary Team (IDPT) reviewed 100% of all current resident□s to evaluate for the presence of a significant change. Any resident identified to have a change in two or more areas shall have a SCSA MDS initiated and a member of the IDPT shall complete a note in the EHR. Results of this audit shall be reported to the QAPI committee. The "Change of Condition" policy has been reviewed and updated. IDPT and nursing Staff education will be provided by at least one of the following means: 1:1 meetings, standups, or scheduled meetings on 6/18/19 and 6/20/19 to include review of the "Change in Condition" policy and F637. The Interdisciplinary Team shall review 100% of all current resident□s weekly x 4, then monthly x 3 months. Any resident identified to have a change in two or more areas shall have a SCSA MDS initiated. Results of the audit shall be reported to	

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F 637	Continued From page 2 incontinence pattern worsened from frequently incontinent to totally incontinent of bladder, and totally continent to totally incontinent of bowel. R8 was newly coded for supplemental oxygen use and a mechanically altered diet for meals. Review of R8's progress notes from 3/20/19, to 5/15/19, revealed the following: On 4/8/19, R8 was noted to have an open area to the buttocks which measured 0.5 inches. The nurse planned to apply Mepilex (a foam absorbent dressing used to treat acute and chronic ulcers and wounds) after R8 had received a morning bath. On 4/9/19, the Interdisciplinary Team (IDT) reviewed R8's wound to the buttocks and identified the wound as shearing. The note further indicated treatment would be administered as ordered and Ammens powder (a powder utilized for minor skin irritations) would be applied to keep the area dry and to prevent breakdown. The note identified a ROHO cushion (a cushion used for pressure relief) would be utilized in R8's wheelchair and staff would monitor the wound daily and document at least weekly until healed. On 5/15/19, a Mepilex dressing was changed on R8's right buttock. Nursing staff indicated a small to moderate amount of tan colored drainage was noted on the old dressing and no odor was detected. The open area measured 2 cm. (centimeters) in width by 2.5 cm. in length. The nursing staff further indicated darker pink tissue surrounded the wound and the entire wound measured which included the open wound and the surrounding dark pink tissue 3 cm. The color of the majority of the wound bed was light yellow	F 637	the QAPI committee for further recommendations.	

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in color and the proximal area of the open wound had a 0.25 cm. dark red-brown area.

Further review of R8's progress notes revealed the following:

On 3/20/19, documentation indicated R8 had a significant weight loss in the past 180 days of 21 lbs.(pounds) (10% loss). The note indicated R8 had variable intakes from 25% - 100%. The note identified staff were to continue to encourage food/fluid intake, monitor weights and plan of care closely for significant changes.

On 4/10/19, R8's weight was noted to be 185 lbs. which was a loss of 3.6 % in 30 days and 10.1% in 180 days. The note indicated R8 continued to have varying intakes at meals from 25% to 100%. The note identified staff were to continue to monitor and refer to the registered dietician (RD)-D at the next site visit. The note lacked any documentation of a pressure ulcer or wound present on R8.

On 5/2/19, R8's weight was 181.6 lbs. which indicated a loss of 19 lbs. in the past 180 days. The note indicated R8 continued with varying intakes at mealtimes. The note identified staff were to provide cueing at mealtimes and R8 may need more assistance with eating. Further, the note indicated staff were to continue to monitor and refer to the RD-D at the next site visit. The note lacked any documentation of a pressure ulcer or wound present on R8.

On 5/15/19, RD-D was notified of weight loss and development of pressure ulcer. The note indicated R8's weight was 180.4 lbs. which was a loss of three lbs. (2%) in 30 days, nine lbs. in 90

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days and 18 lbs. in 180 days (9%). The note identified R8 had variable meal intakes and a recommendation was made to trial four ounces of ensure at dinner/supper meals to provide additional protein, calories and fluid. The staff were to encourage protein rich foods and fluids when able. The RD-D planned to follow-up and visit with R8 at the next RD-D site visit.

On 5/16/19, at 12:32 p.m. nurse manager (NM)-A confirmed she completed the MDS assessments for all residents and a SCSA MDS should have been completed within 14 days when two or more areas of decline were noted. NM-A explained she was unsure whether R8 had a decline in two or more areas. NM-A reviewed R8's progress note in the electronic health record (EHR) from 4/10/19, and confirmed the progress note stated R8 had a significant weight loss. Further, NM-A confirmed R8 had a wound present on her right buttocks. NM-A confirmed SCSA MDS had not been completed on R8.

On 5/16/19, at 2:02 p.m. the director of nursing (DON) stated a SCSA MDS should have been completed on R8 when two or more areas of decline had been noted. DON confirmed R8 had developed a pressure ulcer to her right buttocks which had slough present and additionally R8 had experienced weight loss which would meet criteria to complete a SCSA MDS.

Review of facility's 1/19 policy Change in Condition, indicated the care plan and MDS would be updated as required with any pertinent information as appropriate.

The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment

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F 637	Continued From page 5 Instrument (RAI) 3.0 User's Manual dated 10/2018, indicated the definition of a significant change as a decline or improvement in a resident's status of which: "1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting, 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan." The manual further directed when the interdisciplinary team (IDT) determined that a significant change occurred, the facility should have documented the initial identification of the significant change in the EHR. The final decision regarding what constituted a significant change in status must be based upon the judgement of the IDT. Further, the manual clarified that MDS assessments are not required for minor or temporary variations in the resident status.	F 637		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		6/25/19

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F 686	Continued From page 6 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately assess, identify and monitor facility acquired pressure ulcers for 2 of 2 residents (R8, R27) who were observed for pressure ulcer care. This deficient practice resulted in actual harm for R8 who initially had an open area caused by shearing (occurs when layers of skin rubs against each other or when the skin remains stationary and the underlying tissue moves and stretches and tears underlying capillaries and blood vessel causing tissue damage) identified to the right buttocks which worsened to an unstageable pressure ulcer (observed full-thickness skin and tissue loss in which the extent of the damage cannot be confirmed due to the wound bed obscured with slough or eschar). Findings include: R8's quarterly Minimum Data Set (MDS) dated 2/19/19, indicated R8 had diagnoses of heart failure, Alzheimer's disease, 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. The MDS further 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	F 686	All residents with identified risk for Pressure Ulcers and/or residents with current pressure ulcers have the potential to be affected by this practice. A Braden Scale was completed for 100% of all residents to evaluate pressure ulcer risk. Care plans were reviewed and updated, as appropriate for 100% of all residents with known risk and/or history of skin breakdown. Results of this audit shall be reported to the QAPI Committee. The IDPT will review 100% of all residents with pressure ulcers. Any resident with an identified pressure ulcer was assessed and documentation completed in the EHR to include: location, stage, size, exudate, odor, pain, wound bed, description of wound edges and surrounding tissue of present pressure ulcers. The review will also include evaluation of nutritional status, notification of the Registered Dietitian (RD) appropriateness of current treatment and interventions. The resident□s care plan reviewed and revised as appropriate. Results of this audit shall be reported to the QAPI Committee. Developing a skin care management policy and procedure with a defined wound care team.	

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F 686	Continued From page 7 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. The MDS further identified R8 was frequently incontinent of bladder and always incontinent of bowel. R8's annual Care Area Assessment (CAA) dated 9/5/18, indicated R8 required assistance with ADL's due to progressing Alzheimer's disease and dementia. The CAA revealed R8 was at risk for developing pressure ulcers due to immobility and the need to be repositioned by staff. The CAA identified R8 had no current skin issues at the time of the assessment. The CAA further indicated R8 was at risk for weight and fluid changes due to intake and abnormal labs. The CAA further identified R8 was at nutritional risk due to heart disease with heart failure, acute kidney failure, dementia and atrial fibrillation (quivering or irregular heartbeat). The CAA indicated R8 was to be toileted three times a day on the commode utilizing the mechanical lift to transfer, provide the bedpan as needed and to provide incontinence care as needed. R8's care plan revised 5/14/19, revealed R8 required extensive to total assistance with ADL's which included bed mobility, transfers, locomotion, dressing, toileting, personal hygiene and bathing. The care plan indicated R8 required supervision with set-up for eating tasks. The care plan identified R8 had an open area to her right buttock as a result of shearing. The care plan instructed staff to apply a Mepilex dressing to the open area and to change the dressing every three days or more often if needed. The care plan further instructed staff to encourage and assist with every two hour repositioning while seated	F 686	Facility standing orders wounds/ skin care have been reviewed and updated. The Nutritional Care and Documentation policy has been reviewed and revised. The Certified Dietary Manager(CDM) will enter a note in the EHR when the consulting RD has been informed of any pressure ulcers. The CDM, or designee will audit EHR to ensure appropriate notification to RD and completion of assessment/review of nutritional status by RD in EHR monthly x 3 then quarterly X 3. Results shall be reported to the QAPI committee. Staff will receive education by on the means: 1:1 meetings, standups, scheduled meetings on 6/18/19 and 6/20/19 to review skin, wound and nutrition policies, F686, and the National Pressure Ulcer and Prevention Guidelines (NPUAP). Education will include utilization of EHR for documentation requirements in accordance with F686 and facility policy. Essentia Health Medical staff shall receive education on 6/19/19 related to need for documentation upon notification of changes in resident status, and/or other pertinent health information.	

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and every three hours when laying in bed. The care plan indicated staff would monitor for skin breakdown and report to the nurse if breakdown occurred. The care plan instructed staff to encourage R8 to consume a well balanced diet as well as consume all fluids offered at meal times. The care plan identified the resident was to use a geo matt (a therapeutic overlay mattress to aid in prevention and treatment of pressure ulcers) placed on the bed and a Vicair Liberty cushion (a cushion prescribed for pressure ulcer prevention) with an antishear cushion cover to be used in R8's wheelchair. R8's care plan instructed staff to toilet R8 three times a day on the commode utilizing the mechanical lift to transfer, provide the bedpan as needed and to provide incontinence care as needed.

On 5/14/19, at 1:00 p.m. nursing assistant (NA)-B and occupational therapy assistant (OTA)-C placed sling for a mechanical lift behind R8's back and looped it under her legs while she was seated in the wheelchair with plans to lay R8 down in bed. Once the loops of the sling had been applied to the mechanical lift, NA-B operated the lift to transfer R8 out of the wheelchair and lowered her into her bed while OTA-C guided R8 in the sling. At 1:09 p.m. NA-B and OTA-C turned R8 to the left side in bed and removed an incontinent brief. A square Mepilex dressing was noted to R8's right lower buttocks area and was intact with a quarter sized area of dark brown drainage noted on the dressing. NA-B cleansed perineal area and proceeded to apply a new brief to R8. NA-B and OTA-C positioned R8 on the left side and placed a pillow behind the right side to keep R8 on the left side. NA-B provided call light to R8 and covered her up with blankets. NA-B and OTA-C completed hand

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hygiene after removing gloves.

On 5/14/19, at 1:58 p.m. registered nurse (RN)-A assessed Mepilex dressing noted on R8's right lower buttocks and noted there was a quarter sized area of dark brown drainage in the center of the dressing that was visible however had not soaked through. RN-A stated the dressing had just been changed the day before and indicated she would not be changing it at that time.

On 5/14/19, at 3:30 p.m. R8 was noted to be seated on a pressure reducing cushion in a wheelchair in the dayroom attending a music activity.

On 5/15/19, at 7:47 a.m. R8 was noted to be laying in bed on her back as NA-A and NA-C provided morning cares to R8. At 7:50 a.m. NA-C removed the front of the soiled brief and proceeded to cleanse R8's front perineal area. NA-C and NA-A positioned R8 on the right side and removed the brief completely and provided perineal cares to her back side. A Mepilex dressing to right lower buttocks was noted to be intact with the quarter sized area of dark brown drainage present. At 7:56 p.m. NA-C placed a new brief under R8 and with assistance from NA-A, applied the brief while turning R8 from side to side in the bed. NA-A and NA-C applied pants and placed sling for the mechanical lift under R8 while turning R8 from side to side. At 8:01 a.m. NA-A operated the lift and NA-C guided R8 into the wheelchair on top of the wheelchair cushion. NA-A and NA-C removed the sling and positioned R8 in an upright properly aligned position in the wheelchair. NA-A proceeded to remove R8's nightgown, cleansed chest and applied deodorant to R8's underarms. At 8:04 a.m. NA-A applied bra

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and hook of bra scratched right arm near R8's elbow which resulted in a skin tear. NA-A immediately provided pressure to stop the bleeding and asked for assistance from nursing staff. At 8:08 a.m. RN-A entered R8's room and assessed the skin tear and stated she would obtain dressings to treat the skin tear and would return. At 8:10 a.m. director of nursing (DON) entered the room and stated she would return shortly with supplies to treat the skin tear. At 8:14 a.m. NA-A proceeded to apply R8's shirt and glasses. At 8:16 a.m. DON returned to room with supplies, applied gloves and placed a cold washcloth to the skin tear that had bled slightly. DON indicated the measurements of the skin tear were 5 cm long and 0.7 cm in width. DON proceeded to cleanse the wound with normal saline and applied three steri strips to the skin tear after using a cotton-tip applicator to realign the skin together. DON placed a dressing over the skin tear and wrapped the arm with kling wrap. At 8:21 a.m. NA-A provided oral cares to R8 and brushed her hair. DON and NA-A completed hand hygiene after cares and NA-A brought R8 to the dining room for breakfast.

On 5/15/19, at 1:21 p.m. RN-A and Infection Control Coordinator (ICC)-F were both present in R8's room during a dressing change to her right buttocks area. RN-A and ICC-F positioned R8 on the left side. RN-A removed old Mepilex dressing from right buttocks and indicated the dressing had a little bit of dark brown drainage present. RN-A stated most of the wound bed had yellow slough present and additionally had a 0.25 cm dark brown area to the proximal area of the wound bed. RN-A measured the wound and indicated the width of the wound was 2 cm and the length of the wound was 2.5 cm. RN-A

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statedd there was about 0.1 cm depth to the wound. RN-A confirmed the wound had worsened since she had seen it last as there had been no yellow slough present in the wound bed when she'd last assessed the wound. RN-A was not able to recall the date she had last seen the wound. RN-A stated she would classify the wound as a stage two pressure ulcer due to the depth of the wound and ICC-F concurred. RN-A applied clean gloves, cleansed the wound with normal saline and applied a new Mepilex dressing. RN-A removed her gloves and completed hand hygiene. RN-A stated the wound had been caused by friction from a sling and as a result staff identified it as an abrasion.

Review of R8's Braden scale (tool used to determine risk for pressure ulcer development) dated 11/19/18, indicated R8 was at risk for developing pressure ulcers due to the following risk factors: slightly limited sensory perception, moisture, chairfast, slightly limited with mobility and had a potential problem with friction and shearing. The Braden scale revealed R8 had the additional risk factors which included cardiovascular disease, chronic incontinence, diabetes, and thyroid disease. The Braden further indicated R8 required extensive assistance with bed mobility, required the use of a mechanical lift for transfers and was always incontinent of bowel.

Review of R8's Braden scale dated 2/16/19, indicated R8 was at moderate risk for developing pressure ulcers due to the following risk factors: slightly limited sensory perception, was often moist, chairfast, slightly limited mobility and a problem with friction and shearing. The Braden scale revealed R8 had additional risk factors

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which included cardiovascular disease, chronic incontinence and cognitive impairment. The Braden scale further indicated R8 required extensive assistance with bed mobility, required the use of a mechanical lift and was always incontinent of bowel.

The medical record lacked any additional Braden scale assessments completed after 2/16/19.

Review of R8's Skin Integrity Event for 4/8/19, revealed the following:

-R8 developed a skin tear to her right buttocks that was noted to be shallow and measured 0.5 centimeters (cm.). The wound had a small amount of bleeding and had smooth wound edges. It was unknown how the wound developed. The wound was cleansed with soap and water and a Mepilex dressing was applied to it after R8's bath. The event indicated the physician and family had been notified.

Review of the interdisciplinary progress notes from the electronic health record (EHR) from 4/8-5/16/19, revealed the following:

- 4/8/19, R8 was noted to have an open area to her buttocks that measured 0.5 [cm]. Nurse planned to apply Mepilex (a foam absorbent dressing used to treat acute and chronic ulcers and wounds) after R8 had received morning bath.

- 4/9/19, Interdisciplinary Team (IDT) reviewed R8's wound to the buttocks and identified the wound as shearing. The note further indicated treatment would be administered as ordered and Ammens powder (a powder utilized for minor skin irritations) would be applied to keep the area dry

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and to prevent breakdown. The note identified a ROHO cushion (a cushion used for pressure relief) would be utilized in R8's wheelchair and staff would monitor the wound daily and document at least weekly until healed.

- 4/13/19, 0.5 cm raw area noted to R8's right buttock as well as another 0.5 cm. located 1 cm laterally to the initial area. R8 had a large loose foul-smelling bowel movement (BM) and bowel medications were not administered as a result. Nursing staff applied a new Mepilex dressing to the right buttock area.

-4/14/19, R8 had a large loose foul-smelling BM and dressing had been changed again as a result. The note indicated the inferior (older) area measured 1 x 1 cm and the superior (new) area measured 0.8 x 0.8 cm.

-4/20/19, R8's dressing had been soiled again and nursing staff cleansed the area and applied a new dressing. Nursing staff noted the area appeared to be increasing in size and would ask the director of nursing (DON) to assess the area.

- 4/23/19, R8's dressing had been changed on 4/22/19, and 4/23/19, due to large loose BM's. The lower open area had been noted to be very superficial and nearly healed. The upper open area had been noted to be approximately 2 cm in diameter with four spots covering and about 1/3 of the wound barely through the skin and superficial.

-4/27/19, dressing changed to R8's right buttock after R8 had a large BM. The area was noted to be 2 x 2 cm and the area was 100% blanchable (area returns to normal skin color when pressure

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F 686	Continued From page 14 is applied and removed). -5/1/19, R8's dressing to her right buttock was noted to be all curled up. Nursing staff removed the old dressing and applied a new Mepilex dressing. R8's area had no drainage, had clean edges and was noted to be dark red in color. - 5/3/19, R8's dressing was noted to be coming off and a new Mepilex dressing was applied. No drainage or any signs of change had been noted to the wound. - 5/5/19, R8 was noted to continue to have a 2 cm x 2 cm open area that was dressed with a Mepilex dressing. The wound had no drainage and the dark red area had clean edges. R8 was noted to have had recurrent incontinent BM's. - 5/6/19, OT (occupational therapy) staff evaluated R8 for positioning needs and instructed staff to position R8 on the left side. The note further indicated the ROHO cushion (pressure relieving cushion) was not holding air and OT staff were checking with vendors for other cushion options. - 5/7/19, Mepilex dressing completed to R8's right buttock due to soiled. Area noted to be slightly more shallow and lighter pink in color. - 5/8/19, OT staff provided education to nursing staff on proper use of the hygiene sling. The progress note further indicated the DM (dietary manager) was aware of the skin concern and nutrition had been addressed. - 5/9/19, dressing change completed to R8's right buttock due to soiled. Area noted to have had	F 686		

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F 686	Continued From page 15 slow healing. - 5/10/19, dressing change completed to R8's right buttock and noted to have a round area that measured 1.5 cm in the center and superficial skin noted to be missing in 1 cm border of the wound. The center area had been noted to be pink in color. - 5/11/19, R8's old dressing had been removed and was noted to be soiled and difficult to remove. The area was noted to be 3.0 cm. x 3.0 cm, had an odor and was noted to be moist. -5/12/19, the dressing to R8's right buttock shearing area was removed and a new Mepilex dressing had been applied. -5/15/19, Mepilex dressing changed to R8's right buttock. Nursing staff indicated a small to moderate amount of tan colored drainage was noted on the old dressing and no odor had been detected. The open area measured 2 cm in width by 2.5 cm in length. The nursing staff further indicated darker pink tissue surrounded the wound and the entire wound measured, which included the open wound and the surrounding dark pink tissue 3 cm. The color of the majority of the wound bed was light yellow in color and the proximal area of the open wound had a 0.25 cm dark red-brown area. The progress notes lacked documentation of staging of the pressure 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 stated R8 required extensive to total assist with all ADL's except for eating which she required	F 686		

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limited assistance with. NA-B stated R8 had a shearing to her right buttocks from her old lift sling and OTA-C assisted with determining best positioning practices as well as suggesting the use of the hygiene sling in an attempt to prevent further shearing. NA-B stated licensed nurses were notified by NA's when skin issues develop and skin was checked every day by NAs during morning cares.

On 5/15/19, at 11:21 a.m. OTA-C stated occupational therapy staff received an order to evaluate and make recommendations for pressure relieving devices for R8 to use as well as suggesting positioning strategies. OTA-C confirmed R8 had been changed to a hygiene sling to prevent further shearing from occurring. OTA-C stated OT staff provided education to nursing staff on proper use of slings as well as proper positioning for R8.

On 5/15/19, at 11:46 a.m. NA-C stated R8 required extensive assist with ADL's and minimal assistance with eating tasks. NA-C indicated R8 had been changed from the old lift sling to a hygiene sling due to the old one causing irritation to her skin. NA-C further stated the sore on her right buttocks developed from the use of the old sling.

Review of R8's current physician orders as of 5/15/19, which included the following:

- 4/8/19, general nursing order to change dressing weekly on bath day and as needed and document the condition of dressing under results.

- 5/15/19, Vicair cushion for wheelchair.

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Review of R8's treatment administration record (TAR) for May 2019, revealed the following:

- an order on 4/8/19, Ammens Powder- apply light dusting of Ammens Powder to bottom to aide in keeping area dry and prevent breakdown.

- an order on 5/14/19, to change the dressing weekly on R8's bath day and as needed. Additionally, the nursing staff were to document the condition of the dressing under result in the EHR, monitor daily and chart under event at least weekly on Sundays and as needed.

Review of R8's physician progress notes from 3/19- 5/15/19, revealed the following:

- 3/19/19, the physician progress note indicated R8 had no complaints except for feeling tired and no changes with the plan was indicated. The progress note lacked any documentation of any skin issues.

- 4/24/19, the progress note indicated R8 had no complaints except for feeling tired. The progress note identified an increase of lisinopril to 5 milligrams (mg) (prescribed for high blood pressure) and to check labs with the next lab draw. The progress note lacked any documentation of any pressure ulcers or wounds.

- 5/14/19, the progress note lacked documentation of weight loss or a plan to address weight loss. However, there was an addendum note indicating nursing staff had informed the primary physician (MD)-E of R8's gluteal ulcer being treated and the progress toward healing. According to the note, the physician indicated the ulcer had developed due to shear or maceration

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due to friction, seat position and exposure to urine.

-5/15/19, an addendum to the 5/14/19, progress note indicated MD-E had assessed the ulcer and determined the ulcer was the size of a quarter and had shallow pale superficial slough. However, the note did not include any physician assessment of the resident's nutritional status, weight loss, or any plans to address the weight loss. The note indicated the nursing staff believed the ulcer developed from shear or maceration due to friction, seat position and exposure to urine.

Further review of R8's progress notes of the EHR revealed the resident had experienced a significant weight loss:

11/13/18, 200.5 pounds (lbs.)
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 documented she had been notified R8 had an open wound to her right buttocks that measured 2 cm by 2.5 cm with a total width of 3 cm. RD-D also identified R8's weight of 180.4 pounds which equaled an additional 2% weight loss in 30 days, 5% weight loss in 90 days and 9% weight loss in 180 days. The RD-D note indicated R8's meal intakes continued to be variable, and indicated breakfast was where R8 had the best intake 76-100% , while lunch and supper meals ranged from 25% to 75%. RD-D recommended a trial of 4 ounces of ensure at

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lunch and supper meals to provide additional protein, calories and fluids. Additionally, staff were to offer protein-rich food/fluids and offer favorite foods to improve intakes. The note identified goals of stabilizing weight, improve skin integrity, supplement acceptance, improve meal intakes to be equal to or greater than 75% and the RD-D planned to follow-up at the next site visit.

Review of R8's medication administration record (MAR) for May 2019, indicated there had been no nutritional supplements ordered/initiated for R8.

Review of R8's treatment administration record (TAR) for May 2019, also failed to indicate any nutritional supplement order or implementation.

On 5/15/19, at 1:46 p.m. registered nurse manager (RN)-A confirmed R8 had not been receiving any supplements.

On 5/15/19, at 2:35 p.m. DD-B stated weights were reviewed on a weekly basis and if a resident had not been eating well or experienced an unwanted weight loss, offering high caloric foods would be one of the first interventions to implement. DD-B also stated high protein supplements would be implemented for residents who had pressure ulcers or wounds to promote healing. DD-B confirmed RD-D had not seen R8 during her last site visit on 4/24/19 and further confirmed he was not aware R8 had a pressure ulcer. DD-B further confirmed R8 had not been receiving nutritional supplements.

On 5/16/19, at 10:07 a.m. during a phone interview with RD-D, RD-D stated she worked closely with DD-B to monitor nutritional concerns

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and further stated she made onsite visits on a monthly basis. RD-D explained for any needs that developed inbetween her visits, DD-B would email or call her on the telephone. RD-D stated she would expect to be notified within 48 hours if any resident developed a pressure ulcer or had a significant weight loss. RD-D confirmed she had first been notified by DD-B of R8's pressure ulcer and significant weight loss on 5/15/19, and would have expected to have been notified earlier for both. RD-D stated she'd reviewed R8's EHR at 5:56 p.m. on 5/15/19, to determine intakes and weight loss had occurred. RD-D confirmed R8 had experienced a significant weight loss in the past six months. Further, RD-D made recommendations for a supplement at the lunch and supper meals, and encouraging high caloric foods to promote wound healing and to prevent further weight loss. RD-D stated she planned on evaluating R8 in person during her next onsite visit which she planned to do within the next couple of weeks.

On 5/15/19, at 1:46 p.m. nurse manager (NM)-A stated the process for skin care involved the nurses assessing the pressure ulcers and wounds and determining if the pressure ulcer was blanchable or not. NM-A further stated if the pressure ulcer had been determined to be caused by friction or shearing the staff identified it as an abrasion. NM-A indicated R8's pressure ulcer had been caused by shearing from her incontinence brief. NM-A stated she was not aware R8's pressure ulcer had yellow slough present and would have had to assess it herself to determine that. NM-A stated the expectation was for nursing staff to utilize the E-Z Graph Wound Assessment Worksheet at least weekly and document in the events and progress notes

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of the EHR. NM-A stated it was expected nursing staff would comment on whether the pressure ulcer was improving or not at least weekly.

Review of R8's E-Z Graph Wound Assessment Worksheet dated 5/11/19, indicated R8 had a wound to the "Butt - R [right] side." The worksheet indicated a length of 3.0 cm, width of 3.0 cm and a depth of 0.5 cm. The worksheet indicated the presence of an odor and eschar/slough present. The worksheet had a hand drawn diagram of an irregular shaped circle with an inner circle with a line from it indicating "yellow". To the right of the hand drawn diagram was the handwritten words "Soft" and "Moist". The worksheet provided space to document wound base, drainage amount, drainage type, periwound appearance, age of wound, pain present, and wound status however, these areas were left blank. No further E-Z Graph Wound Assessment Worksheet were provided for R8.

On 5/16/19, at 12:55 p.m. primary physician (MD)-E indicated he expected, and the facility normally, would contact him immediately via fax when a wound or pressure ulcer developed on a resident. MD-E confirmed he assessed R8's pressure ulcer on 5/15/19, and R8 had a pressure ulcer to her right lower buttocks that was unstageable due to the wound bed covered in slough. MD-E stated he planned to continue current treatment and interventions and expected the pressure ulcer would heal.

On 5/16/19, at 2:02 p.m. the director of nursing (DON) 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. The DON also stated the expectation for identifying,

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F 686	Continued From page 22 monitoring and treating a pressure ulcer or wound involved the nursing staff completing an event form, updating the care plan, and documenting the appearance of the pressure ulcer or wound at least weekly. The DON stated it was expected the pressure ulcer documentation would include the location of the wound, the measurements of the wound, if there was drainage or odor present, any signs or symptoms of infection, if there was pain present and a thorough description of the wound. The DON explained R8's pressure ulcer started as a shearing abrasion from the incontinent brief or sling utilized with the mechanical lift and verified the pressure ulcer had worsened to an unstageable pressure ulcer which had yellow slough present. The DON stated licensed nursing staff recently watched a webinar in March 2019, regarding pressure ulcer prevention and repositioning requirements. R27's quarterly MDS dated 4/17/19, indicated moderate cognitive impairment and diagnoses of heart failure, hypertension, peripheral vascular disease, Diabetes Mellitus, and dementia. The MDS indicated R27 required extensive assistance from 2 staff with activities of daily living (ADL)s including bed mobility, transferring, toileting, dressing and personal hygiene. R27's annual care area assessment (CAA) dated 1/25/19, revealed R27 was cognitively impaired, and indicated at risk for pressure ulcers but had no skin issues. In addition, the CAA identified R27 required staff assistance with ADLs including dressing the lower body. The CAA indicated R27 was at risk for skin breakdown related to advanced aging, peripheral vascular disease and	F 686		

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thin fragile skin.

R27's current care plan described various interventions and instructions for self care deficits, and required assistance with all ADLs. In addition, the care plan addressed R27's risk for skin breakdown on her feet related to structural problems, needing assist with ADL's, diagnoses of Diabetes Mellitus with peripheral vascular disease (PVD), advanced age, and history of easily bruising related to thin fragile skin.

During an interview on 5/13/19, at 1:47 p.m. R27 stated she had a sore toe and indicated staff were aware and had been applying salve to the area, but indicated it was not helping.

A review of R27's active medication administration record (MAR) orders on 5/15/19, instructed staff were to apply topical animal scents to callous on right foot at bedtime, and instructed staff to put on TED stockings and leg protectors in the morning and remove at bedtime.

Review of R27's progress notes reviewed from 3/5-5/14/19, lacked any documentation of skin issues or interventions utilized. In addition, a nursing progress note dated 3/16/19, at 7:00 p.m. indicated R27 had a reddened area on second toe on the right foot and indicated she also had rubbing from her shoes on her left foot, that she wore toe sleeves and indicated staff would make sure she was wearing the toe sleeves.

R27's electronic medication administration record (EMAR) and electronic treatment administration record (ETAR) were reviewed and lacked monitoring or documentation of the redness identified on R27's toe, use of the toe sleeve, or

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monitoring of R27's toes or feet.

Review of a podiatry consult on 3/5/19, did not address any reports of redness or irritation of her feet/toes or use of the toe sleeve to reduce friction or rubbing during the visit and indicated no skin concerns were noted at the time of the visit.

On 5/14/19, 2:41 p.m. R27 was seated in her room with her feet elevated in a recliner chair. R27 was wearing black diabetic shoes and had tan compression socks on bilateral lower extremities with tan Geri sleeves (protective sleeves) on both lower legs under her pants.

On 5/15/19, at 7:16 a.m. Nursing Assistant (NA)-C stated she looked at all residents' skin head to toe with morning and bedtime cares. NA-C stated if she observed any changes or issues with a resident's skin she would notify the nurse right away. NA-C stated R27 had redness on the left second toe and indicated it was not new for R27 and staff were putting a foam toe sleeve on R27's toe to separate the toes and prevent rubbing in her shoes.

On 5/16/19, at 8:39 a.m. NA-D stated she checked the resident's skin every day with morning and evening cares, and indicated the bath aide completed a head to toe skin assessment on each resident's bath day and would report any concerns to the nurse. NA-D stated NAs do not document the skin issues, but report them to the nurse so a skin assessment/documentation could be completed. NA-D stated if there were any skin issues or interventions they would be care planned and on the eTAR so nursing staff could monitor and document on the area. NA-D stated she had

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cared for R27 and observed redness on her toes which she had made nursing staff aware of. NA-D said nursing was monitoring the areas and were applying padding to the reddened toes with morning cares.

On 5/16/19, at 8:52 a.m. NA-E stated she would look at the resident's skin when she is providing cares in the morning and evenings, checking them over head to toe. NA-E stated if there are any issues such as bruising, redness, or anything different she would report it to the nurse. NA-E stated the process for reporting a skin issue was to complete a Stop N Watch (alert). NA-E stated if a resident had Diabetes or other skin issues she would pay close attention to their feet. NA-E stated the nurse would then assess the skin issue and complete the documenting and tracking until resolved. NA-E stated she had worked with R27 and stated staff look at her skin and feet with cares. NA-E also explained staff help R27 apply stockings and remove them every day and indicated they look at feet and legs at that time. NA-E stated she had observed redness on R27's left second toe and had reported the concern to the nurse several months ago. NA-E stated they apply toe cushion wraps as an intervention, and stated R27's toes did not look any different than they had for the last couple of months.

On 5/16/19, at 10:30 a.m. registered nurse (RN)-A stated the process for routine skin monitoring was to complete the licensed nurse data collection (LNDC) weekly assessment for all the residents which included questions regarding skin condition. RN-A stated the bath aide and NAs looked at the residents' skin during daily cares and notify nursing if there are any changes in skin integrity. RN-A stated she looked at the

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ESSENTIA HEALTH GRACE HOME	116 WEST SECOND STREET GRACEVILLE, MN 56240

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resident's skin head to toe each week for the LNDC and indicated she thought that was the facility policy. RN-A stated R27 was at risk for skin breakdown due to history of hammer toes, and stated they get red and sore. RN-A verified there was no monitoring for this issue currently in place. In addition, RN-A stated she was not aware of any current skin issues with R27, and reviewed the most current temporary care plan in the resident's chart and verified monitoring of the redness on her toes was not in temporary care plan. RN-A stated the care plan instructed staff to monitor any changes in skin and report to nursing, but indicated the care plan lacked anything specific about monitoring R27's feet or toes, or effectiveness of the use of R27's toe sleeves. RN-A verified she had not been notified of redness on R27's toes, and would expect NA staff to notify her of any skin concerns.

On 5/16/19, at 1:13 p.m. Infection Control Registered Nurse (ICRN)- F stated she would look at R27's toes again, and stated R27's red toes were reported to the resident's medical provider today and he came over from the clinic to look at them. ICRN-F stated the medical provider discontinued use of the toe sleeves, and Ted stockings, stating they were actually putting pressure on her toes related to deformities in her feet, causing her toes to rub together. The multiple reddened areas measured were as follows:

- Right great toe first knuckle 0.4 cm x 0.5 cm wide reddened area 100% blanchable, R27 verbalized her toes hurt.

- Right foot second toe red 100% blanchable area measuring 0.5 cm X 0.3 cm.

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F 686	Continued From page 27 - Right foot second toe top of knuckle calloused area with 100% blanchable reddened area measured 0.5 cm X 0.4 cm. - Right top of foot scabbed area measured 0.5 cm dry with no drainage. - Left foot second toe first knuckle 100% red blanchable area which measured 0.5 cm X 0.5 cm. - Left foot second knuckle 0.7 cm X 0.6 cm resident expressed discomfort with palpation, center of the reddened area which measured 0.3 cm X 0.2 cm red area not blanchable. - Left foot third toe 100% red blanchable area which measured 0.4 cm x 0.5 cm. - Left foot redness on the side of the third toe which measured 1.5 cm long. On 5/16/19, at 1:31 p.m. ICRN-F verified "today was the first time" she had been notified of the reddened areas on R27's toes. ICRN-F stated she would expect staff to report issues with skin integrity to nursing staff for monitoring. In addition, ICRN-F stated the toe socks, Ted stockings, and skin checks should be completed by licensed staff weekly and any issues added to the care plan and eTAR for monitoring until resolved. ICRN-F verified that R27 was at high risk for skin issues on her feet related to her advanced age, history of Diabetes Mellitus, and edema. She indicated she should have her feet monitored and documented on daily. On 5/16/19, at 3:00 p.m. the DON stated she had	F 686		

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not been aware of R27's sore reddened areas on her toes, and stated she would expect staff who observe alterations in skin condition to notify the charge nurse and implement the process to begin monitoring and documentation until resolved. The DON stated licensed nursing staff should have assessed and documented on R27's redness and foot tenderness with daily monitoring, but verified this had not been done. The DON stated the nursing staff should be completing a thorough head to toe skin assessment when completing the weekly LNDC, and verified this had not been done for R27.

Review of facility's policy Pressure Ulcer and Non-Surgical Wound Documentation and Management revised 1/19, instructed staff to provide the following documentation of pressure ulcers and wounds at least weekly: wound type, location, stage, depth, measurement, description of drainage, tissue description, signs of infection, condition of skin surrounding the ulcer, if pain present, and appropriate care and treatment. The policy further instructed the dietician to review nutritional status of the resident and to make recommendations to promote healing. The policy identified the physician would be notified when the stage increases. The policy indicated licensed staff would verify weekly that documentation was accurate and appropriate.

Review of facility's policy Skin Inspection revised 3/19, indicated licensed staff would complete a weekly head to toe skin inspection which included undressing the portion of the body with a pressure ulcer or wound present. The policy identified licensed nurses would manage any changes or alterations in skin noted. Further, the policy indicated licensed staff would create a skin

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event to ensure monitoring, documentation and measuring of the skin alteration was completed weekly and as needed.

The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2018, identified Section M: Skin Conditions to be completed to identify the risk, presence, appearance and change of pressure ulcers/injures. The manual defines a pressure ulcer/injury as a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure in combination of shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful. The manual further identified it was imperative to determine the etiology of all wounds and lesions as that would determine and direct the proper treatment and management of the wound.

- The manual defines a stage one pressure ulcer/injury as "an observable, pressure-related alteration of intact skin whose indicators, as compared to an adjacent or opposite area of the body, may include changes in one or more of the following parameters: skin temperature (warmth or coolness), tissue consistency (firm or boggy), sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the injury may appear with persistent red, blue or purple hues."

- The manual defines a stage two pressure ulcer/injury as "partial thickness loss of dermis presenting as a shallow open crater with a red-pink wound bed, without slough or bruising."

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F 686	Continued From page 30 - 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." - The manual defines a stage four pressure ulcer/injury as "Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed." - The manual stated " pressure ulcers covered with slough and/or eschar, and the wound bed cannot be visualized, should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined."	F 686		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to	F 692		6/25/19

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F 692	Continued From page 31 maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete accurate and ongoing nutritional assessment for 1 of 2 residents (R8) reviewed for nutrition. R8 sustained harm when the facility failed to accurately and timely assess nutritional status, address risk factors for impaired nutritional status, and implement approaches to maintain acceptable nutritional parameters for R8 who experienced a clinically severe weight loss of over 10% in six months. Findings include: R8's quarterly Minimum Data Set (MDS) dated 2/19/19, indicated R8 had diagnoses which 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.	F 692	The Registered Dietician (RD) was notified by the Certified Dietary Manager (CDM) of the identified resident R8 additional weight loss and change in skin condition on 5/15/19, since previously, notifying the RD of a significant weight loss on 3/20/19 and documentation noted "may benefit from a gradual weight loss to reduce stress on organs and joints." On 5/15/19 RD made recommendation for nutritional interventions "trial of 4oz. Ensure at Dinner/ Supper meal to provide additional protein, calories, and fluids. Encourage protein rich foods and fluids when able. Offer favorite foods to improve intake." On 5/24/19 CDM added additional nutritional supplement of Plus 2 Protein Shakes TID between meals. RD and care plan updated to reflect changes. The nutritional/ hydration status of current residents was reviewed by IDPT and those at risk have been referred to RD for monthly onsite assessment, nutritional interventions put in place care plans reviewed and updated, as appropriate. Results of this audit shall be reported to the QAPI committee.	

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F 692	Continued From page 32 R8's annual Care Area Assessment (CAA) dated 9/5/18, indicated R8 required assistance with ADL's due to progressing Alzheimer's Dementia. The CAA revealed R8 was at risk for developing pressure ulcers due to immobility and the need to be repositioned by staff. The CAA identified R8 had no current skin issues at the time of the assessment. The CAA indicated R8 was at risk for weight and fluid changes due to intake and abnormal labs. The CAA further identified R8 was at nutritional risk due to heart disease with heart failure, acute kidney failure, dementia and atrial fibrillation (quivering or irregular heartbeat). R8's care plan revised 5/14/19, revealed R8 required extensive to total assistance with ADL's which included bed mobility, transfers, locomotion, dressing, toileting, personal hygiene and bathing. The care plan indicated R8 required supervision with set-up for eating tasks and staff were to monitor the resident's need for increased assistance. The care plan identified R8 had an open area to her right buttock as a result of shearing. The care plan instructed staff to encourage R8 to consume a well balanced diet as well as consume all fluids offered at meal times. The care plan identified R8 was on a regular diet with nectar thin liquids and R8 was to be seated at the supervision table due to occasionally required increased assistance with eating tasks from staff. The care plan further instructed staff to monitor and record intake and to report any significant changes to the physician and family. On 5/14/19, at 12:20 p.m. R8 was observed to be seated in her wheelchair at the dining room table being assisted by nursing assistant (NA)-B to eat	F 692	The "Nutritional Care and Documentation" policy has been reviewed and revised. Staff will receive education regarding the updated policy and F692 by one of the following means: 1:1 meetings, standups, or scheduled meetings on 6/18/19 and 6/20/19. The IDPT will review all residents with current impaired nutritional status weekly x4, then monthly thereafter. CDM will notify RD per "Nutritional Care and Documentation" policy & procedure. Results of the audit will be reported to the QAPI Committee for further recommendations.	

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her lunch. R8 consumed one half of her sherbet and one fourth of her hotdish. R8 drank all of her apple juice.

On 5/15/19, at 8:42 a.m. NA-A wheeled R8 to the dining room and placed her at the dining room table. R8 was provided her breakfast tray consisting of a banana, toast, scrambled eggs and yogurt as well as two glasses of juice. R8 was noted to be leaning to her left in her wheelchair. R8 was provided a fork by NA-A and attempted to feed herself bites of her banana with difficulty. At 8:46 a.m. NA-A sat down next to R8 and attempted to position R8 in a more upright position in her wheelchair. R8 proceeded to feed herself her breakfast slowly with cueing and occasional assistance from NA-A with placing food on her fork and guiding it to R8's mouth. At 9:20 a.m. R8 continued to drink her juices and was no longer eating anymore of her food. R8 consumed all of her banana, half a slice of toast and a couple bites of the yogurt and eggs.

On 5/15/19, at 11:14 a.m. R8 was seated in her wheelchair at the dining room table waiting for lunch to be served. At 12:15 p.m. R8 was brought back to her room due to complaints of nausea. R8 had not eaten her lunch as a result of the nausea.

Review of R8's weight record from the electronic health record (EHR) were reviewed from 11/13/18, to 5/13/19 and included:

11/13/18, 200.5 pounds (lbs.)
12/13/18, 196 lbs.
1/13/19, 193 lbs.
2/13/19, 188.3 lbs.
3/12/19, 188.8 lbs.

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F 692	Continued From page 34 4/15/19, 183.9 lbs. 5/13/19, 180.4 lbs. Review of R8's 2/19/19, nutritional screening revealed R8's weight was noted to be 190.2 lbs., this compared to 192.9 lbs. 30 days prior and 201.5 lbs. 180 days prior. The screening indicated R8's usual body weight was 190- 200 lbs. The screening further indicated R8 had swallowing problems and utilized adaptive equipment. The screening identified R8's usual intake was 51%- 75% and she typically consumed under 1000 milliliters (ml.) of fluids. The screening further identified R8's skin as intact, and indicated the team should continue the current plan of care. Review of progress notes from 3/20-5/15/19, revealed the following: 3/20/19, registered dietician (RD)-D noted R8's weight was 188.3 lbs. and R8 had experienced a significant weight loss of 21 lbs. (10%) in 180 days. The note indicated R8 may benefit from a gradual weight loss to reduce stress on organs and joints. The note further indicated R8's meal intakes varied from 25% to 100%. The note identified R8 required encouragement and indicated staff would continue to monitor weights, intakes and plan of care for significant changes. 4/10/19, dietary director (DD)-B noted R8's weight was 185 pounds which equaled a 3.6% weight loss in 30 days and a 10.1% weight loss in 180 days. The note identified R8's intakes varied from 25% to 100% per meal. The note indicated the plan to continue to monitor and to refer to RD-D at the next site visit.	F 692		

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F 692	Continued From page 35 5/2/19, DD-B noted R8's weight was 181.6 pounds which equaled a 19 pound weight loss in 180 days. The note indicated R8's intake varied by meal. Further, the note indicated R8 required cueing to dine as needed, and indicated R8 may require more assistance with eating. The note indicated staff would continue to monitor and the RD-D would see R8 at next site visit. 5/15/19, RD-D stated she had been notified R8 had an open wound to her right buttocks that measured 2 cm by 2.5 cm with a total width of 3 cm. RD-D also identified R8's weight of 180.4 pounds which equaled an additional 2% weight loss in 30 days, 5% weight loss in 90 days and 9% weight loss in 180 days. RD-D indicated R8's meal intakes continued to be variable, and indicated breakfast was where R8 had the best intake 76-100% , while lunch and supper meals ranged from 25% to 75%. RD-D recommended a trial of 4 ounces of ensure at lunch and supper meals to provide additional protein, calories and fluids. Additionally, staff were to offer protein-rich food/fluids and offer favorite foods to improve intakes. The note identified goals of stabilizing weight, improve skin integrity, supplement acceptance, improve meal intakes to be equal to or greater than 75% and the RD-D planned to follow-up at the next site visit. Review of the physician's progress notes in the electronic health record (EHR) were reviewed from 2/22-5/15/19, revealing the following: 2/22/19, the progress note lacked documentation regarding R8's weight loss or a plan to address weight loss. 3/15/19, the progress note lacked documentation regarding R8's weight loss or a plan to address	F 692		

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weight loss.
4/24/19, the progress note lacked documentation regarding R8's weight loss or a plan to address weight loss.
5/14/19, the progress note lacked documentation of weight loss or a plan to address weight loss. However, there was an addendum note indicating nursing staff had informed the primary physician (MD)-E of R8's gluteal ulcer being treated and the progress toward healing. According to the note, the physician indicated the ulcer had developed due to shear or maceration due to friction, seat position and exposure to urine.
5/15/19, an addendum to the 5/14/19, progress note indicated MD-E had assessed the ulcer and determined the ulcer was the size of a quarter and had shallow pale superficial slough. However, the note did not include any physician assessment of the resident's nutritional status, weight loss, or any plans to address the weight loss.

Review of R8's signed physician orders dated 5/16/19, indicated R8 was on a regular diet with nectar thickened fluids and required weekly weights. Additionally, there were general orders dated 6/28/17, regarding nutritional supplement per RD-D or DD-B recommendation, noted.

Review of R8's medication administration record (MAR) for May 2019, indicated there had been no nutritional supplements ordered/initiated for R8.

Review of R8's treatment administration record (TAR) for May 2019, also failed to indicate any nutritional supplement order or implementation.

On 5/15/19, at 8:36 a.m. NA-A stated R8 could feed herself with cueing but did occasionally

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require assistance from staff with eating. NA-A further indicated R8 had a fair appetite but had experienced weight loss. NA-A wasn't sure how much weight R8 had lost.

On 5/15/19, at 11:46 a.m. NA-C stated R8 required assistance with eating at times, and often refused meals at noontime. NA-C stated R8 had experienced a weight loss but did not receive nutritional supplements. NA-C wasn't sure how much weight R8 had lost.

On 5/15/19, at 1:46 p.m. registered nurse manager (RN)-A stated DD-B monitored the weights for all residents, and would start new nutritional interventions if a resident required it due to weight loss. RN-A stated she wasn't sure if R8 had experienced a weight loss or not, and reviewed the weights in R8's EHR to determine if a weight loss had occurred. Upon review of R8's records, RN-A confirmed R8 had experienced a significant weight loss. RN-A again stated DD-B, and RD-D, managed weight loss concerns for all residents. RN-A also confirmed R8 had not been receiving any supplements for the weight loss.

On 5/15/19, at 2:35 p.m. DD-B stated weights were reviewed on a weekly basis and if a resident had not been eating well or experienced an unwanted weight loss, offering high caloric foods would be one of the first interventions to implement. DD-B also stated nutritional supplements would be offered to promote stabilization of weight or weight gain. Further, a referral to RD-D would be initiated, and she would see the resident in person during her monthly visits. DD-B stated when a resident triggered a significant weight loss of 5% or more in 30 days, or 10% or more in 180 days, RD-D would be

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	245579	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH GRACE HOME	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 38	F 692		

notified via phone or email instead of waiting for the monthly visit. DD-B also stated high protein supplements would be implemented for residents who had pressure ulcers or wounds to promote healing. DD-B confirmed RD-D had not seen R8 during her last site visit on 4/24/19 and further confirmed he was not aware R8 had a pressure ulcer. DD-B further confirmed R8 had not been receiving nutritional supplements.

On 5/16/19, at 10:07 a.m. during a phone interview with RD-D, RD-D stated she worked closely with DD-B to monitor nutritional concerns and further stated she made onsite visits on a monthly basis. RD-D explained for any needs that developed inbetween her visits, DD-B would email or call her on the telephone. RD-D stated she would expect to be notified within 48 hours if any resident developed a pressure ulcer or had a significant weight loss. RD-D confirmed she had first been notified by DD-B of R8's pressure ulcer and significant weight loss on 5/15/19, and would have expected to have been notified earlier for both. RD-D stated she'd reviewed R8's EHR at 5:56 p.m. on 5/15/19, to determine intakes and weight loss had occurred. RD-D confirmed R8 had experienced a significant weight loss in the past six months. Further, RD-D made recommendations for a supplement at the lunch and supper meals, and encouraging high caloric foods to promote wound healing and to prevent further weight loss. RD-D stated she planned on evaluating R8 in person during her next onsite visit which she planned to do within the next couple of weeks.

On 5/16/19, at 2:02 p.m. the director of nursing (DON) stated DD-B and RD-D monitor all residents for weight loss and provided

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F 692	Continued From page 39	F 692		

recommendations for interventions to promote 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 assessments would cover dietary needs of residents and any recommended changes as a resident's condition changed. The policy identified DD-B would monitor weights, intakes, labs and recommended 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 (RAI) 3.0 User's Manual dated 10/2018, identified Section K: Swallowing/Nutritional Status to be completed with an intent to assess the many conditions that cold affect the resident's ability to maintain adequate nutrition and hydration. Under K0300: Weight Loss Planning for Care:

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F 692	Continued From page 40 - "Weight loss may be an important indicator of a change in the resident's health status or environment. - If significant weight loss is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medication (e.g. diuretics), or changed fluid volume status. - Weight loss should be monitored on a continuing basis; weight loss should be assessed and care planned at the time of detection and not delayed until the next MDS assessment."	F 692		

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	245579	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/15/2019**

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ESSENTIA HEALTH GRACE HOME	**116 WEST SECOND STREET** **GRACEVILLE, MN 56240**

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF 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.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Essentia Health - Grace Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

"If participating in the E-POC process, a paper copy of the plan of correction is not required."

EPOC

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/13/2019

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.

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K 000	Continued From page 1 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Essentia Health - Grace Home is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1976 and was determined to be of Type II(111) construction. In 1998, 3 additions were added to the southeast, northeast and northwest that were determined to be of Type II(111)construction. Because the original building and the addition meet the construction types allowed for existing buildings, the facility was surveyed as one building. The building is protected by a complete fire sprinkler system. The facility has a fire alarm system with smoke detection by the smoke barrier doors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 40 beds and had a census of 33 at the time of the	K 000		

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K 000	Continued From page 2 survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview the facility failed to inspect the cooking equipment, every six months, as stated in the Life	K 324	The kitchen hood and cooking equipment will be inspected semi-annually by a qualified contractor. The next inspection	6/7/19

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K 324	Continued From page 3 Safety Code (NFPA 101) 2012 edition section 9.2.3 & NFPA 96 section 11.2. This deficient practice could allow for the spread of fire if the hood suppression system did not operate properly, affecting an isolated amount of residents, staff and visitors. Findings include: On the facility tour between 8:00 am to 11:30 am on 05/15/2019 documentation review revealed there was record of only one semi annual hood inspection in the last 12 months. This deficient condition was confirmed by the Maintenance Supervisor.	K 324	has been scheduled for 10-02-2019 Tom Montonye, Maintenance Supervisor will be responsible to see that work is completed. The inspection report will be submitted to the Safety committee and the Quality Assurance Committee for review.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one smoke barrier as required by the 2012 Life Safety Code (NFPA	K 372	All smoke penetrations will be sealed above the ceiling along the length of the smoke barrier by the administration	6/20/19

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K 372	Continued From page 4 101) section 19.3.7.3, 8.5.6.2. This deficient practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of 12 of the 40 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 11:30 am on 05/15/2019 observations revealed the smoke barrier by the administration offices contained several unprotected penetrations above the ceiling along its length. This deficient condition was confirmed by the Maintenance Supervisor.	K 372	offices. A qualified contractor will be completing the work. Work is scheduled to start 6-13-19 and scheduled to complete 6-17-19 Tom Montonye, Maintenance Supervisor will be responsible to see that work is completed. The repair work information will be submitted to the Safety committee and the Quality Assurance Committee for review.	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview the facility failed to maintain a Fire Safety Plan as required in NFPA 101 Life Safety	K 711	The Fire Safety Plan has been revised to include items: 7, 8 & 9 listed in NFPA101. The updated Fire Safety Plan was	6/1/19

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K 711	Continued From page 5 Code, 2012 edition section 19.7.2.2. This deficient practice could cause confusion in an emergency and affect all 40 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 11:30 am on 05/15/2019 documentation review revealed the fire safety plan did not clearly address all nine items listed in NFPA 101. (Items 7, 8 & 9 were not addressed) This deficient condition was confirmed by the Maintenance Supervisor.	K 711	reviewed and approved by the safety committee on 6/12/19. Tom Montonye, Maintenance Supervisor will be responsible to see that work is completed. The revised Fire Safety Plan will be submitted to the Safety committee and the Quality Assurance Committee for review.	
K 781 SS=E	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on documentation review, observation and staff interview, the facility allowed the use of a portable space heater without having a policy on file as stated in NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.8. This deficient practice could affect an undetermined amount of residents, staff, and visitors. Findings include:	K 781	The space heater in the front lobby has been removed. Tom Montonye, Maintenance Supervisor will be responsible to see that work is completed.	5/21/19

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K 781	Continued From page 6 On the facility tour between 8:00 am to 11:30 am on 05/15/2019 documentation review & observations revealed there was no policy to address the portable space heater located in the main entry sitting area. This deficient condition was confirmed by the Maintenance Supervisor.	K 781	The information on the removal of the space heater will be submitted to the Safety committee and the Quality Assurance Committee for review.	

DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00762	A. BUILDING: _____ B. WING _____	05/16/2019

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 5/13/19, to 5/16/19, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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	00762	A. BUILDING: _____ B. WING _____	05/16/2019

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 545	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after the date of admission; B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS) when two or more areas of change in resident status were noted for 1 of 16 (R8) residents reviewed for decline in health status. Findings include: R8's annual MDS dated 8/29/18, indicated R8 had diagnoses of heart failure, Alzheimer's disease, dementia, anxiety and depression. The MDS identified R8 had severe cognitive impairment and required extensive to total assistance for activities of daily living (ADL's), except eating R8 required supervision. The MDS further identified R8 was frequently incontinent of bladder, was always continent of bowel, did not use supplemental oxygen, had no pressure ulcers and had no weight loss or gain.	2 545	A Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS) was initiated for the identified resident R8 on 5/16/19 and documented in the Electronic Health Record (EHR). All residents with a change in status have the potential to be affected by this practice. The Interdisciplinary Team (IDPT) reviewed 100% of all current residents to evaluate for the presence of a significant change. Any resident identified to have a change in two or more areas shall have a SCSA MDS initiated and a member of the IDPT shall complete a note in the EHR. Results of this audit shall be reported to the QAPI committee. The "Change of Condition" policy has been reviewed and updated. IDPT and	6/25/19

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2 545	Continued From page 3 R8's quarterly MDS dated 2/19/19, indicated R8 had diagnoses of heart failure, Alzheimer's disease, dementia, anxiety and depression. The MDS identified R8 had severe cognitive impairment and required extensive to total assistance with ADL's, except eating R8 required limited assistance. The MDS further indicated R8 had no current pressure ulcers, no weight loss, always incontinent of bowel and bladder, utilized supplemental oxygen, and received a mechanically altered diet for meals. Review of the above assessments indicated R8's incontinence pattern worsened from frequently incontinent to totally incontinent of bladder, and totally continent to totally incontinent of bowel. R8 was newly coded for supplemental oxygen use and a mechanically altered diet for meals. Review of R8's progress notes from 3/20/19, to 5/15/19, revealed the following: On 4/8/19, R8 was noted to have an open area to the buttocks which measured 0.5 inches. The nurse planned to apply Mepilex (a foam absorbent dressing used to treat acute and chronic ulcers and wounds) after R8 had received a morning bath. On 4/9/19, the Interdisciplinary Team (IDT) reviewed R8's wound to the buttocks and identified the wound as shearing. The note further indicated treatment would be administered as ordered and Ammens powder (a powder utilized for minor skin irritations) would be applied to keep the area dry and to prevent breakdown. The note identified a ROHO cushion (a cushion used for pressure relief) would be utilized in R8's wheelchair and staff would monitor the wound daily and document at least weekly until healed.	2 545	nursing Staff education will be provided by at least one of the following means: 1:1 meetings, standups, or scheduled meetings on 6/18/19 and 6/20/19 to include review of the "Change in Condition" policy and F637. The Interdisciplinary Team shall review 100% of all current residents weekly x 4, then monthly x 3 months. Any resident identified to have a change in two or more areas shall have a SCSA MDS initiated. Results of the audit shall be reported to the QAPI committee for further recommendations.	

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2 545	Continued From page 4 On 5/15/19, a Mepilex dressing was changed on R8's right buttock. Nursing staff indicated a small to moderate amount of tan colored drainage was noted on the old dressing and no odor was detected. The open area measured 2 cm. (centimeters) in width by 2.5 cm. in length. The nursing staff further indicated darker pink tissue surrounded the wound and the entire wound measured which included the open wound and the surrounding dark pink tissue 3 cm. The color of the majority of the wound bed was light yellow in color and the proximal area of the open wound had a 0.25 cm. dark red-brown area. Further review of R8's progress notes revealed the following: On 3/20/19, documentation indicated R8 had a significant weight loss in the past 180 days of 21 lbs.(pounds) (10% loss). The note indicated R8 had variable intakes from 25% - 100%. The note identified staff were to continue to encourage food/fluid intake, monitor weights and plan of care closely for significant changes. On 4/10/19, R8's weight was noted to be 185 lbs. which was a loss of 3.6 % in 30 days and 10.1% in 180 days. The note indicated R8 continued to have varying intakes at meals from 25% to 100%. The note identified staff were to continue to monitor and refer to the registered dietician (RD)-D at the next site visit. The note lacked any documentation of a pressure ulcer or wound present on R8. On 5/2/19, R8's weight was 181.6 lbs. which indicated a loss of 19 lbs. in the past 180 days. The note indicated R8 continued with varying intakes at mealtimes. The note identified staff	2 545		

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2 545	Continued From page 5 were to provide cueing at mealtimes and R8 may need more assistance with eating. Further, the note indicated staff were to continue to monitor and refer to the RD-D at the next site visit. The note lacked any documentation of a pressure ulcer or wound present on R8. On 5/15/19, RD-D was notified of weight loss and development of pressure ulcer. The note indicated R8's weight was 180.4 lbs. which was a loss of three lbs. (2%) in 30 days, nine lbs. in 90 days and 18 lbs. in 180 days (9%). The note identified R8 had variable meal intakes and a recommendation was made to trial four ounces of ensure at dinner/supper meals to provide additional protein, calories and fluid. The staff were to encourage protein rich foods and fluids when able. The RD-D planned to follow-up and visit with R8 at the next RD-D site visit. On 5/16/19, at 12:32 p.m. nurse manager (NM)-A confirmed she completed the MDS assessments for all residents and a SCSA MDS should have been completed within 14 days when two or more areas of decline were noted. NM-A explained she was unsure whether R8 had a decline in two or more areas. NM-A reviewed R8's progress note in the electronic health record (EHR) from 4/10/19, and confirmed the progress note stated R8 had a significant weight loss. Further, NM-A confirmed R8 had a wound present on her right buttocks. NM-A confirmed SCSA MDS had not been completed on R8. On 5/16/19, at 2:02 p.m. the director of nursing (DON) stated a SCSA MDS should have been completed on R8 when two or more areas of decline had been noted. DON confirmed R8 had developed a pressure ulcer to her right buttocks which had slough present and additionally R8 had	2 545		

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2 545	Continued From page 6 experienced weight loss which would meet criteria to complete a SCSA MDS. Review of facility's 1/19 policy Change in Condition, indicated the care plan and MDS would be updated as required with any pertinent information as appropriate. The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2018, indicated the definition of a significant change as a decline or improvement in a resident's status of which: "1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting, 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan." The manual further directed when the interdisciplinary team (IDT) determined that a significant change occurred, the facility should have documented the initial identification of the significant change in the EHR. The final decision regarding what constituted a significant change in status must be based upon the judgement of the IDT. Further, the manual clarified that MDS assessments are not required for minor or temporary variations in the resident status. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies and procedures for comprehensive significant change assessments. Nursing staff could be educated as	2 545		

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2 545	Continued From page 7 necessary to the importance of significant change comprehensive assessments. The DON or designee, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 545		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately assess, identify and monitor facility acquired pressure ulcers for 2 of 2 residents (R8, R27) who were observed for pressure ulcer care. This deficient practice resulted in actual harm for R8 who initially had an open area caused by shearing (occurs when layers of skin rubs against each	2 900	All residents with identified risk for Pressure Ulcers and/or residents with current pressure ulcers have the potential to be affected by this practice. A Braden Scale was completed for 100% of all residents to evaluate pressure ulcer risk. Care plans were reviewed and	6/25/19

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2 900	Continued From page 8 other or when the skin remains stationary and the underlying tissue moves and stretches and tears underlying capillaries and blood vessel causing tissue damage) identified to the right buttocks which worsened to an unstageable pressure ulcer (observed full-thickness skin and tissue loss in which the extent of the damage cannot be confirmed due to the wound bed obscured with slough or eschar). Findings include: R8's quarterly Minimum Data Set (MDS) dated 2/19/19, indicated R8 had diagnoses of heart failure, Alzheimer's disease, 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. The MDS further 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. The MDS further identified R8 was frequently incontinent of bladder and always incontinent of bowel. R8's annual Care Area Assessment (CAA) dated 9/5/18, indicated R8 required assistance with ADL's due to progressing Alzheimer's disease and dementia. The CAA revealed R8 was at risk for developing pressure ulcers due to immobility and the need to be repositioned by staff. The CAA identified R8 had no current skin issues at	2 900	updated, as appropriate for 100% of all residents with known risk and/or history of skin breakdown. Results of this audit shall be reported to the QAPI Committee. The IDPT will review 100% of all residents with pressure ulcers. Any resident with an identified pressure ulcer was assessed and documentation completed in the EHR to include: location, stage, size, exudate, odor, pain, wound bed, description of wound edges and surrounding tissue of present pressure ulcers. The review will also include evaluation of nutritional status, notification of the Registered Dietitian (RD) appropriateness of current treatment and interventions. The resident□s care plan reviewed and revised as appropriate. Results of this audit shall be reported to the QAPI Committee. Developing a skin care management policy and procedure with a defined wound care team. Facility standing orders wounds/ skin care have been reviewed and updated. The Nutritional Care and Documentation policy has been reviewed and revised. The Certified Dietary Manager(CDM) will enter a note in the EHR when the consulting RD has been informed of any pressure ulcers. The CDM, or designee will audit EHR to ensure appropriate notification to RD and completion of assessment/review of nutritional status by RD in EHR monthly x 3 then quarterly X 3. Results shall be reported to the QAPI committee.	

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2 900	Continued From page 9 the time of the assessment. The CAA further indicated R8 was at risk for weight and fluid changes due to intake and abnormal labs. The CAA further identified R8 was at nutritional risk due to heart disease with heart failure, acute kidney failure, dementia and atrial fibrillation (quivering or irregular heartbeat). The CAA indicated R8 was to be toileted three times a day on the commode utilizing the mechanical lift to transfer, provide the bedpan as needed and to provide incontinence care as needed. R8's care plan revised 5/14/19, revealed R8 required extensive to total assistance with ADL's which included bed mobility, transfers, locomotion, dressing, toileting, personal hygiene and bathing. The care plan indicated R8 required supervision with set-up for eating tasks. The care plan identified R8 had an open area to her right buttock as a result of shearing. The care plan instructed staff to apply a Mepilex dressing to the open area and to change the dressing every three days or more often if needed. The care plan further instructed staff to encourage and assist with every two hour repositioning while seated and every three hours when laying in bed. The care plan indicated staff would monitor for skin breakdown and report to the nurse if breakdown occurred. The care plan instructed staff to encourage R8 to consume a well balanced diet as well as consume all fluids offered at meal times. The care plan identified the resident was to use a geo matt (a therapeutic overlay mattress to aid in prevention and treatment of pressure ulcers) placed on the bed and a Vicair Liberty cushion (a cushion prescribed for pressure ulcer prevention) with an antishear cushion cover to be used in R8's wheelchair. R8's care plan instructed staff to toilet R8 three times a day on the commode utilizing the mechanical lift to	2 900	Staff will receive education by on the means: 1:1 meetings, standups, scheduled meetings on 6/18/19 and 6/20/19 to review skin, wound and nutrition policies, F686, and the National Pressure Ulcer and Prevention Guidelines (NPUAP). Education will include utilization of EHR for documentation requirements in accordance with F686 and facility policy. Essentia Health Medical staff shall receive education on 6/19/19 related to need for documentation upon notification of changes in resident status, and/or other pertinent health information.	

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2 900	Continued From page 10 transfer, provide the bedpan as needed and to provide incontinence care as needed. On 5/14/19, at 1:00 p.m. nursing assistant (NA)-B and occupational therapy assistant (OTA)-C placed sling for a mechanical lift behind R8's back and looped it under her legs while she was seated in the wheelchair with plans to lay R8 down in bed. Once the loops of the sling had been applied to the mechanical lift, NA-B operated the lift to transfer R8 out of the wheelchair and lowered her into her bed while OTA-C guided R8 in the sling. At 1:09 p.m. NA-B and OTA-C turned R8 to the left side in bed and removed an incontinent brief. A square Mepilex dressing was noted to R8's right lower buttocks area and was intact with a quarter sized area of dark brown drainage noted on the dressing. NA-B cleansed perineal area and proceeded to apply a new brief to R8. NA-B and OTA-C positioned R8 on the left side and placed a pillow behind the right side to keep R8 on the left side. NA-B provided call light to R8 and covered her up with blankets. NA-B and OTA-C completed hand hygiene after removing gloves. On 5/14/19, at 1:58 p.m. registered nurse (RN)-A assessed Mepilex dressing noted on R8's right lower buttocks and noted there was a quarter sized area of dark brown drainage in the center of the dressing that was visible however had not soaked through. RN-A stated the dressing had just been changed the day before and indicated she would not be changing it at that time. On 5/14/19, at 3:30 p.m. R8 was noted to be seated on a pressure reducing cushion in a wheelchair in the dayroom attending a music activity.	2 900		

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2 900	Continued From page 11 On 5/15/19, at 7:47 a.m. R8 was noted to be laying in bed on her back as NA-A and NA-C provided morning cares to R8. At 7:50 a.m. NA-C removed the front of the soiled brief and proceeded to cleanse R8's front perineal area. NA-C and NA-A positioned R8 on the right side and removed the brief completely and provided perineal cares to her back side. A Mepilex dressing to right lower buttocks was noted to be intact with the quarter sized area of dark brown drainage present. At 7:56 p.m. NA-C placed a new brief under R8 and with assistance from NA-A, applied the brief while turning R8 from side to side in the bed. NA-A and NA-C applied pants and placed sling for the mechanical lift under R8 while turning R8 from side to side. At 8:01 a.m. NA-A operated the lift and NA-C guided R8 into the wheelchair on top of the wheelchair cushion. NA-A and NA-C removed the sling and positioned R8 in an upright properly aligned position in the wheelchair. NA-A proceeded to remove R8's nightgown, cleansed chest and applied deodorant to R8's underarms. At 8:04 a.m. NA-A applied bra and hook of bra scratched right arm near R8's elbow which resulted in a skin tear. NA-A immediately provided pressure to stop the bleeding and asked for assistance from nursing staff. At 8:08 a.m. RN-A entered R8's room and assessed the skin tear and stated she would obtain dressings to treat the skin tear and would return. At 8:10 a.m. director of nursing (DON) entered the room and stated she would return shortly with supplies to treat the skin tear. At 8:14 a.m. NA-A proceeded to apply R8's shirt and glasses. At 8:16 a.m. DON returned to room with supplies, applied gloves and placed a cold washcloth to the skin tear that had bled slightly. DON indicated the measurements of the skin tear were 5 cm long and 0.7 cm in width. DON proceeded to cleanse the wound with normal	2 900		

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2 900	Continued From page 12	2 900		

saline and applied three steri strips to the skin tear after using a cotton-tip applicator to realign the skin together. DON placed a dressing over the skin tear and wrapped the arm with kling wrap. At 8:21 a.m. NA-A provided oral cares to R8 and brushed her hair. DON and NA-A completed hand hygiene after cares and NA-A brought R8 to the dining room for breakfast.

On 5/15/19, at 1:21 p.m. RN-A and Infection Control Coordinator (ICC)-F were both present in R8's room during a dressing change to her right buttocks area. RN-A and ICC-F positioned R8 on the left side. RN-A removed old Mepilex dressing from right buttocks and indicated the dressing had a little bit of dark brown drainage present. RN-A stated most of the wound bed had yellow slough present and additionally had a 0.25 cm dark brown area to the proximal area of the wound bed. RN-A measured the wound and indicated the width of the wound was 2 cm and the length of the wound was 2.5 cm. RN-A statedd there was about 0.1 cm depth to the wound. RN-A confirmed the wound had worsened since she had seen it last as there had been no yellow slough present in the wound bed when she'd last assessed the wound. RN-A was not able to recall the date she had last seen the wound. RN-A stated she would classify the wound as a stage two pressure ulcer due to the depth of the wound and ICC-F concurred. RN-A applied clean gloves, cleansed the wound with normal saline and applied a new Mepilex dressing. RN-A removed her gloves and completed hand hygiene. RN-A stated the wound had been caused by friction from a sling and as a result staff identified it as an abrasion.

Review of R8's Braden scale (tool used to determine risk for pressure ulcer development)

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	00762	A. BUILDING: _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH GRACE HOME	116 WEST SECOND STREET GRACEVILLE, MN 56240

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2 900	Continued From page 13 dated 11/19/18, indicated R8 was at risk for developing pressure ulcers due to the following risk factors: slightly limited sensory perception, moisture, chairfast, slightly limited with mobility and had a potential problem with friction and shearing. The Braden scale revealed R8 had the additional risk factors which included cardiovascular disease, chronic incontinence, diabetes, and thyroid disease. The Braden further indicated R8 required extensive assistance with bed mobility, required the use of a mechanical lift for transfers and was always incontinent of bowel. Review of R8's Braden scale dated 2/16/19, indicated R8 was at moderate risk for developing pressure ulcers due to the following risk factors: slightly limited sensory perception, was often moist, chairfast, slightly limited mobility and a problem with friction and shearing. The Braden scale revealed R8 had additional risk factors which included cardiovascular disease, chronic incontinence and cognitive impairment. The Braden scale further indicated R8 required extensive assistance with bed mobility, required the use of a mechanical lift and was always incontinent of bowel. The medical record lacked any additional Braden scale assessments completed after 2/16/19. Review of R8's Skin Integrity Event for 4/8/19, revealed the following: -R8 developed a skin tear to her right buttocks that was noted to be shallow and measured 0.5 centimeters (cm.). The wound had a small amount of bleeding and had smooth wound edges. It was unknown how the wound developed. The wound was cleansed with soap	2 900		

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2 900	Continued From page 14 and water and a Mepilex dressing was applied to it after R8's bath. The event indicated the physician and family had been notified. Review of the interdisciplinary progress notes from the electronic health record (EHR) from 4/8-5/16/19, revealed the following: - 4/8/19, R8 was noted to have an open area to her buttocks that measured 0.5 [cm]. Nurse planned to apply Mepilex (a foam absorbent dressing used to treat acute and chronic ulcers and wounds) after R8 had received morning bath. - 4/9/19, Interdisciplinary Team (IDT) reviewed R8's wound to the buttocks and identified the wound as shearing. The note further indicated treatment would be administered as ordered and Ammens powder (a powder utilized for minor skin irritations) would be applied to keep the area dry and to prevent breakdown. The note identified a ROHO cushion (a cushion used for pressure relief) would be utilized in R8's wheelchair and staff would monitor the wound daily and document at least weekly until healed. - 4/13/19, 0.5 cm raw area noted to R8's right buttock as well as another 0.5 cm. located 1 cm laterally to the initial area. R8 had a large loose foul-smelling bowel movement (BM) and bowel medications were not administered as a result. Nursing staff applied a new Mepilex dressing to the right buttock area. -4/14/19, R8 had a large loose foul-smelling BM and dressing had been changed again as a result. The note indicated the inferior (older) area measured 1 x 1 cm and the superior (new) area measured 0.8 x 0.8 cm.	2 900		

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2 900	Continued From page 15 -4/20/19, R8's dressing had been soiled again and nursing staff cleansed the area and applied a new dressing. Nursing staff noted the area appeared to be increasing in size and would ask the director of nursing (DON) to assess the area. - 4/23/19, R8's dressing had been changed on 4/22/19, and 4/23/19, due to large loose BM's. The lower open area had been noted to be very superficial and nearly healed. The upper open area had been noted to be approximately 2 cm in diameter with four spots covering and about 1/3 of the wound barely through the skin and superficial. -4/27/19, dressing changed to R8's right buttock after R8 had a large BM. The area was noted to be 2 x 2 cm and the area was 100% blanchable (area returns to normal skin color when pressure is applied and removed). -5/1/19, R8's dressing to her right buttock was noted to be all curled up. Nursing staff removed the old dressing and applied a new Mepilex dressing. R8's area had no drainage, had clean edges and was noted to be dark red in color. - 5/3/19, R8's dressing was noted to be coming off and a new Mepilex dressing was applied. No drainage or any signs of change had been noted to the wound. - 5/5/19, R8 was noted to continue to have a 2 cm x 2 cm open area that was dressed with a Mepilex dressing. The wound had no drainage and the dark red area had clean edges. R8 was noted to have had recurrent incontinent BM's. - 5/6/19, OT (occupational therapy) staff evaluated R8 for positioning needs and instructed	2 900		

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2 900	Continued From page 16 staff to position R8 on the left side. The note further indicated the ROHO cushion (pressure relieving cushion) was not holding air and OT staff were checking with vendors for other cushion options. - 5/7/19, Mepilex dressing completed to R8's right buttock due to soiled. Area noted to be slightly more shallow and lighter pink in color. - 5/8/19, OT staff provided education to nursing staff on proper use of the hygiene sling. The progress note further indicated the DM (dietary manager) was aware of the skin concern and nutrition had been addressed. - 5/9/19, dressing change completed to R8's right buttock due to soiled. Area noted to have had slow healing. - 5/10/19, dressing change completed to R8's right buttock and noted to have a round area that measured 1.5 cm in the center and superficial skin noted to be missing in 1 cm border of the wound. The center area had been noted to be pink in color. - 5/11/19, R8's old dressing had been removed and was noted to be soiled and difficult to remove. The area was noted to be 3.0 cm. x 3.0 cm, had an odor and was noted to be moist. -5/12/19, the dressing to R8's right buttock shearing area was removed and a new Mepilex dressing had been applied. -5/15/19, Mepilex dressing changed to R8's right buttock. Nursing staff indicated a small to moderate amount of tan colored drainage was noted on the old dressing and no odor had been	2 900		

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2 900	Continued From page 17 detected. The open area measured 2 cm in width by 2.5 cm in length. The nursing staff further indicated darker pink tissue surrounded the wound and the entire wound measured, which included the open wound and the surrounding dark pink tissue 3 cm. The color of the majority of the wound bed was light yellow in color and the proximal area of the open wound had a 0.25 cm dark red-brown area. The progress notes lacked documentation of staging of the pressure 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 stated R8 required extensive to total assist with all ADL's except for eating which she required limited assistance with. NA-B stated R8 had a shearing to her right buttocks from her old lift sling and OTA-C assisted with determining best positioning practices as well as suggesting the use of the hygiene sling in an attempt to prevent further shearing. NA-B stated licensed nurses were notified by NA's when skin issues develop and skin was checked every day by NAs during morning cares. On 5/15/19, at 11:21 a.m. OTA-C stated occupational therapy staff received an order to evaluate and make recommendations for pressure relieving devices for R8 to use as well as suggesting positioning strategies. OTA-C confirmed R8 had been changed to a hygiene sling to prevent further shearing from occurring. OTA-C stated OT staff provided education to nursing staff on proper use of slings as well as proper positioning for R8. On 5/15/19, at 11:46 a.m. NA-C stated R8 required extensive assist with ADL's and minimal	2 900		

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2 900	Continued From page 18 assistance with eating tasks. NA-C indicated R8 had been changed from the old lift sling to a hygiene sling due to the old one causing irritation to her skin. NA-C further stated the sore on her right buttocks developed from the use of the old sling. Review of R8's current physician orders as of 5/15/19, which included the following: - 4/8/19, general nursing order to change dressing weekly on bath day and as needed and document the condition of dressing under results. - 5/15/19, Vicair cushion for wheelchair. Review of R8's treatment administration record (TAR) for May 2019, revealed the following: - an order on 4/8/19, Ammens Powder- apply light dusting of Ammens Powder to bottom to aide in keeping area dry and prevent breakdown. - an order on 5/14/19, to change the dressing weekly on R8's bath day and as needed. Additionally, the nursing staff were to document the condition of the dressing under result in the EHR, monitor daily and chart under event at least weekly on Sundays and as needed. Review of R8's physician progress notes from 3/19- 5/15/19, revealed the following: - 3/19/19, the physician progress note indicated R8 had no complaints except for feeling tired and no changes with the plan was indicated. The progress note lacked any documentation of any skin issues. - 4/24/19, the progress note indicated R8 had no	2 900		

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2 900	Continued From page 19	2 900		

complaints except for feeling tired. The progress note identified an increase of lisinopril to 5 milligrams (mg) (prescribed for high blood pressure) and to check labs with the next lab draw. The progress note lacked any documentation of any pressure ulcers or wounds.

- 5/14/19, the progress note lacked documentation of weight loss or a plan to address weight loss. However, there was an addendum note indicating nursing staff had informed the primary physician (MD)-E of R8's gluteal ulcer being treated and the progress toward healing. According to the note, the physician indicated the ulcer had developed due to shear or maceration due to friction, seat position and exposure to urine.

-5/15/19, an addendum to the 5/14/19, progress note indicated MD-E had assessed the ulcer and determined the ulcer was the size of a quarter and had shallow pale superficial slough. However, the note did not include any physician assessment of the resident's nutritional status, weight loss, or any plans to address the weight loss. The note indicated the nursing staff believed the ulcer developed from shear or maceration due to friction, seat position and exposure to urine.

Further review of R8's progress notes of the EHR revealed the resident had experienced a significant weight loss:

11/13/18, 200.5 pounds (lbs.)
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.

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2 900	Continued From page 20 5/13/19, 180.4 lbs. 5/15/19, RD-D documented she had been notified R8 had an open wound to her right buttocks that measured 2 cm by 2.5 cm with a total width of 3 cm. RD-D also identified R8's weight of 180.4 pounds which equaled an additional 2% weight loss in 30 days, 5% weight loss in 90 days and 9% weight loss in 180 days. The RD-D note indicated R8's meal intakes continued to be variable, and indicated breakfast was where R8 had the best intake 76-100% , while lunch and supper meals ranged from 25% to 75%. RD-D recommended a trial of 4 ounces of ensure at lunch and supper meals to provide additional protein, calories and fluids. Additionally, staff were to offer protein-rich food/fluids and offer favorite foods to improve intakes. The note identified goals of stabilizing weight, improve skin integrity, supplement acceptance, improve meal intakes to be equal to or greater than 75% and the RD-D planned to follow-up at the next site visit. Review of R8's medication administration record (MAR) for May 2019, indicated there had been no nutritional supplements ordered/initiated for R8. Review of R8's treatment administration record (TAR) for May 2019, also failed to indicate any nutritional supplement order or implementation. On 5/15/19, at 1:46 p.m. registered nurse manager (RN)-A confirmed R8 had not been receiving any supplements. On 5/15/19, at 2:35 p.m. DD-B stated weights were reviewed on a weekly basis and if a resident had not been eating well or experienced an unwanted weight loss, offering high caloric foods	2 900		

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2 900	Continued From page 21 would be one of the first interventions to implement. DD-B also stated high protein supplements would be implemented for residents who had pressure ulcers or wounds to promote healing. DD-B confirmed RD-D had not seen R8 during her last site visit on 4/24/19 and further confirmed he was not aware R8 had a pressure ulcer. DD-B further confirmed R8 had not been receiving nutritional supplements. On 5/16/19, at 10:07 a.m. during a phone interview with RD-D, RD-D stated she worked closely with DD-B to monitor nutritional concerns and further stated she made onsite visits on a monthly basis. RD-D explained for any needs that developed inbetween her visits, DD-B would email or call her on the telephone. RD-D stated she would expect to be notified within 48 hours if any resident developed a pressure ulcer or had a significant weight loss. RD-D confirmed she had first been notified by DD-B of R8's pressure ulcer and significant weight loss on 5/15/19, and would have expected to have been notified earlier for both. RD-D stated she'd reviewed R8's EHR at 5:56 p.m. on 5/15/19, to determine intakes and weight loss had occurred. RD-D confirmed R8 had experienced a significant weight loss in the past six months. Further, RD-D made recommendations for a supplement at the lunch and supper meals, and encouraging high caloric foods to promote wound healing and to prevent further weight loss. RD-D stated she planned on evaluating R8 in person during her next onsite visit which she planned to do within the next couple of weeks. On 5/15/19, at 1:46 p.m. nurse manager (NM)-A stated the process for skin care involved the nurses assessing the pressure ulcers and wounds and determining if the pressure ulcer was	2 900		

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blanchable or not. NM-A further stated if the pressure ulcer had been determined to be caused by friction or shearing the staff identified it as an abrasion. NM-A indicated R8's pressure ulcer had been caused by shearing from her incontinence brief. NM-A stated she was not aware R8's pressure ulcer had yellow slough present and would have had to assess it herself to determine that. NM-A stated the expectation was for nursing staff to utilize the E-Z Graph Wound Assessment Worksheet at least weekly and document in the events and progress notes of the EHR. NM-A stated it was expected nursing staff would comment on whether the pressure ulcer was improving or not at least weekly.

Review of R8's E-Z Graph Wound Assessment Worksheet dated 5/11/19, indicated R8 had a wound to the "Butt - R [right] side." The worksheet indicated a length of 3.0 cm, width of 3.0 cm and a depth of 0.5 cm. The worksheet indicated the presence of an odor and eschar/slough present. The worksheet had a hand drawn diagram of an irregular shaped circle with an inner circle with a line from it indicating "yellow". To the right of the hand drawn diagram was the handwritten words "Soft" and "Moist". The worksheet provided space to document wound base, drainage amount, drainage type, periwound appearance, age of wound, pain present, and wound status however, these areas were left blank. No further E-Z Graph Wound Assessment Worksheet were provided for R8.

On 5/16/19, at 12:55 p.m. primary physician (MD)-E indicated he expected, and the facility normally, would contact him immediately via fax when a wound or pressure ulcer developed on a resident. MD-E confirmed he assessed R8's pressure ulcer on 5/15/19, and R8 had a pressure

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2 900	Continued From page 23 ulcer to her right lower buttocks that was unstageable due to the wound bed covered in slough. MD-E stated he planned to continue current treatment and interventions and expected the pressure ulcer would heal. On 5/16/19, at 2:02 p.m. the director of nursing (DON) 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. The DON also stated the expectation for identifying, monitoring and treating a pressure ulcer or wound involved the nursing staff completing an event form, updating the care plan, and documenting the appearance of the pressure ulcer or wound at least weekly. The DON stated it was expected the pressure ulcer documentation would include the location of the wound, the measurements of the wound, if there was drainage or odor present, any signs or symptoms of infection, if there was pain present and a thorough description of the wound. The DON explained R8's pressure ulcer started as a shearing abrasion from the incontinent brief or sling utilized with the mechanical lift and verified the pressure ulcer had worsened to an unstageable pressure ulcer which had yellow slough present. The DON stated licensed nursing staff recently watched a webinar in March 2019, regarding pressure ulcer prevention and repositioning requirements. R27's quarterly MDS dated 4/17/19, indicated moderate cognitive impairment and diagnoses of heart failure, hypertension, peripheral vascular disease, Diabetes Mellitus, and dementia. The MDS indicated R27 required extensive assistance from 2 staff with activities of daily living (ADL)s including bed mobility, transferring, toileting, dressing and personal hygiene.	2 900		

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2 900	Continued From page 24 R27's annual care area assessment (CAA) dated 1/25/19, revealed R27 was cognitively impaired, and indicated at risk for pressure ulcers but had no skin issues. In addition, the CAA identified R27 required staff assistance with ADLs including dressing the lower body. The CAA indicated R27 was at risk for skin breakdown related to advanced aging, peripheral vascular disease and thin fragile skin. R27's current care plan described various interventions and instructions for self care deficits, and required assistance with all ADLs. In addition, the care plan addressed R27's risk for skin breakdown on her feet related to structural problems, needing assist with ADL's, diagnoses of Diabetes Mellitus with peripheral vascular disease (PVD), advanced age, and history of easily bruising related to thin fragile skin. During an interview on 5/13/19, at 1:47 p.m. R27 stated she had a sore toe and indicated staff were aware and had been applying salve to the area, but indicated it was not helping. A review of R27's active medication administration record (MAR) orders on 5/15/19, instructed staff were to apply topical animal scents to callous on right foot at bedtime, and instructed staff to put on TED stockings and leg protectors in the morning and remove at bedtime. Review of R27's progress notes reviewed from 3/5-5/14/19, lacked any documentation of skin issues or interventions utilized. In addition, a nursing progress note dated 3/16/19, at 7:00 p.m. indicated R27 had a reddened area on second toe on the right foot and indicated she also had rubbing from her shoes on her left foot, that she wore toe sleeves and indicated staff would make	2 900		

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2 900	Continued From page 25 sure she was wearing the toe sleeves. R27's electronic medication administration record (EMAR) and electronic treatment administration record (ETAR) were reviewed and lacked monitoring or documentation of the redness identified on R27's toe, use of the toe sleeve, or monitoring of R27's toes or feet. Review of a podiatry consult on 3/5/19, did not address any reports of redness or irritation of her feet/toes or use of the toe sleeve to reduce friction or rubbing during the visit and indicated no skin concerns were noted at the time of the visit. On 5/14/19, 2:41 p.m. R27 was seated in her room with her feet elevated in a recliner chair. R27 was wearing black diabetic shoes and had tan compression socks on bilateral lower extremities with tan Geri sleeves (protective sleeves) on both lower legs under her pants. On 5/15/19, at 7:16 a.m. Nursing Assistant (NA)-C stated she looked at all residents' skin head to toe with morning and bedtime cares. NA-C stated if she observed any changes or issues with a resident's skin she would notify the nurse right away. NA-C stated R27 had redness on the left second toe and indicated it was not new for R27 and staff were putting a foam toe sleeve on R27's toe to separate the toes and prevent rubbing in her shoes. On 5/16/19, at 8:39 a.m. NA-D stated she checked the resident's skin every day with morning and evening cares, and indicated the bath aide completed a head to toe skin assessment on each resident's bath day and would report any concerns to the nurse. NA-D stated NAs do not document the skin issues, but	2 900		

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2 900	Continued From page 26	2 900		

report them to the nurse so a skin assessment/documentation could be completed. NA-D stated if there were any skin issues or interventions they would be care planned and on the eTAR so nursing staff could monitor and document on the area. NA-D stated she had cared for R27 and observed redness on her toes which she had made nursing staff aware of. NA-D said nursing was monitoring the areas and were applying padding to the reddened toes with morning cares.

On 5/16/19, at 8:52 a.m. NA-E stated she would look at the resident's skin when she is providing cares in the morning and evenings, checking them over head to toe. NA-E stated if there are any issues such as bruising, redness, or anything different she would report it to the nurse. NA-E stated the process for reporting a skin issue was to complete a Stop N Watch (alert). NA-E stated if a resident had Diabetes or other skin issues she would pay close attention to their feet. NA-E stated the nurse would then assess the skin issue and complete the documenting and tracking until resolved. NA-E stated she had worked with R27 and stated staff look at her skin and feet with cares. NA-E also explained staff help R27 apply stockings and remove them every day and indicated they look at feet and legs at that time. NA-E stated she had observed redness on R27's left second toe and had reported the concern to the nurse several months ago. NA-E stated they apply toe cushion wraps as an intervention, and stated R27's toes did not look any different than they had for the last couple of months.

On 5/16/19, at 10:30 a.m. registered nurse (RN)-A stated the process for routine skin monitoring was to complete the licensed nurse data collection (LNDC) weekly assessment for all

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2 900	Continued From page 27 the residents which included questions regarding skin condition. RN-A stated the bath aide and NAs looked at the residents' skin during daily cares and notify nursing if there are any changes in skin integrity. RN-A stated she looked at the resident's skin head to toe each week for the LNDC and indicated she thought that was the facility policy. RN-A stated R27 was at risk for skin breakdown due to history of hammer toes, and stated they get red and sore. RN-A verified there was no monitoring for this issue currently in place. In addition, RN-A stated she was not aware of any current skin issues with R27, and reviewed the most current temporary care plan in the resident's chart and verified monitoring of the redness on her toes was not in temporary care plan. RN-A stated the care plan instructed staff to monitor any changes in skin and report to nursing, but indicated the care plan lacked anything specific about monitoring R27's feet or toes, or effectiveness of the use of R27's toe sleeves. RN-A verified she had not been notified of redness on R27's toes, and would expect NA staff to notify her of any skin concerns. On 5/16/19, at 1:13 p.m. Infection Control Registered Nurse (ICRN)- F stated she would look at R27's toes again, and stated R27's red toes were reported to the resident's medical provider today and he came over from the clinic to look at them. ICRN-F stated the medical provider discontinued use of the toe sleeves, and Ted stockings, stating they were actually putting pressure on her toes related to deformities in her feet, causing her toes to rub together. The multiple reddened areas measured were as follows: - Right great toe first knuckle 0.4 cm x 0.5 cm wide reddened area 100% blanchable, R27	2 900		

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2 900	Continued From page 28 verbalized her toes hurt. - Right foot second toe red 100% blanchable area measuring 0.5 cm X 0.3 cm. - Right foot second toe top of knuckle calloused area with 100% blanchable reddened area measured 0.5 cm X 0.4 cm. - Right top of foot scabbed area measured 0.5 cm dry with no drainage. - Left foot second toe first knuckle 100% red blanchable area which measured 0.5 cm X 0.5 cm. - Left foot second knuckle 0.7 cm X 0.6 cm resident expressed discomfort with palpation, center of the reddened area which measured 0.3 cm X 0.2 cm red area not blanchable. - Left foot third toe 100% red blanchable area which measured 0.4 cm x 0.5 cm. - Left foot redness on the side of the third toe which measured 1.5 cm long. On 5/16/19, at 1:31 p.m. ICRN-F verified "today was the first time" she had been notified of the reddened areas on R27's toes. ICRN-F stated she would expect staff to report issues with skin integrity to nursing staff for monitoring. In addition, ICRN-F stated the toe socks, Ted stockings, and skin checks should be completed by licensed staff weekly and any issues added to the care plan and eTAR for monitoring until resolved. ICRN-F verified that R27 was at high risk for skin issues on her feet related to her advanced age, history of Diabetes Mellitus, and edema. She indicated she should have her feet	2 900		

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2 900	Continued From page 29 monitored and documented on daily. On 5/16/19, at 3:00 p.m. the DON stated she had not been aware of R27's sore reddened areas on her toes, and stated she would expect staff who observe alterations in skin condition to notify the charge nurse and implement the process to begin monitoring and documentation until resolved. The DON stated licensed nursing staff should have assessed and documented on R27's redness and foot tenderness with daily monitoring, but verified this had not been done. The DON stated the nursing staff should be completing a thorough head to toe skin assessment when completing the weekly LNDC, and verified this had not been done for R27. Review of facility's policy Pressure Ulcer and Non-Surgical Wound Documentation and Management revised 1/19, instructed staff to provide the following documentation of pressure ulcers and wounds at least weekly: wound type, location, stage, depth, measurement, description of drainage, tissue description, signs of infection, condition of skin surrounding the ulcer, if pain present, and appropriate care and treatment. The policy further instructed the dietician to review nutritional status of the resident and to make recommendations to promote healing. The policy identified the physician would be notified when the stage increases. The policy indicated licensed staff would verify weekly that documentation was accurate and appropriate. Review of facility's policy Skin Inspection revised 3/19, indicated licensed staff would complete a weekly head to toe skin inspection which included undressing the portion of the body with a pressure ulcer or wound present. The policy identified licensed nurses would manage any	2 900		

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2 900	Continued From page 30 changes or alterations in skin noted. Further, the policy indicated licensed staff would create a skin event to ensure monitoring, documentation and measuring of the skin alteration was completed weekly and as needed. The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2018, identified Section M: Skin Conditions to be completed to identify the risk, presence, appearance and change of pressure ulcers/injures. The manual defines a pressure ulcer/injury as a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure in combination of shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful. The manual further identified it was imperative to determine the etiology of all wounds and lesions as that would determine and direct the proper treatment and management of the wound. - The manual defines a stage one pressure ulcer/injury as "an observable, pressure-related alteration of intact skin whose indicators, as compared to an adjacent or opposite area of the body, may include changes in one or more of the following parameters: skin temperature (warmth or coolness), tissue consistency (firm or boggy), sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the injury may appear with persistent red, blue or purple hues." - The manual defines a stage two pressure ulcer/injury as "partial thickness loss of dermis presenting as a shallow open crater with a red-pink wound bed, without slough or bruising."	2 900		

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2 900	Continued From page 31 - 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." - The manual defines a stage four pressure ulcer/injury as "Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed." - The manual stated " pressure ulcers covered with slough and/or eschar, and the wound bed cannot be visualized, should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined." SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure identified quality of care concerns with pressure ulcer treatment and prevention and are reviewed by the quality assessment and assurance committee and action plans developed to address the concerns. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 900		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status	2 965		6/25/19

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2 965	Continued From page 32 Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete accurate and ongoing nutritional assessment for 1 of 2 residents (R8) reviewed for nutrition. R8 sustained harm when the facility failed to accurately and timely assess nutritional status, address risk factors for impaired nutritional status, and implement approaches to maintain acceptable nutritional parameters for R8 who experienced a clinically severe weight loss of over 10% in six months. Findings include: R8's quarterly Minimum Data Set (MDS) dated 2/19/19, indicated R8 had diagnoses which 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	2 965	The Registered Dietician (RD) was notified by the Certified Dietary Manager (CDM) of the identified resident R8 additional weight loss and change in skin condition on 5/15/19, since previously, notifying the RD of a significant weight loss on 3/20/19 and documentation noted "may benefit from a gradual weight loss to reduce stress on organs and joints." On 5/15/19 RD made recommendation for nutritional interventions "trial of 4oz. Ensure at Dinner/ Supper meal to provide additional protein, calories, and fluids. Encourage protein rich foods and fluids when able. Offer favorite foods to improve intake." On 5/24/19 CDM added additional nutritional supplement of Plus 2 Protein Shakes TID between meals. RD and care plan updated to reflect changes. The nutritional/ hydration status of current residents was reviewed by IDPT and those at risk have been referred to RD for monthly onsite assessment, nutritional	

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2 965	Continued From page 33 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. R8's annual Care Area Assessment (CAA) dated 9/5/18, indicated R8 required assistance with ADL's due to progressing Alzheimer's Dementia. The CAA revealed R8 was at risk for developing pressure ulcers due to immobility and the need to be repositioned by staff. The CAA identified R8 had no current skin issues at the time of the assessment. The CAA indicated R8 was at risk for weight and fluid changes due to intake and abnormal labs. The CAA further identified R8 was at nutritional risk due to heart disease with heart failure, acute kidney failure, dementia and atrial fibrillation (quivering or irregular heartbeat). R8's care plan revised 5/14/19, revealed R8 required extensive to total assistance with ADL's which included bed mobility, transfers, locomotion, dressing, toileting, personal hygiene and bathing. The care plan indicated R8 required supervision with set-up for eating tasks and staff were to monitor the resident's need for increased assistance. The care plan identified R8 had an open area to her right buttock as a result of shearing. The care plan instructed staff to encourage R8 to consume a well balanced diet as well as consume all fluids offered at meal times. The care plan identified R8 was on a regular diet with nectar thin liquids and R8 was to be seated at the supervision table due to occasionally required increased assistance with eating tasks from staff. The care plan further instructed staff to monitor and record intake and to report any significant changes to the physician	2 965	interventions put in place care plans reviewed and updated, as appropriate. Results of this audit shall be reported to the QAPI committee. The "Nutritional Care and Documentation" policy has been reviewed and revised. Staff will receive education regarding the updated policy and F692 by one of the following means: 1:1 meetings, standups, or scheduled meetings on 6/18/19 and 6/20/19. The IDPT will review all residents with current impaired nutritional status weekly x4, then monthly thereafter. CDM will notify RD per "Nutritional Care and Documentation" policy & procedure. Results of the audit will be reported to the QAPI Committee for further recommendations.	

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2 965	Continued From page 34 and family. On 5/14/19, at 12:20 p.m. R8 was observed to be seated in her wheelchair at the dining room table being assisted by nursing assistant (NA)-B to eat her lunch. R8 consumed one half of her sherbet and one fourth of her hotdish. R8 drank all of her apple juice. On 5/15/19, at 8:42 a.m. NA-A wheeled R8 to the dining room and placed her at the dining room table. R8 was provided her breakfast tray consisting of a banana, toast, scrambled eggs and yogurt as well as two glasses of juice. R8 was noted to be leaning to her left in her wheelchair. R8 was provided a fork by NA-A and attempted to feed herself bites of her banana with difficulty. At 8:46 a.m. NA-A sat down next to R8 and attempted to position R8 in a more upright position in her wheelchair. R8 proceeded to feed herself her breakfast slowly with cueing and occasional assistance from NA-A with placing food on her fork and guiding it to R8's mouth. At 9:20 a.m. R8 continued to drink her juices and was no longer eating anymore of her food. R8 consumed all of her banana, half a slice of toast and a couple bites of the yogurt and eggs. On 5/15/19, at 11:14 a.m. R8 was seated in her wheelchair at the dining room table waiting for lunch to be served. At 12:15 p.m. R8 was brought back to her room due to complaints of nausea. R8 had not eaten her lunch as a result of the nausea. Review of R8's weight record from the electronic health record (EHR) were reviewed from 11/13/18, to 5/13/19 and included: 11/13/18, 200.5 pounds (lbs.)	2 965		

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2 965	Continued From page 35 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. Review of R8's 2/19/19, nutritional screening revealed R8's weight was noted to be 190.2 lbs., this compared to 192.9 lbs. 30 days prior and 201.5 lbs. 180 days prior. The screening indicated R8's usual body weight was 190- 200 lbs. The screening further indicated R8 had swallowing problems and utilized adaptive equipment. The screening identified R8's usual intake was 51%- 75% and she typically consumed under 1000 milliliters (ml.) of fluids. The screening further identified R8's skin as intact, and indicated the team should continue the current plan of care. Review of progress notes from 3/20-5/15/19, revealed the following: 3/20/19, registered dietician (RD)-D noted R8's weight was 188.3 lbs. and R8 had experienced a significant weight loss of 21 lbs. (10%) in 180 days. The note indicated R8 may benefit from a gradual weight loss to reduce stress on organs and joints. The note further indicated R8's meal intakes varied from 25% to 100%. The note identified R8 required encouragement and indicated staff would continue to monitor weights, intakes and plan of care for significant changes. 4/10/19, dietary director (DD)-B noted R8's weight was 185 pounds which equaled a 3.6% weight loss in 30 days and a 10.1% weight loss in 180 days. The note identified R8's intakes varied from 25% to 100% per meal. The note indicated	2 965		

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2 965	Continued From page 36 the plan to continue to monitor and to refer to RD-D at the next site visit. 5/2/19, DD-B noted R8's weight was 181.6 pounds which equaled a 19 pound weight loss in 180 days. The note indicated R8's intake varied by meal. Further, the note indicated R8 required cueing to dine as needed, and indicated R8 may require more assistance with eating. The note indicated staff would continue to monitor and the RD-D would see R8 at next site visit. 5/15/19, RD-D stated she had been notified R8 had an open wound to her right buttocks that measured 2 cm by 2.5 cm with a total width of 3 cm. RD-D also identified R8's weight of 180.4 pounds which equaled an additional 2% weight loss in 30 days, 5% weight loss in 90 days and 9% weight loss in 180 days. RD-D indicated R8's meal intakes continued to be variable, and indicated breakfast was where R8 had the best intake 76-100% , while lunch and supper meals ranged from 25% to 75%. RD-D recommended a trial of 4 ounces of ensure at lunch and supper meals to provide additional protein, calories and fluids. Additionally, staff were to offer protein-rich food/fluids and offer favorite foods to improve intakes. The note identified goals of stabilizing weight, improve skin integrity, supplement acceptance, improve meal intakes to be equal to or greater than 75% and the RD-D planned to follow-up at the next site visit. Review of the physician's progress notes in the electronic health record (EHR) were reviewed from 2/22-5/15/19, revealing the following: 2/22/19, the progress note lacked documentation regarding R8's weight loss or a plan to address weight loss.	2 965		

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2 965	Continued From page 37 3/15/19, the progress note lacked documentation regarding R8's weight loss or a plan to address weight loss. 4/24/19, the progress note lacked documentation regarding R8's weight loss or a plan to address weight loss. 5/14/19, the progress note lacked documentation of weight loss or a plan to address weight loss. However, there was an addendum note indicating nursing staff had informed the primary physician (MD)-E of R8's gluteal ulcer being treated and the progress toward healing. According to the note, the physician indicated the ulcer had developed due to shear or maceration due to friction, seat position and exposure to urine. 5/15/19, an addendum to the 5/14/19, progress note indicated MD-E had assessed the ulcer and determined the ulcer was the size of a quarter and had shallow pale superficial slough. However, the note did not include any physician assessment of the resident's nutritional status, weight loss, or any plans to address the weight loss. Review of R8's signed physician orders dated 5/16/19, indicated R8 was on a regular diet with nectar thickened fluids and required weekly weights. Additionally, there were general orders dated 6/28/17, regarding nutritional supplement per RD-D or DD-B recommendation, noted. Review of R8's medication administration record (MAR) for May 2019, indicated there had been no nutritional supplements ordered/initiated for R8. Review of R8's treatment administration record (TAR) for May 2019, also failed to indicate any nutritional supplement order or implementation. On 5/15/19, at 8:36 a.m. NA-A stated R8 could	2 965		

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	00762	A. BUILDING: _____ B. WING _____	05/16/2019

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2 965	Continued From page 38 feed herself with cueing but did occasionally require assistance from staff with eating. NA-A further indicated R8 had a fair appetite but had experienced weight loss. NA-A wasn't sure how much weight R8 had lost. On 5/15/19, at 11:46 a.m. NA-C stated R8 required assistance with eating at times, and often refused meals at noontime. NA-C stated R8 had experienced a weight loss but did not receive nutritional supplements. NA-C wasn't sure how much weight R8 had lost. On 5/15/19, at 1:46 p.m. registered nurse manager (RN)-A stated DD-B monitored the weights for all residents, and would start new nutritional interventions if a resident required it due to weight loss. RN-A stated she wasn't sure if R8 had experienced a weight loss or not, and reviewed the weights in R8's EHR to determine if a weight loss had occurred. Upon review of R8's records, RN-A confirmed R8 had experienced a significant weight loss. RN-A again stated DD-B, and RD-D, managed weight loss concerns for all residents. RN-A also confirmed R8 had not been receiving any supplements for the weight loss. On 5/15/19, at 2:35 p.m. DD-B stated weights were reviewed on a weekly basis and if a resident had not been eating well or experienced an unwanted weight loss, offering high caloric foods would be one of the first interventions to implement. DD-B also stated nutritional supplements would be offered to promote stabilization of weight or weight gain. Further, a referral to RD-D would be initiated, and she would see the resident in person during her monthly visits. DD-B stated when a resident triggered a significant weight loss of 5% or more in 30 days, or 10% or more in 180 days, RD-D would be	2 965		

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2 965	Continued From page 39	2 965		

notified via phone or email instead of waiting for the monthly visit. DD-B also stated high protein supplements would be implemented for residents who had pressure ulcers or wounds to promote healing. DD-B confirmed RD-D had not seen R8 during her last site visit on 4/24/19 and further confirmed he was not aware R8 had a pressure ulcer. DD-B further confirmed R8 had not been receiving nutritional supplements.

On 5/16/19, at 10:07 a.m. during a phone interview with RD-D, RD-D stated she worked closely with DD-B to monitor nutritional concerns and further stated she made onsite visits on a monthly basis. RD-D explained for any needs that developed inbetween her visits, DD-B would email or call her on the telephone. RD-D stated she would expect to be notified within 48 hours if any resident developed a pressure ulcer or had a significant weight loss. RD-D confirmed she had first been notified by DD-B of R8's pressure ulcer and significant weight loss on 5/15/19, and would have expected to have been notified earlier for both. RD-D stated she'd reviewed R8's EHR at 5:56 p.m. on 5/15/19, to determine intakes and weight loss had occurred. RD-D confirmed R8 had experienced a significant weight loss in the past six months. Further, RD-D made recommendations for a supplement at the lunch and supper meals, and encouraging high caloric foods to promote wound healing and to prevent further weight loss. RD-D stated she planned on evaluating R8 in person during her next onsite visit which she planned to do within the next couple of weeks.

On 5/16/19, at 2:02 p.m. the director of nursing (DON) stated DD-B and RD-D monitor all residents for weight loss and provided recommendations for interventions to promote

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2 965	Continued From page 40 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 assessments would cover dietary needs of residents and any recommended changes as a resident's condition changed. The policy identified DD-B would monitor weights, intakes, labs and recommended 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 (RAI) 3.0 User's Manual dated 10/2018, identified Section K: Swallowing/Nutritional Status to be completed with an intent to assess the many conditions that cold affect the resident's ability to maintain adequate nutrition and hydration. Under K0300: Weight Loss Planning for Care: - "Weight loss may be an important indicator of a	2 965		

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2 965	Continued From page 41 change in the resident's health status or environment. - If significant weight loss is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medication (e.g. diuretics), or changed fluid volume status. - Weight loss should be monitored on a continuing basis; weight loss should be assessed and care planned at the time of detection and not delayed until the next MDS assessment." SUGGESTED METHOD FOR CORRECTION: The Director of Nursing (DON) or designee could develop and implement policies and procedures to ensure residents at nutritonal risk received appropriate interventions to maintain nutrition as determined necessary by their individualized assessment. The DON or her designee could educate all appropriate staff on the policies and procedures. The DON could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 965		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar	21942		6/25/19

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21942	Continued From page 42 year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to establish a family council after four resident representatives had shown interest, as required. This had the potential to affect all 33 residents in the facility. Findings include: On 5/13/19, at 12:58 p.m. during the survey entrance conference the director of nursing (DON) confirmed the facility did not currently have a family council. On 5/13/19, at 5:29 p.m. social service designee (SSD)-A indicated the facility made attempts annually to establish a family council. SSD-A indicated she had last sent out questionnaire forms regarding a family council to the resident's representatives in January 2019. SSD-A indicated the form had three questions; would you want a family council established, are you willing to be an organizer and be active in maintaining the council if it was established, and lastly would you serve on it if asked. SSD-A indicated the form also included a contact name and phone number. SSD-A indicated 29 forms were sent out and 18 were returned. SSD-A indicated four had answered yes that they would want a family council established. SSD-A indicated none had indicated they would want to organize it and only three had indicated they would want to serve on it. SSD-A indicted the facility did not establish a	21942	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 to develop a family council. If had been agreed to meet 6/12/19, but then three of the four were not able to attend this date and time. Meeting is now re-scheduled for 6/19/19. SSD or designee will continue to assist residents and families on establishing a family council. SSD or designee will continue to document at least yearly the attempts to establish a family council if these interested parties determine not to establish a family council. The facility will continue to promote family council during facility gatherings/ events like "family picnic" periodically in Family newsletter and all new admits. Policy "Family Council" was developed. 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	

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21942	Continued From page 43 family council, even though four had shown interest because none of the respondents agreed to organize it. SSD-A indicated the facility would assist them if they could, but felt it was up to the family members to facilitate it. SSD-A indicated no formal response to those who had shown interest in having a family council established had been completed. On 5/15/19, at 9:06 a.m. SSD-A indicated the facility had sent out 30 mailings, which included the questionnaire regarding family council. SSD-A indicated 22 had been returned. SSD-A indicated the reason the facility had not established a family council after four resident representatives had shown interest was because they had not responded that they would organize or maintain it. SSD-A confirmed she had not responded to the four who had shown interest in a family council and indicated she would include the results of the family council questionnaire in the facility June newsletter. On 5/15/19, at 9:10 a.m. DON confirmed she was aware there was some interest in the facility establishing a family council, but understood none of those who responded wanted to organize or maintain it. DON confirmed the facility had not established a family council. The facility forms titled Annual Reminder of Important Information-Acknowledgement of Receipt, included the section identified in bold script; Family Council-Please answer yes or no below to each question. Review of the twenty forms provided by the facility that were returned by resident representatives identified four had answered yes to the question "Would you want a Family Council established at Grace Home?". The forms were signed 1/24/19, 1/29/19, 1/30/19,	21942	committee.	

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21942	Continued From page 44 and 1/30/19. The facility letter included in the admission packet reviewed the Family Council definition and annual survey results conducted for a family council. The letter included direction to consider if whether or not they would like to see a family council established at the facility and whether or not they were willing to commit themselves to participate in organizing and maintaining such a council by attending meetings, serving as an officer and developing and organizing programs for scheduled meetings. The letter further indicated family council was an independent self-led and self-determining group of families and friends of residents. The form indicated it was important to complete and return the questionnaire and that their response was important to demonstrate to the State of Minnesota and other individuals that facility was making families and friends of residents aware of their right to organize a Family Council if they wished to do so. The bottom of the letter had a questionnaire which included three questions; Do you want to have a family council established at Grace home?, Are you willing to be an organizer and active in maintaining a family council? , and If a family council were established at Grace Home would you serve on it if asked? A facility policy for Family Council was requested and not provided. On 5/16/19, at 9:00 a.m. SSD-A confirmed the facility did not have a policy for Family Council. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21942		