DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| | | | | | TE SURVEY AGENCY | | ID: 88VH Facility ID: 00762 |
|---|----------------------|--|------------------------|----------------------|---|--|---|
| 1. MEDICARE/MEDICAID PROVID (L1) 245579 2.STATE VENDOR OR MEDICAID (L2) 030525100 | | 3. NAME AND AD (L3) ESSENTIA I (L4) 116 WEST S (L5) GRACEVIL | HEALTH GR ECOND STR | ACE HOM | (L6) 56240 | 4. TYPE OF AC 1. Initial 3. Termination 5. Validation | 2. Recertification 4. CHOW 6. Complaint |
| 5. EFFECTIVE DATE CHANGE OF (L9)6. DATE OF SURVEY 07/1 | 4/2015 (L34) | 7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual | 05 HHA 06 PRTF | 09 ESRD 10 NF | 02 (L7) 13 PTIP 22 CLIA 14 CORF | 7. On-Site Visi 8. Full Survey FISCAL YEAR E | After Complaint |
| 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other | (L10) | 03 SNF/NF/Distinct 04 SNF | 07 X-Ray 08 OPT/SP | 11 ICF/III 12 RHC | 16 HOSPICE | 09/30 | Mario Ditte. (E.S) |
| 11LTC PERIOD OF CERTIFICATIO From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds | 45 (L18) 45 (L17) | Compliance1. As | | gram | And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A | 6. Scope o | of Services Limit al Director Room Size |
| 14. LTC CERTIFIED BED BREAKDO | OWN | 1 | | | 15. FACILITY MEETS | | |
| 18 SNF 18/19 SNF | 19 SNF | ICF | IID | | 1861 (e) (1) or 1861 (j) (1): | (L15) | |
| (L37) (L38) | (L39) | (L42) | (L43) | | | | |
| 16. STATE SURVEY AGENCY REM | MARKS (IF APPLICA | BLE SHOW LTC CA | NCELLATION | DATE): | | | |
| See Attached Remarks | | | | | | | |
| 17. SURVEYOR SIGNATURE | | Date : | | | 18. STATE SURVEY AGENCY | APPROVAL | Date: |
| Christina Martinson, | HFE NEII | 0 | 7/20/2015 | (L19) | Mark Meath | , Enforcement Sp | 08/19/2015 (L20 |
| PA | RT II - TO BE | COMPLETED I | BY HCFA RI | EGIONAI | L OFFICE OR SINGLE S | STATE AGENCY | Y |
| 19. DETERMINATION OF ELIGIBE X 1. Facility is Eligible to | | | IPLIANCE WITH | H CIVIL | 21. 1. Statement of Fina2. Ownership/Contr3. Both of the Above | ol Interest Disclosure | |
| 2. Facility is not Eligibl | e (L21) | | | | | | |
| 22. ORIGINAL DATE | 23. LTC AGREE | MENT 24 | LTC AGREE | MENT | 26. TERMINATION ACTION | : | (L30) |
| OF PARTICIPATION 07/08/1991 | BEGINNING | DATE | ENDING DA | TE | VOLUNTARY 00 01-Merger, Closure | 05-Fa | DLUNTARY il to Meet Health/Safety |
| (L24) | (L41) | | (L25) | | 02-Dissatisfaction W/ Reimburs | | il to Meet Agreement |
| 25. LTC EXTENSION DATE: | 27. ALTERNATI | | | | 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal | OTHI | ER ovider Status Change |
| (L27) | | n of Admissions: | (L44) | | or outer reason for management | 00-Ac | - |
| | | | (L45) | | | | |
| 28. TERMINATION DATE: | 29 | . INTERMEDIARY/ | CARRIER NO. | | 30. REMARKS | | |
| | | 03001 | | | | | |
| | (L28) | | | (L31) | | | |
| 31. RO RECEIPT OF CMS-1539 | 32 | . DETERMINATION | OF APPROVAI | L DATE | | | |
| | (L32) | 06/02/2015 | | (L33) | DETERMINATION APP | ROVAL | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART L. TO BE COMPLETED BY THE STATE SURVEY AGENCY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00762

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24 5579

On July 14, 2015, a Post Certification Revisit (PCR) was completed by the Departments of Health to verify the facility had achieved and maintained compliance with Federal certification regulations pursuant to the June 17, 2015, PCR. Based on our visit, we have determined the facility has achieved substantial compliance with deficiencies issued pursuant to the April 23, 2015 standard survey, effective July 13, 2015. As a result of the July 14, 2015 PCR, this Department has discontinued the Category 1 remedy of State Monitoring and recommended the following action related to the remedy imposed in our letter June 25, 2015:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions (DPNA), effective July 23, 2015, be rescinded (42 CFR 488.417 (b))

Since the facility did not go into DPNA, the two year loss of NATCEP that was to begin July 23, 2015, would also be rescinded.

Refer to the CMS 2567b for the results of this visit.

Effective July 13, 2015, the facility is certified for 45 skilled nursing facilty beds.



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245579

August 19, 2015

Mr. John Campion, Administrator Essentia Health Grace Home 116 West Second Street Graceville, Minnesota 56240

Dear Mr. Campion:

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 July 13, 2015 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 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 Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this letter / eNotice.

Sincerely,

Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered July 20, 2015

Mr. John Campion, Administrator Essentia Health Grace Home 116 West Second Street Graceville, Minnesota 56240

RE: Project Number S5579025

Dear Mr. Campion:

On June 25, 2015, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective June 30, 2015. (42 CFR 488.422)

On June 25, 2015, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective July 23, 2015. (42 CFR 488.417 (b))

Also, we notified you in our letter of June 25, 2015, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 23, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on April 23, 2015, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on June 17, 2015. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On July 14, 2015, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on June 17, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 13, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on June 17, 2015, as of July 13, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 13, 2015.

Essentia Health Grace Home July 20, 2015 Page 2

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of June 25, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 23, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective July 23, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective July 23, 2015, is to be rescinded.

In our letter of June 25, 2015, we advised you that, 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 July 23, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 13, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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 related to this eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

Electronicallyl delivered August 19, 2015

Mr. John Campion, Administrator Essentia Health Grace Home 116 West Second Street Graceville, Minnesota 56240

RE: Project Number S5579025

Dear Mr. Campion:

On July 14, 2015, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on July 14, 2015, imposed a daily fine in the amount of \$300.00.

On July 14, 2015, an acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on July 14, 2015 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is being delivered electronically.

Therefore, the total amount of the assessment is \$300.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling \$342.20, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of \$642.20, within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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 related to this eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Program Assurance Unit Penalty Assessment Deposit Staff

Minnesota Department of Health • Health Regulation Division • General Information: 651-201-5000 • Toll-free: 888-345-0823 http://www.health.state.mn.us

An equal opportunity employer

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

| (Y1) | Provider / Supplier / CLIA / Identification Number 245579 | (Y2) Multiple Construction A. Building B. Wing | | (Y3) Date of Revisit 7/14/2015 |
|------|---|--|--|--------------------------------|
| Name | of Facility | | Street Address, City, State, Zip Code | |
| ES | SENTIA HEALTH GRACE HOME | | 116 WEST SECOND STREET GRACEVILLE, MN 56240 | |

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

| Correction Completed Com | (Y4) Item | | (Y5) | Date | (Y4) | Item | (Y5) | Date | (Y | 4) Item | (| Y5) | Date |
|--|----------------------------------|--------|------------|--|----------|-----------|--------------------|------------|----|-----------|---|-------|-------------------|
| ID Prefix | | | | Correction | | | | Correction | | | | | Correction |
| Reg. # 483.85 Reg. # LSC | | | | Completed | | | | Completed | | | | | Completed |
| LSC | ID Prefix | F0441 | | 07/13/2015 | | ID Prefix | | - | | ID Prefix | | | _ |
| Correction | Reg. # | 483.65 | | | | Reg. # | | | | | | | |
| Correction Completed ID Prefix Reg. # LSC Completed ID Prefix Reg. # Reg | LSC | | | | | LSC | | | | LSC | | | |
| Completed ID Prefix | | | | | | | | | | | | | |
| ID Prefix Reg. # LSC Reg. # Reg. # Reg. # Reg. # LSC Reg. # LSC Reg. # LSC Reg. # LSC Reg. # Reg. # LSC Reg. # Reg. # LSC Reg. # LSC Reg. # LSC Reg. # Reg. # LSC Reg. # Reg. # LSC Reg. # LSC Reg. # Reg. # Reg. # LSC Reg. # LSC Reg. # Reg. # Reg. # LSC Reg. # Reg. # LSC Reg. # Reg. # Reg. # LSC Reg. # Reg. | | | | Correction | | | | Correction | | | | | Correction |
| Reg. # LSC | ID Desfer | | | Completed | | ID Deefee | | Completed | | ID D. f. | | | Completed |
| LSC | | - | | | | | | - | | | | | _ |
| Correction Completed ID Prefix Reg. # LSC LSC LSC Completed ID Prefix Reg. # LSC | - | | | | | - | | - | | | | | _ |
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| LSC | ID Prefix | | | | | ID Prefix | | | | ID Prefix | | | _ |
| Correction Completed ID Prefix Reg. # LSC Reviewed By State Agency GA/mm Reviewed By CMS RO Correction Completed C | Reg. # | | | | | Reg. # | | | | Reg. # | | | |
| Completed D Prefix | LSC | | | | | LSC | | - | | LSC | | | - - |
| Completed D Prefix | | | | | | | | | | | | | |
| Reg. # Reg. # Reg. # LSC | | | | Correction | | | | Correction | | | | | Correction |
| Reg. # LSC | ID Drofiv | | | | | ID Drofiv | | | | ID Drofiv | | | |
| Reviewed By Reviewed By Date: Signature of Surveyor: Date: State Agency GA/mm 07/21/2015 32600 07/14/2015 Reviewed By Reviewed By Date: Signature of Surveyor: Date: CMS RO Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies. | | | | | | | | - | | | | | _ |
| Reviewed By Reviewed By Date: Signature of Surveyor: Date: State Agency GA/mm 07/21/2015 32600 07/14/2015 Reviewed By Reviewed By Date: Signature of Surveyor: Date: CMS RO Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies. | - | | | | | | | | | Reg. # | | | _ |
| State Agency GA/mm 07/21/2015 32600 07/14/2015 Reviewed By Reviewed By Date: Signature of Surveyor: Date: Followup to Survey Completed on: Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies. | LSC | | | | <u> </u> | LSC | | | | | | | _ |
| State Agency GA/mm 07/21/2015 32600 07/14/2015 Reviewed By Reviewed By Date: Signature of Surveyor: Date: Followup to Survey Completed on: Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies. | | | | | | | | | | | | | |
| Reviewed By Reviewed By Date: Signature of Surveyor: Date: CMS RO Followup to Survey Completed on: Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies. | Reviewed By | | Reviewed B | Зу | Da | te: | Signature of Surve | yor: | | | | Date: | |
| CMS RO Followup to Survey Completed on: Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS 2567) Sout to the Facility? | State Agency | , | GA/mm | | 07 | 7/21/2015 | | | 60 | 0 | | 07/14 | /2015 |
| CMS RO Followup to Survey Completed on: Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS 2567) Sout to the Facility? | Reviewed By | | Reviewed E | Зу | Da | te: | Signature of Surve | yor: | | | | Date: | |
| Uncorrected Deficiencies (CMS 2567) Sout to the Facility? | CMS RO | | | | | | | | | | | | |
| Uncorrected Deficiencies (CMS 2567) Sont to the Excility? | Followup to Survey Completed on: | | | Check for any Uncorrected Deficiencies. Was a Summary of | | | | | | | | | |
| | | 4/23/2 | 2015 | | | | | | | | _ | YES | NO |

State Form: Revisit Report (Y1) Provider / Supplier / CLIA / (Y2) Multiple Construction (Y3) Date of Revisit A. Building

Name of Facility

7.14/2015

Street Address, City, State, Zip Code

ESSENTIA HEALTH GRACE HOME

116 WEST SECOND STREET GRACEVILLE, MN 56240

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

| (Y4) Item | (Y5) | Date | (Y4) Item | (Y5) | Date | (Y4) | Item | | (Y5) | Date |
|-----------------------|-----------------------------------|-------------------|-----------------------|-----------------------------|----------------------|----------|-----------|-------------------------------|-------|-------------------------|
| | | Correction | | | Correction | | | | | Correction |
| | | Completed | | | Completed | | | | | Completed |
| ID Prefix | 21375 | _07/13/2015 | ID Prefix | | _ | | | | | |
| • | MN Rule 4658.0800 Subp. | _ | Reg. # | | - | | Reg. # | | | _ |
| LSC | | - | LSC ₋ | | | <u> </u> | LSC | | | _ |
| | | Correction | | | Correction | | | | | Correction |
| | | Completed | | | Completed | | | | | Completed |
| ID Prefix | | - - | ID Prefix | | - | | ID Prefix | | | |
| Reg. # | | | Reg. # | | | | | | | |
| LSC | | - | LSC | | | | LSC | | | - - |
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| ID Prefix | | Completed | ID Prefix | | Completed | | ID Prefix | | | Completed |
| Reg. # | | | Reg.# | | | | Rea # | | | |
| - | | - - | | | - - | | LSC | | | |
| | | | | | | | | | | |
| | | Correction | | | Correction | | | | | Correction |
| ID Prefix | | Completed | ID Prefix | | Completed | | ID Prefix | | | Completed |
| Reg. # | | | Reg.# | | | | Reg. # | | | |
| LSC | | - - | | | - | | _ | | | _ |
| | | - " | | | | | | | | |
| | | Correction | | | Correction Completed | | | | | Correction Completed |
| ID Prefix | | Completed | ID Prefix | | Completed | | ID Prefix | | | Completed |
| Reg. # | | _ | Reg. # | | - | | Reg. # | | | _ |
| LSC | | - - | LSC | | . | | | | | _ |
| | | | | | | | | | | |
| Reviewed By | Reviewed | Ву | Date: | Signature of Surve | yor: | | | | Date: | |
| State Agency | GA/mn | n | 08/19/20 ⁻ | _ | 3260 | 00 | | | | 4/2015 |
| Reviewed By CMS RO | Reviewed | Ву | Date: | Signature of Surve | eyor: | | | | Date: | |
| Followup to | Survey Completed on: 4/23/2015 | | | Check for any Uncorrecte | | | | a Summary of to the Facility? | YES | NO |
| | | | 1 | | | | | | | *** |



Protecting, Maintaining and Improving the Health of Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

| On July 1 | 4, 2015, | |
|-----------|---|--|
| I. | | . received |
| ¬, | (Name)(Please Print) | (Title)(Please Print) |
| | e of Penalty Assessment dated July 16 | |
| | Essentia Health Grace Home | |
| | 116 West Second Street | |
| | Graceville, MN 56240 | |
| The Pena | lty Assessments and licensing orders a | attached hereto have been corrected as of July 14, 2015. |
| Signed: | ······································ | , Date (Title)(Please Print) |
| | (Name)(Please Print) | (Title)(Please Print) |
| 0.11.1 | | S PENALTY ASSESSMENT NOTICE |
| On July 1 | | |
| I, | , | , of the Division of (Title)(Please Print) |
| | (Name)(Please Print) | (Title)(Please Print) |
| | nce Monitoring, Minnesota Departmenty 16, 2015 and issued to: | at of Health, delivered the Notice of Penalty Assessment |
| | Essentia Health Grace Home | |
| | 116 West Second Street | |
| | Graceville, MN 56240 | |
| The Notic | ce of Penalty Assessment was handed | to, |
| | | (Name)(Please Print) |
| | , Date | |
| (Title)(P | lease Print) | |
| Signed: | ,, | , Date |
| | (Name)(Please Print) | (Title)(Please Print) |
| | | |

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 88VH

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

| | PART | I - TO BE COM | PLETED BY T | THE STAT | E SURVEY | AGENCY | 1 | Facility ID: 00762 |
|--|---|--|---|-------------------------------|--------------------------------|--|---|---|
| 1. MEDICARE/MEDICAID PROVIDER N (L1) 245579 2.STATE VENDOR OR MEDICAID NO. (L2) 030525100 | 0. | 3. NAME AND ADI (L3) ESSENTIA H (L4) 116 WEST SI (L5) GRACEVILI | ECOND STREE | Е НОМЕ | (| L6) 56240 | 4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation | 2. Recertification 4. CHOW 6. Complaint |
| 5. EFFECTIVE DATE CHANGE OF OWI | | 7. PROVIDER/SUF | PLIER CATEGOR | Y 09 ESRD | 02 13 PTIP | (L7) 22 CLIA | 7. On-Site Visit 8. Full Survey After Co | 9. Other omplaint |
| 6. DATE OF SURVEY 06/17 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other | (L34) — (L10) | 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF | 06 PRTF 07 X-Ray 08 OPT/SP | 10 NF 11 ICF/IID 12 RHC | 14 CORF 15 ASC 16 HOSPIC | CE | FISCAL YEAR ENDING | DATE: (L35) |
| 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds | 45 (L18) 45 (L17) | X B. Not in Com | ce With quirements Based On: cceptable POC | n | 2. 3. 4. | pproved Waivers Of The Technical Personnel 24 Hour RN 7-Day RN (Rural SNF Life Safety Code | 6. Scope of Servi 7. Medical Direc 8. Patient Room 9. Beds/Room | tor |
| 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 45 (L37) (L38) | 19 SNF (L39) | ICF (L42) | IID (L43) | | 15. FACILIT | Y MEETS 1) or 1861 (j) (1): | (L15) | |
| 16. STATE SURVEY AGENCY REMARK See Attached Remarks | | | | | 10 CTATE 6 | CUDATEV A CENTOV A | DDBOVAL | Date: |
| 17. SURVEYOR SIGNATURE Denise Erickson, HF | E NEII | | 07/09/2015 | (L19) | | SURVEY AGENCY A | 、, Enforcement Speci | |
| | PART II - TO | BE COMPLETE | D BY HCFA R | EGIONAI | OFFICE O | OR SINGLE STA | TE AGENCY | |
| DETERMINATION OF ELIGIBILITY _X | | | PLIANCE WITH (ITS ACT: | CIVIL | 21. | | cial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA:::::::::::::::::::::::::::::::::::: | A-1513) |
| 22. ORIGINAL DATE OF PARTICIPATION 07/08/1991 (L24) | 23. LTC AGREEMI BEGINNING (L41) | | 4. LTC AGREEMI ENDING DAT (L25) | | VOLUNTAF 01-Merger, C | _ | 00 INVOLUN' 05-Fail to M | L30) FARY feet Health/Safety feet Agreement |
| 25. LTC EXTENSION DATE: (L27) | 27. ALTERNATIVI A. Suspension of B. Rescind Sus | of Admissions: | (L44) (L45) | | | avoluntary Termination | OTHER 07-Provider 00-Active | Status Change |
| 28. TERMINATION DATE: | 29 (L28) | . INTERMEDIARY/C | | (L31) | 30. REMAR | KS | | |
| 31. RO RECEIPT OF CMS-1539 | 32 (L32) | DETERMINATION (06/02/2015 | DF APPROVAL DA | (L33) | | 1 07/15/2015 C | | |

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00762

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24 5579

A Post Certification Revisit (PCR) was completed by the Departments of Health and Public Safety to verify the facility had achieved and maintained compliance with Federal certification regulations pursuant to the April 23, 2015 standard survey. Based on our visit, we have determined the facility had not achieved substantial compliance and the following health deficiency was reissued:

F441 - S/S: D - 483.65 - Infection Control, Prevent Spread Linens

As a result of the revisit findings, this Department imposed the following Category 1 remedy:

State Monitoring, effective June 30, 2015. (42 CFR 488.422)

In addition, this Department recommended the following action to the CMS Region V Office, CMS concurred and authorized this Department to notify the facility of the imposition:

Mandatory Denial of Payment for New Medicare and Medicaid Admissions (DPNA), effective July 23, 2015. (42 CFR 488.417 (b))

If DPNA goes into effect the facility would be subject to a two year loss of NATCEP, beginning July 23, 2015

Refer to the CMS 2567b, CMS 2567 along with the facilitys plan of correction. PCR to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered June 25, 2015

Mr. John Campion, Administrator Essentia Health Grace Home 116 West Second Street Graceville, Minnesota 56240

RE: Project Number S5579025

Dear Mr. Campion:

On May 6, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 23, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On June 17, 2015, the Minnesota Department of Health and on May 21, 2015, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 23, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 29, 2015. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on April 23, 2015. The deficiency(ies) not corrected is/are as follows:

F0441 -- S/S: D -- 483.65 -- Infection Control, Prevent Spread, Linens

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective June 30, 2015. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the

Essentia Health Grace Home June 25, 2015 Page 2

last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective July 23, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective July 23, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 23, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Essentia Health Grace Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 23, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

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:

Jan.Suzuki@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:

Essentia Health Grace Home June 25, 2015 Page 3

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 Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov.

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor Fergus Falls Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: gail.anderson@state.mn.us

Phone: (218) 332-5140 Fax: (218) 332-5196

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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 revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

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

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 October 23, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process Minnesota Department of Health 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath, Enforcement Specialist

mark Weath

Program Assurance Unit
Licensing and Certification Program
Health Regulation Division

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 07/09/2015 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | INSTRUCTION | COMF | SURVEY PLETED |
|--------------------------|---|---|--------------------|-------|--|------|----------------------------|
| | | 245579 | B. WING _ | | | 1 | R / 17/2015 |
| | ROVIDER OR SUPPLIER | IE | | 116 \ | EET ADDRESS, CITY, STATE, ZIP CODE WEST SECOND STREET ACEVILLE, MN 56240 | 1 00 | 11112010 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 000} | INITIAL COMMENT An onsite post certific completed on 6/17/1 were corrected can Also there are tag/s and/or new tags were PCR which are local. Because you are ensignature is not requipage of the CMS-25 submission of the Poverification of complements. Upon receipt of an anon-site revisit of you validate that substar regulations has been your verification. 483.65 INFECTION SPREAD, LINENS The facility must est Infection Control Prosafe, sanitary and control to the prevent the confidence of disease and infection Control The facility must est Program under which (1) Investigates, continuity in the facility; (2) Decides what proshould be applied to | fication revisit (PCR) was 15. The certification tags that be found on the CMS2567B. that were not found corrected re issued at the time of onsite ted on the CMS2567. rolled in ePOC, your uired at the bottom of the first 167 form. Your electronic OC will be used as iance. receptable electronic POC, an r facility will be conducted to nitial compliance with the n attained in accordance with CONTROL, PREVENT ablish and maintain an ogram designed to provide a comfortable environment and development and transmission tion. Program ablish an Infection Control th it - utrols, and prevents infections occedures, such as isolation, an individual resident; and rd of incidents and corrective | GA 07/09 mm | V15 | | ATE | 7/13/15 |
| LAROPATORY | DIDECTOR'S OF PROVINCE | R/SLIPPLIER REPRESENTATIVE'S SIGNATUR | <u> </u> | | TITI F | | (X6) DATE |

07/09/2015 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.

Electronically Signed

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|--|--------------------|-----|---|-------------------------------|----------------------------|--|
| | | | | _ | | F | ₹ | |
| | | 245579 | B. WING | | | 06/ | 17/2015 | |
| | ROVIDER OR SUPPLIER A HEALTH GRACE HOME | | | 11 | REET ADDRESS, CITY, STATE, ZIP CODE 6 WEST SECOND STREET RACEVILLE, MN 56240 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| {F 441} | prevent the spread of isolate the resident. (2) The facility must promunicable disease from direct contact will trar (3) The facility must rhands after each direct hand washing is indicaprofessional practice. (c) Linens Personnel must hand | d of Infection n Control Program ident needs isolation to f infection, the facility must prohibit employees with a se or infected skin lesions ith residents or their food, if nsmit the disease. require staff to wash their cet resident contact for which cated by accepted | {F 4 | 41} | | | | |
| | This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adequate hand hygiene after perineal care for 1 of 3 residents (R14) observed receiving perineal care. Findings include: During observation on 6/17/15 at 1:43 p.m. R14 was seated in a wheelchair in the dining area of the facility. Nursing assistant (NA)-A and NA-B approached R14 and proceeded to transport her in her wheelchair to the bathroom area located behind the south nurses station. NA-A positioned R14's wheelchair outside of the bathroom door, while NA-B went to get R14's front wheeled walker from her room. | | | | It is current Policy and Procedure for a Essentia Health Grace Home nursing assistants to follow proper infection control procedures including proper han hygiene at the appropriate times. NA-A and NA-B were educated on prophand hygiene. All Nursing Assistants will be educated mandatory meetings 7/8/15 regarding proper hand hygiene. An Audit of nursing assistants will occuregarding proper hand hygiene during toileting and peri-cares, a total of 20 audits will be completed by 7/13/15 and sustain compliant will be achieved by | nd per at | | |

| OLIVILIV | OT OIL WEDTON THE G | MEDIO/ ND OLIVIOLO | | | | <u> </u> | 2. 0000 0001 |
|--------------------------|--|--|--------------------|---------------|--|----------|----------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | | CONSTRUCTION | ` ' | SURVEY PLETED |
| | | | A. BOILD | _ | | | R |
| | | 245579 | B. WING | | | | /17/2015 |
| NAME OF P | ROVIDER OR SUPPLIER | L | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 00/ | 11/2013 |
| | | | | | 16 WEST SECOND STREET | | |
| ESSENTIA | A HEALTH GRACE HOME | E | | | GRACEVILLE, MN 56240 | | |
| ()(1) ID | CLIMMADV CT | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (VE) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | (EACH CORRECTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 441} | Continued From page | e 2 | {F 4 | l 4 1} | | | |
| , , | | onned gloves to both hands, | | , | 7/13/15. DON will report these auditin | a | |
| | | ed to put the transfer belt | | | findings to Quality Assurance | 9 | |
| | around R14's waist. N | | | | Performance Improvement committee | on | |
| | perform hand hygiene | e prior starting cares for | | | 7/20/15. | | |
| | R14. | | | | With assured compliance the frequence | y of | |
| | | use of the transfer belt and | | | audits will decrease to 2X/ wk for 1 mo | | |
| | | A and NA-B assisted R14 to | | | Then monthly X 2 months and report t |) | |
| | J . | nd proceeded to assist her to | | | Quality Assurance Performance | | |
| | | hroom. R14 stood in front of | | | Improvement committee on 10/19/15 f | or | |
| | | ned down and pulled R14's tinent product down her legs | | | any further recommendations. | | |
| | and assisted R14 to s | | | | | | |
| | | 14 was seated on the toilet, | | | | | |
| | • | rty incontinent product from | | | | | |
| | | and placed the incontinent | | | | | |
| | product in the garbag | e can while NA-B donned | | | | | |
| | gloves on both hands | s. NA-B applied gloved to her | | | | | |
| | | w incontinent product from a | | | | | |
| | | I handed it to NA-A. With the | | | | | |
| | | nds, NA-A immediately | | | | | |
| | | plied the incontinent product | | | | | |
| | | a. NA-A wore the same the entire observation. | | | | | |
| | | nd NA-B assisted R14 to | | | | | |
| | - | et using the transfer belt | | | | | |
| | | the front wheeled walker. | | | | | |
| | | omplete perineal cares for | | | | | |
| | · · | ed hand and stated R14 had | | | | | |
| | _ | mear. NA-A continued to | | | | | |
| | clean R14's perineal area, then immediately pulled up R14's incontinent product and pants with the soiled left gloved hand. With the | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | same soiled gloves, NA-A and NA-B immediately | | | | | | |
| | reached out and held R14's transfer belt and bars | | | | | | |
| | of the walker and assisted her into the | | | | | | |
| | wheelchair. NA-A and NA-B wore the same soiled | | | | | | |
| | gloves for the entire procedureAt 1:54 p.m. NA-A and NA-B removed their | | | | | | |
| | | the garbage located in the | | | | | |

| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION G | | DATE SURVEY COMPLETED |
|--------------------------|--|--|---------|---|-----------|----------------------------|
| | | 245579 | B. WING | | | R |
| | OVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240 | I | 06/17/2015 |
| (X4) ID PREFIX TAG | REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| | out into the hallway to NA-A and NA-B them nurses station and properties of the same observation while took were performed for Fouring interview on a confirmed she wore time while performing stated "I usually take cares, I should have washed my hands." I do taking her gloves a walker, transfer belt at this is not good infection control of nursing (DON) concerned their gloves a cares and to wash the any other tasks with gloves should have the good infection control. Review of facility pol Hand Hygiene, revise to wash their hands I contact with resident blood, body fluids, semembranes, or non in | A proceeded to wheel R14 to the south nurses station. In walked behind the south proceeded to wash their receded to period the same gloves the entire removed my gloves and NA-A also verified she should off before handling R14's and clothing and stated "no receded to wash the same gloves and wash their receded to after performing period to after performing period the resident and stated "the peen removed, this is not of practice." The proceeded to wheel R14 is a walked before performing the receded to wash their receded to | {F 44 | .1} | | |

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

| (Y1) | Provider / Supplier / CLIA / Identification Number 245579 | (Y2) Multiple Construction A. Building B. Wing | | (Y3) Date of Revisit 6/17/2015 |
|------|---|--|---------------------------------------|-----------------------------------|
| Name | of Facility | | Street Address, City, State, Zip Code | |
| ES | SENTIA HEALTH GRACE HOME | | 116 WEST SECOND STREET | |
| | | | GRACEVILLE, MN 56240 | |

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

| (Y4) Item | | (Y5) | Date | (Y4) | Item | | (Y5) | Date | (Y4 | Item | C | Y5) | Date |
|--|-----------------------|----------------|---|------|----------------------------|------------------------------|-------|---|-----|-------------------------------|-------------------|---------|---|
| ID Prefix | F0225 | | Correction Completed 05/26/2015 | | ID Prefix | F0226 | | Correction Completed 05/29/2015 | | ID Prefix | F0279 | | Correction Completed 05/13/2015 |
| Peg # | 483.13(c)(1)(ii)- | (iii) (c)(2) - | · (4) | | | 483.13(c) | | - | | | 483.20(d), 483.20 | n/k\/1\ | |
| LSC | 400.10(0)(1)(11) | (111), (0)(2) | (4) | | LSC | 400.10(0) | | | | LSC | 400.20(0), 400.20 | O(K)(T) | _ |
| ID Prefix Reg. # LSC | F0311 483.25(a)(2) | | Correction Completed 05/13/2015 Correction Completed | | ID Prefix Reg. # LSC | F0431 483.60(b), (d), (e) | | Correction Completed 05/26/2015 Correction Completed | | Reg. # | | | Correction Completed Correction Completed |
| Reg. # | | | • | | Reg.# | | | - | | Reg. # | | | _ |
| LSC | | | | | LSC | | | | | | | | |
| ID Prefix Reg. # LSC | | | | | ID Prefix Reg. # LSC | | | | | Reg. # | | | Correction Completed |
| ID Prefix Reg. # LSC | | | | | ID Prefix Reg. # LSC | | | | | | | | |
| | | | | | | | | | | | | | |
| Reviewed By | | Reviewed E | Зу | Da | te: | Signature of | Surve | yor: | | | | Date: | |
| State Agency | , | GA/mm | | 06 | /25/201 | 15 | ; | 31256 | | | | 06/1 | 7/2015 |
| Reviewed By | | Reviewed E | Зу | Da | te: | Signature of | Surve | yor: | | | | Date: | |
| Followup to Survey Completed on: 4/23/2015 | | | | | | - | | | | a Summary of to the Facility? | YES | NO | |

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

| (Y1) | Provider / Supplier / CLIA / Identification Number 245579 | (Y2) Multiple Construction A. Building B. Wing | | N BUILDING 01 | (Y3) Date of Revisit 5/21/2015 | | | |
|------|---|--|--|---------------------------------------|-----------------------------------|--|--|--|
| Name | of Facility | | | Street Address, City, State, Zip Code | | | | |
| ES | SENTIA HEALTH GRACE HOME | | | 116 WEST SECOND STREET | | | | |
| | | | | GRACEVILLE MN 56240 | | | | |

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

| Correction Completed ID Prefix Correction Completed ID Prefix LSC Correction Completed ID Prefix LSC Correction Completed ID Prefix ID Prefix Completed ID Prefix Reg. # LSC LSC Completed ID Prefix Reg. # LSC LSC Completed ID Prefix Reg. # LSC LSC Correction Completed ID Prefix Reg. # LSC Correction Completed ID Prefix Reg. # LSC LSC Correction Completed ID Prefix Reg. # LSC LSC Correction Completed ID Prefix Reg. # LSC Correction Completed ID Prefix | (Y4) Item | | (Y5) | Date | (Y4) | Item | (Y5) | Date | (Y | 4) Item | (| (Y5) I | Date |
|--|--------------|---------------------|-------|------------|------|-----------|--------------------|-------------|-----|----------------|--------------|--------|-------------------|
| ID Prefix | | | | Correction | | | | Correction | | | | | Correction |
| Reg. # NFPA 101 | | | | | | | | Completed | | | | | Completed |
| LSC LSC | ID Prefix | | | 05/14/2015 | | ID Prefix | | - | | ID Prefix | | | _ |
| Correction Completed ID Prefix Reg. # LSC LSC | Reg. # | NFPA 101 | | | | | | | | | | | _ |
| Correction Completed ID Prefix Reg. # LSC Reg. # Reg. # LSC Reg. # R | LSC | K0144 | | | | LSC | | | | LSC | | | _ |
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| Reg. # LSC | ID D. G. | | | Completed | | ID Desfer | | Completed | | ID D. f. | | | Completed |
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| Uncompared Deficiencies (OMO 0507) Constant Facilities | CMS RO | | | | | | | | | | | | |
| Haraman et al Definition size (CMO 0507) Court to the Facility C | Followup to | Survey Completed on | 1: | | | | Check for any | Uncorrected | Def | iciencies. Was | a Summary of | 1 | |
| | | 4/21/2015 | | | | | <u>-</u> | | | | _ | YES | NO |



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered July 9, 2015

Mr. John Campion, Administrator Essentia Health Grace Home 116 West Second Street Graceville, Minnesota 56240

RE: Project Number S5579025

Dear Mr. Campion:

On June 17, 2015, a Post Certification Revisit was completed at your facility. You have alleged that the deficiencies cited on that visit by the Minnesota Department of Health, Licensing and Certification Program staff (F tags) have been corrected. We are accepting your plan of correction and presume that your facility will achieve substantial compliance.

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

Sincerely,

Gail Anderson, Unit Supervisor

Licensing and Certification Program

ail anderson

Health Regulation Division

Email: gail.anderson@state.mn.us

Phone: (218) 332-5140 Fax: (218) 332-5196

POCA HEALTH PCR.ORC

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 88VH

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

| | PART I - | TO BE COMPI | LETED BY T | THE STAT | TE SURVEY | AGENCY | | Facility ID: 00762 | |
|--|---|--|---|-------------------------------|---|--|---|---|--|
| MEDICARE/MEDICAID PROVIDIO (L1) 245579 2.STATE VENDOR OR MEDICAID N (L2) 030525100 | 3. NAME AND ADDRESS OF FACILITY (L3) ESSENTIA HEALTH GRACE HOME (L4) 116 WEST SECOND STREET (L5) GRACEVILLE, MN | | | | 56240 | 4. TYPE OF A | 2. Recertification n 4. CHOW 6. Complaint | | |
| 5. EFFECTIVE DATE CHANGE OF (L9) | | 7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD | | | <u>02</u> (L7) 13 PTIP | 22 CLIA | 7. On-Site Visit 9. Other 8. Full Survey After Complaint | | |
| 6. DATE OF SURVEY 04/23 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other | 3/2015 (L34) (L10) | 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF | 06 PRTF 07 X-Ray 08 OPT/SP | 10 NF 11 ICF/IID 12 RHC | 14 CORF 15 ASC 16 HOSPICE | | FISCAL YEAR E | ENDING DATE: (L35) | |
| 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds | 45 (L18) 45 (L17) | Complianc1. A X B. Not in Con | nce With equirements e Based On: cceptable POC | gram | 2. Tecl 3. 24 I 4. 7-D 5. Life | hnical Personnel | 7. Medica | of Services Limit al Director Room Size | |
| 14. LTC CERTIFIED BED BREAKDO | WN | | | | 15. FACILITY N | MEETS | | | |
| 18 SNF 18/19 SNF 45 | 19 SNF | ICF | IID | | 1861 (e) (1) o | r 1861 (j) (1): | (L15) | | |
| (L37) (L38) | (L39) | (L42) | (L43) | | | | | | |
| 16. STATE SURVEY AGENCY REM | ARKS (IF APPLICA | ABLE SHOW LTC CA | ANCELLATION | DATE): | | | | | |
| 17. SURVEYOR SIGNATURE | | Date : | | | 18. STATE SU | RVEY AGENCY | APPROVAL | Date: | |
| Tammy Williams, F | HFE NEII | | 5/26/2015 | (L19) | Mark | Meath, | Enforcement Sp | 06/02/2015 (L20 | |
| PA | RT II - TO BE | COMPLETED I | BY HCFA RI | EGIONAL | OFFICE O | R SINGLE S | TATE AGENC | , | |
| 19. DETERMINATION OF ELIGIBIL 1. Facility is Eligible to F 2. Facility is not Eligible | Participate | | IPLIANCE WIT HTS ACT: | H CIVIL | 2. (| | ncial Solvency (HCFA Il Interest Disclosure | | |
| 2. Pacinty is not Engine | (L21) | | | | | | | | |
| 22. ORIGINAL DATE OF PARTICIPATION 07/08/1991 | 23. LTC AGREED BEGINNING | | 4. LTC AGREEI ENDING DA | | VOLUNTARY 01-Merger, Clos | ATION ACTION: 00 sure on W/ Reimburse | 05-Fa | (L30) DLUNTARY ail to Meet Health/Safety ail to Meet Agreement | |
| (L24) 25. LTC EXTENSION DATE: | (L41) 27. ALTERNATI | VE SANCTIONS | (L25) | | | untary Termination | | C | |
| 23. LIC EXTENSION DATE. | | n of Admissions: | (L44) | | 04-Other Reason | n for Withdrawal | | rovider Status Change | |
| (L27) | B. Rescind St | uspension Date: | , | | | | | | |
| | | | (L45) | | | | | | |
| 28. TERMINATION DATE: | 29 |). INTERMEDIARY/ | CARRIER NO. | | 30. REMARKS | 1 | | | |
| | (L28) | 03001 | | (L31) | | | | | |
| 31. RO RECEIPT OF CMS-1539 | 32 | . DETERMINATION | OF APPROVAL | L DATE | | | | | |
| | (L32) | | | (L33) | DETERMIN | ATION APPR | ROVAL | | |



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered May 6, 2015

Mr. Kevin Gish, Administrator Essentia Health Grace Home 116 West Second Street Graceville, Minnesota 56240

RE: Project Number S5579025

Dear Mr. Gish:

On April 23, 2015, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

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

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104 Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 2, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 2, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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 form will be used as verification of compliance. 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and 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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by July 23, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

Essentia Health Grace Home May 6, 2015 Page 5

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 23, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process Minnesota Department of Health 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division pat.sheehan@state.mn.us Telephone: (651) 201-7205

Fax: (651) 215-0525

Essentia Health Grace Home May 6, 2015 Page 6

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 06/02/2015 FORM APPROVED OMB NO. 0938-0391

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
|--|--|---|---------------------|--|--------------------------------|----------------------------|
| | | 245579 | B. WING | | 04 | /23/2015 |
| NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH GRACE HOME | | | | STREET ADDRESS, CITY, STATE, ZIP 116 WEST SECOND STREET GRACEVILLE, MN 56240 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COME (CONTROL OF COME ACTION OF COME | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENT | rs | F 0 | 00 | | |
| | as your allegation of Department's acception enrolled in ePOC, year the bottom of the | of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance. | | | | |
| F 225 SS=D | on-site revisit of you validate that substate regulations has been your verification. | PORT | F 2 | 25 | | 5/26/15 |
| | been found guilty or mistreating residen had a finding entered registry concerning of residents or mistand and report any known court of law against indicate unfitness for | at employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a tan employee, which would or service as a nurse aide or the State nurse aide registry ties. | | | | |
| | involving mistreatm including injuries of misappropriation of immediately to the to other officials in a through established State survey and co | usure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law d procedures (including to the ertification agency). | | TITLE | | (X6) DATE |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

05/15/2015

Electronically Signed

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.

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION G | | SURVEY |
|--------------------------|--|--|---------------------|--|--|----------------------------|
| | | 245579 | B. WING _ | | 04/2 | 23/2015 |
| | PROVIDER OR SUPPLIER | OME | | STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240 | <u> </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 225 | violations are thoro prevent further pote investigation is in p The results of all into the administrator representative and with State law (includent) and if the significant of the s | eve evidence that all alleged ughly investigated, and must ential abuse while the rogress. | F 22 | 5 | | |
| | by: Based on interview facility failed to imm administrator and Scomplete a thoroug unknown origin for significant bruise of Finding include: R31's significant ch (MDS) dated 1/27/1 cognitively intact, refor bed mobility, limit transfers and extentoileting, dressing a Review of R31's present a significant characteristic cognitively intact, refor bed mobility, limit transfers and extentoileting, dressing a Review of R31's present control of R | AT is not met as evidenced and document review, the nediately report to the stage agency (SA) and h investigation for injuries of 1 of 1 resident (R31) with a unknown origin. The ange Minimum Data Set 5, identified R31 was equired supervision of one staff for sive assistance of one staff for nd personal hygiene. | | 1. When made aware of the un-rebruise of suspicious origin, a Vulner Adult Incident report was filed immer with MDH and the facility administrative was informed on 4.22.14. 2. A subsequent internal investigative was conducted and the report filed MDH, CEP, APS, and the Ombudst 5.1.15. 3. It was the conclusion of the investigator was not able to say with certainty what or who, if anybody, we source of the injury, nor how the initive event report fell through the cracks was not reviewed by the IDP team. Corrective action included coaching nursing regarding behaviors and particularly how best to assist residereduce the risk of bruises or skin team of the IDP team now have available accomputer generated report that lists | rable ediately ator tion with man on any vas the tial and ents to ars. | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPI A. BUILDING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|-----------------------------|---|--|---|
| | | 245579 | B. WING | | 04/23/2015 | |
| | PROVIDER OR SUPPLIER | OME | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240 | , 0 11 20 20 10 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLÉTION | 1 |
| F 225 | Continued From pa | ge 2 | F 225 | | | |
| | present." 4/4/15, re forearm have nearl | ion and no open areas ad bruised area on right y faded with no defined larker area of skin noted on rm. No open areas. | | events/ incidents to better spot posincident of abuse or neglect. This reviewed by the IDP Team daily exweek-ends and holidays this will be reviewed by the DON, or On-Call Onurse to see that VA reports are be filed immediately and timely. | report is report for e Charge eing | |
| | Review of R31's ca R31 had a bruise o | re plan dated, 3/3/14, revealed n right forearm. | | 4. Notice was received from MDI no further action was needed at th on 5.7.15.5. Licensed staff was re-educated | is time | |
| | 2:44 p.m. revealed to his right arm which centimeters (cm) at with slight swelling. origin of the bruise "he got it (bruise) for the night." Further no measures were response, the physnotified and the car report also indicate medical doctor imm for any of the follow origin, bruise associating bruise associations. | rent report dated, 3/3/15, at R31 had a bruise on forearm ch measured 16 x13 and was reddish/blue in color. The report also indicated the was unknown and R31 stated om 2 women in the middle of review of the report revealed taken to the residents ician nor R31's family was be plan was not reviewed. The distaff would notify the nediately by phone or beeper wing: bruising of unknown stated with moderate to severe or loss of range of motion and atted with known incident. | | Vulnerable Adult policy and reporting process during scheduled meetings 5/11-5/13/15, stand up meetings, a meetings followed by competency evaluations. 6. Vulnerable Adult Policy was reviewed 5/22/15. VA policy was reviewed 5/22/15. VA policy was reviewed to include that all suspected incide abuse or maltreatment will be repoint incident. Nursing staff will be recon this revision in the policy. 7. Nurses stations computers have Vulnerable Adult file icon placed or with VA policy and report filing proceed them for ease in submitting a report for ease in submitting a report ference sheet has been placed in Charge Nurse book at both Nurses. | evised ence of orted on the ducated exes in them cess in tr. | |
| | director of nursing of was of unknown or SA nor investigated recall the injury and reported. At 12:13 a resident had a significant, it should be | 4/22/15, at 12:10 p.m. the (DON) confirmed the bruise gin and was not reported to I. The DON stated she did not I assumed it did not get p.m. the DON confirmed when gnificant bruise of unknown immediately reported." The dministrator should have been | | stations to allow easy access to the procedure for reporting. 9. Ombudsman is scheduled to here 6/9/15 for yearly education for staff to review Vulnerable Adult and Rights. 10. To ensure that all reports and filed in a timely manner, DON, Socion Service or designee will monitor designee. | be r all d Rights re being sial | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | CONSTRUCTION | | E SURVEY IPLETED |
|--------------------------|---|--|---------------------|-----|---|----------------------------|----------------------------|
| | | 245579 | B. WING | | | 04/ | 23/2015 |
| | PROVIDER OR SUPPLIER | ОМЕ | | 116 | REET ADDRESS, CITY, STATE, ZIP CODE 6 WEST SECOND STREET RACEVILLE, MN 56240 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | × | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 225 | notified and was not made to the SA and report and thorough been competed and that no one was no know about the bruise of unknown about the bruise of unknown and get reported to confirmed that he wright away if there was acquired and a adult. During interview on registered nurse (Rabout the bruise and they all should asked if an investig stated "not that I known assistant (NA)-D cobruise on his right for recall what they sai NA-D also verified to bruising to the nurse During interview on confirmed R31 had | ott, a report should have been discovered was not and an incident investigation should have discovered was not. The DON confirmed tified and that she did not even ise to R31's right forearm. 4/22/15, at 12:13 p.m. the stated she "vaguely" recalled wn origin and confirmed it did the SA. The SW also would have reported the bruise was no explanation of how it also reported as a vulnerable 4/22/15, at 12:54 p.m. (N)-A stated she did not know did confirmed it did not get hinistrator, DON, SW nor SA have been notified. When ation was completed RN-A low of." 4/22/15, at 1:25 p.m. nursing onfirmed R31 had a large orearm and stated "I cant did happened or how he got it." that she would report any | F 2 | | incident reports with the IDP team audit reports for one quarter and sthese findings for review to Quality Assurance Committee and further monitoring recommendations at the scheduled QA meeting to ensure the reports are being filed immediately timely. | ubmit e next nat all | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION NG | | E SURVEY IPLETED |
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| | | 245579 | B. WING | | 04/ | 23/2015 |
| | PROVIDER OR SUPPLIER | ОМЕ | | STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 225 | Continued From pa (bruising) right awa | _ | F 2 | 25 | | |
| | practical nurse (LPI large bruise on his did not know how h it happened. LPN-A suspicious bruise o ask the resident who where the suspicious bruise of the suspicious bruis | 4/22/15, at 1:45 p.m. licensed N)-A confirmed R31 had a right forearm and stated she e got it nor anyone saying how a stated if she found a f unknown origin she would at happened, talk to the report it to the DON and report. | | | | |
| F 226 SS=D | Vulnerable Adult Podirected staff to repincident of actual or resident or of any reinjury which was not be reported in accostatute. The policy any suspected abus vulnerable adult imsupervisor who was information immedidesignee. 483.13(c) DEVELO ABUSE/NEGLECT | ETC POLICIES evelop and implement written | F 2 | 26 | | 5/29/15 |
| | policies and proced mistreatment, negle and misappropriation | lures that prohibit ect, and abuse of residents on of resident property. | | | | |
| | This REQUIREMEN | NT is not met as evidenced | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | ISTRUCTION | | E SURVEY IPLETED |
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| | | 245579 | B. WING | | | 04/ | 23/2015 |
| | PROVIDER OR SUPPLIER | ОМЕ | | 116 WE | ADDRESS, CITY, STATE, ZIP CODE ST SECOND STREET EVILLE, MN 56240 | , , , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 226 | by: Based on interview facility failed to imp policy and procedur notifying the adminiand thoroughly invewith a significant browship in the significant of actual or resident or of any suspected abuse vulnerable adult improved in the supervisor who was information immediates in the significant characteristic in the sincrease characteristic in the significant characteristic in the s | and document review, the lement their abuse prevention res related to immediately strator, the State agency (SA) estigating 1 of 1 resident (R31) uise of unknown origin. Dicy titled, Grace Home olicy, reviewed on 4/3/14, ort and investigate any resident who had sustained an of reasonably explained shall red with MN. Vulnerable Adult also directed staff to report se, neglect, exploitation of a mediately to his /her responsible to report the ately to the administrator or ange Minimum Data Set 15, identified R31 was equired supervision of one staff for a assistance of one staff for a decident of the administrator or and personal hygiene. | F 2 | 1. 5/8/2. Vuli prod 5/11 med eva revi incid report aware 3. com eve by t wee On-revi report ime 4. 6/9/revi Rig 5. Vuli with their 6. refe Chastat prod 5. filed | Nursing staff re-educated on nerable Adult policy and report cess during scheduled meetings and report of the cess during scheduled meetings followed by competent alluations. 5/22/15 VA policy was liked to include that all suspect dence of abuse or maltreatmented immediately of being make on the incident. Staff will be aducated on this revision of the The IDP team now have available incidents. This report is restricted incidents. This report is restricted and holidays the DON-Call Charge nurse or designation are being filed immediated. | ting ngs and 1:1 y as ted ent will be ade pe policy. lable a sts eviewed N, ee will /A ely and p be here staff to ots nave on them ocess in oort. ess l in each es he e being ocial | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) | | IDENTIFICATION NUMBER. | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 245579 | B. WING | | ···· | 04/2 | 23/2015 |
| | PROVIDER OR SUPPLIER | OME | | 1 | TREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET BRACEVILLE, MN 56240 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | X | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 226 | discoloration, just discoloration, just discoloration, just discoloration, just discoloration discoloration, just discoloration discoloration, discoloration discoloration, discoloration, discoloration discoloration, discol | y faded with no defined arker, are of skin noted on rm. No open areas." | F 2 | 26 | incident reports with the IDP team audit reports for one quarter and st these findings for review to Quality Assurance Committee and further monitoring recommendations at the scheduled QA meeting to ensure the reports are being filed immediately timely. | ubmit e next nat all | |
| | administrator shoul | origin, it should be ed." The DON verified the dhave been notified and was dhave been made to the SA | | | | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | COMPLETED | | |
|--|---|---|---|--|-----------|----------------------------|--|--|
| | | 245579 | B. WING _ | | 04 | /23/2015 | | |
| | PROVIDER OR SUPPLIER | OME | | STREET ADDRESS, CITY, STATE, ZIP CO 116 WEST SECOND STREET GRACEVILLE, MN 56240 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | | |
| F 226 | investigation should was not. The DON | incident report and thorough d have been competed and confirmed that no one was e did not even know about the | F 22 | 26 | | | | |
| | social worker (SW) the bruise of unkno- not get reported to confirmed that he v right away if there v | 4/22/15, at 12:13 p.m. the stated she "vaguely" recalled wn origin and confirmed it did the SA. The SW also would have reported the bruise was no explanation of how it also reported as a vulnerable | | | | | | |
| | registered nurse (Fl about the bruise and reported to the adm and that they all she | 4/22/15, at 12:54 p.m. IN)-A stated she did not know id confirmed it did not get ninistrator, DON, SW nor SA ould have been notified. Investigation was completed at I know of." | | | | | | |
| | assistant (NA)-D co bruise on his right f recall what they sai | 4/22/15, at 1:25 p.m. nursing onfirmed R31 had a large orearm and stated "I cant d happened or how he got it." that she would report any e right away. | | | | | | |
| | confirmed R31 had forearm and stated | 4/22/15, at 1:21 p.m. NA-E a large bruise on his right "I was told about it in report." that she would have reported it y. | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 245579 | B. WING | | | 04/: | 23/2015 |
| | PROVIDER OR SUPPLIER | OME | | 11 | TREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET BRACEVILLE, MN 56240 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 226 | Continued From pa | ge 8 | F 2 | 226 | | | |
| F 279 SS=D | practical nurse (LPI large bruise on his did not know how his happened. LPN-A suspicious bruise of ask the resident who nursing assistants, complete an event 483.20(d), 483.20(k) COMPREHENSIVE A facility must use to develop, review a comprehensive plan. The facility must deplan for each reside objectives and time medical, nursing, an needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any side to the resident's §483.10, including to under §483.10, including to the side of the sid | ch (1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's not care. velop a comprehensive care ent that includes measurable tables to meet a resident's not mental and psychosocial tified in the comprehensive describe the services that are train or maintain the resident's physical, mental, and eing as required under ervices that would otherwise (483.25 but are not provided is exercise of rights under the right to refuse treatment | F 2 | 279 | | | 5/13/15 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 045570 | | | | | |
| | | 245579 | B. WING | | | 04/2 | 23/2015 |
| | PROVIDER OR SUPPLIER IA HEALTH GRACE H | OME | | 11 | FREET ADDRESS, CITY, STATE, ZIP CODE 6 WEST SECOND STREET RACEVILLE, MN 56240 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 279 | facility failed to dev plan that included to (anti-coagulant) for reviewed for non-properties and its plants of the facility comprehensive car assistive hearing do reviewed for commutilizing a pocket ta Finding include: Anticoagulant: R7's Physician Ordindicated R7 was diabetes and deme R7 was prescribed (Coumadin) 3 millig p.m. and 7:00 p.m. Review of R7's carridentify the use of a fibrillation nor did the effects and monitor related to the medic Coumadin was not During interview on of nursing confirme Coumadin for atrial medication was not plants. | v and document review, the elop a comprehensive care he daily use of Coumadin 1 of 3 resident (R7) who was ressure related skin issues. In | F 2 | 279 | 1. R7 care plan was immediately updated for anticoagulant medication. These medications increase the rispotential side effects such as bruisibleeding. Completed 4/23/15 2. Reviewed Care plan policy with management and staff during meet 5/11-5/13/15, 1:1, standup meeting 3. Reviewed medication list of all residents and identified everyone receiving medications with anticoagulation medication with anticoagulation appropriate care plans were in place documented these results on a spreadsheet. Completed 5/7/15 4. Nurses completing monthly DR Rounds will audit the Anticoagulant medication use spreadsheet to see care plans are in place for all reside receiving anticoagulant medication: ensure appropriate care plan changhave been made. This will be start next scheduled rounds on 5/14/15. 5. Anticoagulant care plan added admission packets to see that anticoagulant reare plan is put in pla admission of all new admissions reanticoagulant medications. Complet 4/28/15. 6. Quarterly the audit results will be reviewed with Quality Assurance Committee for any further recommendatins. 7. R43 care plan was immediately updated to include the use of a communication device 4/23/15. 8. Activity staff reviewed all care posed that hearing devices are appropriate appropriate are paparotic and the second and the sec | k for ng/ ng/ ngings s. gulant that that the ents in t | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245579 | B. WING | | 04/ | 23/2015 | |
| | PROVIDER OR SUPPLIER | IOME | | STREET ADDRESS, CITY, STATE, ZIP COI 116 WEST SECOND STREET GRACEVILLE, MN 56240 | • | 20.20.10 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 279 | registered nurse (Recurrently receiving and verified the me R7's care plan. RN had been a care plan. | 4/23/15, at 4:16 p.m. (N)-A confirmed R7 was Coumadin for atrial fibrillation dication was not addressed on -A also stated "there should an developed for the use of r would be monitoring for | F 279 | 9. Activity manager or design audit monthly that hearing developlanned accurately and ensur appropriate changes have bettimely manner. 10. Activity department was care plan documentation and communication device usages 11. DON or designee will audicuracy monthly for one quareview results with Quality Asse Committee for further recommined. | vies are care e that en made in a educated on dit care plan rter and surance | | |
| | Hearing Device: | | | | | | |
| | 2/12/15, identified F impairment, moder hearing aides, had | nimum Data Set (MDS) dated R43 had severe cognitive ate difficulty hearing, utilized clear speech, was understood usually understood by others. | | | | | |
| | R43's Care Plan dated 4/15/15, indicated R43 was at risk for a decline in socialization related to impaired hearing. The plan identified R43 required moderate assistance from activity staff to comprehend and participate in group activities related to her hearing. The facility failed to identify R43's assistive hearing device, correct use of the device and any preventative maintenance requirements for R43's hearing device on her care plan. | | | | | | |
| | dining room during headphones off her | p.m. R43 was observed in the the evening meal with her head and around her neck. | | | | | |

| | ETATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 245579 | B. WING _ | | 04 | /23/2015 | |
| | PROVIDER OR SUPPLIER | IOME | | STREET ADDRESS, CITY, STATE, ZIP CO 116 WEST SECOND STREET GRACEVILLE, MN 56240 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 279 | residents. R43 repended coffle," "Some told registered nurs ache and wanted to what was wrong an am not understand remained around hat the table while Ranother resident with the dining room with by R43's clothing person hearing. R43's stated, "Unless your can't hear you." -At 9:50 a.m. active observed in the hall with R43 seated in holding R43's head in her hand and tell dead, we need to geat to the day room speaker box and here active observed in the hall with R43 seated in holding R43's head in her hand and tell dead, we need to geat to the day room speaker box and here active observed in the hall dead, we need to geat to the day room speaker box and here active observed in the hall dead, we need to geat to the day room speaker box and here active observed in the hall dead, we need to geat to the day room speaker box and here active observed in the hall dead, we need to geat the day room speaker box and here active observed in the hall dead, we need to geat the day room speaker box and here active observed in the hall dead, we need to geat the day room speaker box and here active observed in the hall dead, we need to geat the day room speaker box and here active observed in the hall dead, we need to geat the day room speaker box and here active observed in the hall dead, we need to geat the day room speaker box and here active observed in the hall dead in th | eatedly called out "Nurse, I ebody," for 10 minutes. R43 se (RN)-B she had a stomach o go to bed. RN-B asked R43 ad R43 responded by saying "I ing you." R43's headphones er neck. R43 continued to sit N-B continued to assist | F 2 | 79 | | | |

| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | IPLE CONSTRUCTION NG | | COMPLETED | |
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| | | 245579 | B. WING _ | | 04 | 1/23/2015 | |
| | PROVIDER OR SUPPLIER | IOME | | STREET ADDRESS, CITY, STATE, ZIP COD 116 WEST SECOND STREET GRACEVILLE, MN 56240 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 279 | -At 10:25 a.m. the of A-A proceeded to witheir rooms. R43 restaring at the wall. to her. R43 stated, hear today." When the music, R43 state entered the day roollike to go with her a R43 did not hear he R43 to the activity ractivity. -At 10:35 a.m. R43 end of a long table headphones on. Of members were prewith or to R43. R43 | group ball activity was over. wheel other residents back to emained in the activity room, Polka music was playing next "For some reason, I can't R43 was asked if she liked ted "I can't hear you." A-B om and asked R43 if she would and get her fingernails painted, er or respond. She wheeled room for the nail painting was observed seated at the in the activity room without her ther residents and staff sent however, no one spoke asked if the wind was blowing | F 2' | 79 | | | |
| | laughing with each resident seated new understand what the resident replied, shear anymore and not the only one." -At 10:43 a.m. R43 this." -At 10:46 a.m. R43 headphones. Nine the activity. At this is brought the headph stated he would see R43 stated "I can't | ded. Staff were observed other when R43 asked a act to her if she could be staff were saying, the e did not. R43 stated I cant the resident responded, "your stated "I don't appreciate remained without her other residents were noted in time, another employee had nones to the activity room and to them on top of the fridge. see or hear." A-A grabbed the the top of the fridge and | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245579 | B. WING | | | 04/ | 23/2015 |
| | PROVIDER OR SUPPLIER | ОМЕ | | 1 | TREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET GRACEVILLE, MN 56240 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 279 | around her neck on | ge 13 3's head and the speaker box a lanyard saying, "They es." R43 stated, "You get used | F 2 | :79 | | | |
| | room. The speaker R43's quilted jacket | 143 was observed in the dining box was observed tucked into t and was also covered up with did not respond to this s. | | | | | |
| | day area in front of headphones in plac her lap along with the | was observed in the south the TV without her ce. The headphones were on he speaker box. R43 was ow and not watching the TV. | | | | | |
| | the table sorting so covered by her quilt pushed up to the ta unable to detect my hung from the lanyadid not detect voice the table or it was on R43 repeatedly start you." After the survispoke directly into the liked the earphones R43 stated, "I don't | vas observed in day area at cks. R43's speaker box was ted jacket and she was ble. The speaker box was ard to R43's abdomen and it is when R43 was pushed up to covered by clothing or napkins. The ted to the surveyor "I cant hear eyor picked up the device and the talk box, R43 stated she is and they were comfortable. The hear that good even with the lift just doesn't work to not | | | | | |
| | | 2:42 p.m. nursing assistant could not hear without the | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | FIPLE CONSTRUCTION NG | | E SURVEY MPLETED |
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| | | 245579 | B. WING _ | · · · · · · · · · · · · · · · · · · · | 04 | /23/2015 |
| _ | PROVIDER OR SUPPLIER | OME | | STREET ADDRESS, CITY, STATE, 2 116 WEST SECOND STREET GRACEVILLE, MN 56240 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 279 | headphones/pocke devices utilized for | ge 14 ocket talker. She stated the t talker were the only adaptive enhanced communication with 43 always utilized the devices | F 2' | 79 | | |
| | used the pocket tall R43's left ear was be stated if R43 could understanding then | 2:54 p.m. NA-D stated R43 ker device, read lips and that better than her right. She also not hear staff or had trouble in they would use the hearing ney did not use it, "not | | | | |
| | (LPN)-A stated the R43 was to use her talker and that R43 talker. She stated w | p.m. licensed practical nurse best way to communicate with head phones and pocket heard better with her pocket vithout her headphones R43 say, "I cant hear you, or I cant | | | | |
| | R43's use of the powas not on the care it. RN-A stated the R43 was to use the | 3:25 p.m. RN-A confirmed cket talker / hearing device plan and she had just added only hearing interventions for pocket talker and check her stated R43 would not be able device. | | | | |
| | | 4:55 p.m. the director of ed she would have expected R43's care plan. | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 245579 | B. WING | | 04/23/2015 | |
| | PROVIDER OR SUPPLIER | OME | | STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240 | | |
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| F 279 | that the care plan s resident's daily care available to staff pe | ge 15 If Care Plan Policy," identified hall be used in developing the routine and would be rsonnel who have the oviding care and services to | F 279 | | | |
| F 311 SS=D | identified an individing plan that included in timetables to meet nursing, mental and developed for each 483.25(a)(2) TREATIMPROVE/MAINTAL A resident is given the services to maintain | TMENT/SERVICES TO | F 311 | | 5/13/15 | 5 |
| | by: Based on observat review the facility fa assistive hearing de | ion, interview and document iled to provide the use of an evice in order to maintain or dent's (R43) ability to hear / | | R43 care plan was immediatel updated to include the use of a communication device. 4/23/15 Replacement batteries for communication devices will be stor the nurse s stations and in the act room for easy access for staff to er | ed at ivity | |
| | 2/12/15, identified Fimpairment, modera | imum Data Set (MDS) dated R43 had severe cognitive ate difficulty hearing, utilized clear speech, was understood | | communication device is functionin appropriately. Completed 5/13/15. 3. Staff was in-serviced on the us maintenance of the Communication device and will ensure that resident communication device is functionin properly, put on and placed on the | g e and n t s g | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---|-----|---|--|----------------------------|
| | | 245579 | B. WING | | | 04/2 | 23/2015 |
| | PROVIDER OR SUPPLIER | ОМЕ | STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | X | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 311 | R43's Care Plan da was at risk for a decimpaired hearing. Trequired moderate to comprehend and related to her hearing identify any assistivimprove R43's hear On 4/20/15, at 5:25 dining room during headphones off her R43 was seated at residents. R43 repended coffle," "Some R43's tablemate's van Reuben and a chifor R43 who was served at Reuben and a chifor R43 who was served as RN-B she had a stoto bed. RN-B asked R43 responded by sunderstanding you, around her neck. Featile while RN-B corresident with their nor and the dining room with covered up by the coprevented R43 from hear the surveyor servented resident with surveyor servented resident resi | ted 4/15/15, indicated R43 cline in socialization related to he plan identified R43 assistance from activity staff participate in group activities ng. R43's care plan failed to e devices to maintain or ing and communication. p.m. R43 was observed in the the evening meal with her head and around her neck. the table with 5 other female eatedly called out "Nurse, I ebody," for 10 minutes. All of were offered a choice between cken salad sandwich except erved a pureed meal. R43 told mach ache and wanted to go I R43 what was wrong and saying "I am not " R43's headphones remained R43 continued to sit at the ontinued to assist another | F3 | 311 | of garments worn and blankets bei used. 4. Activity staff was educated or importance of communication deviet the use and maintenance of communication devies. 5. Activity staff reivewed all care for accuracy for all residents using communication devies. 5. Activity manager or designee withat the communication device is functioning and in place daily for or week and weekly for one month an review these results with Quality Assurance committee for further monitoring recommendations. | n the es and e plans vill audit | |

PRINTED: 06/02/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--|-----|---|-------------------------------|----------------------------|
| | | 245579 | B. WING | | | 04/2 | 23/2015 |
| | PROVIDER OR SUPPLIER | | | 11 | TREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET GRACEVILLE, MN 56240 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 311 | observed in the hawith R43 seated in R43's headphones and telling R43, "It to get these fixed. to day room and leand headphones in the At 10:07 a.m. R4during a group base group. R43 did no Before ball was to "Ready [R43's nar proceeded to toss had a surprised reaway. -At 10:25 a.m. the A-A proceeded to their rooms. R43 reaway. -At 10:25 a.m. the A-A proceeded to their rooms. R43 rear ing at the wall to her. R43 stated hear today." When the music, R43 stated hear today. When the did not hear her of the activity room for the activity room for the activity room for members were proceeded in the proceeded to their rooms. R43 rear today. When the music, R43 stated hear today. When the did not hear her of the activity room for the activity ro | rity (A)-A staff member was allway outside of R43's room in wheelchair. A-A was holding is and speaker box in her hand The batteries are dead, we need "A-A proceeded to wheel R43 heave the area with speaker box | F3 | 311 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION IG | ` ' | TE SURVEY MPLETED |
|--------------------------|--|---|---------------------|---|--------|----------------------------|
| | | 245579 | B. WING _ | | 04 | /23/2015 |
| | PROVIDER OR SUPPLIER | OME | | STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240 | , , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 311 | laughing with each resident seated new understand what the resident replied, sh | ge 18 ded. Staff were observed other when R43 asked a kt to her if she could e staff were saying, the e did not. R43 stated I cant the resident responded, "your | F 3 | 11 | | |
| | -At 10:43 a.m. R43 this." | stated "I don't appreciate | | | | |
| | headphones. Nine the activity. At this to brought the headph stated he would see R43 stated "I can't head phones from placed them on R4 around her neck or | remained without her other residents were noted in time, another employee had nones to the activity room and a them on top of the fridge. See or hear." A-A grabbed the the top of the fridge and 3's head and the speaker box a a lanyard and stated, "They es." R43 stated, "You get used | | | | |
| | room. The speaker R43's quilted jacke | 143 was observed in the dining box was observed tucked into t and was also covered up with did not respond to this s. | | | | |
| | day area in front of headphones in plac observed on her lap | was observed in the south the TV without her ee. The headphones were a along with the speaker box. the window and not watching | | | | |

PRINTED: 06/02/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | | E SURVEY PLETED |
|--------------------------|--|--|--------------------|-----|---|------|----------------------------|
| | | 245579 | B. WING | | ···· | 04/: | 23/2015 |
| | PROVIDER OR SUPPLIER | OME | | 1 | TREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET BRACEVILLE, MN 56240 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | X | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 311 | Continued From pa | ge 19 | F3 | 811 | | | |
| | table sorting socks. covered by her quilt pushed up to the ta unable to detect my hanging from the la abdomen and did n was pushed up to the clothing or napkins surveyor "I cant heapicked up the device R43 stated she like were comfortable. If | was observed in day area at a R43's speaker box was ted jacket and she was ble. The speaker box was a voice. The speaker box myard hung just to R43's ot detect voices when she he table, or it was covered by R43 repeatedly told the ar you." After the surveyor e and spoke directly into it, d the earphones and they R43 stated, "I don't hear that ear phones on, and it just wear them either." | | | | | |
| | (NA)-C stated R43 headphones and pole headphones/pocked devices utilized for R43. She confirme times, but could only | 2:42 p.m. nursing assistant could not hear without the ocket talker. She stated the talker were the only adaptive enhanced communication with d R43 attended activities at ly hear the activity when she vices. She stated R43 always during the day. | | | | | |
| | the pocket talker de left ear was better t R43 was able to sta food choices. She hear staff or had tro | 2:54 p.m. D-A stated R43 used evice, read lips and that R43's han her right. She also stated ate her likes and was offered also stated if R43 could not buble understanding them they ing device otherwise, they did yone uses it." | | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | E CONSTRUCTION | | E SURVEY PLETED |
|--------------------------|---|---|--------------------|-----|--|------|----------------------------|
| | | 245579 | B. WING | | | 04/: | 23/2015 |
| | PROVIDER OR SUPPLIER | | | 11 | TREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET RACEVILLE, MN 56240 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 311 | to speak into her of her a motion. She without the pocked would take R43's always have them 04/23/2015 2:49:5 (LPN)-A stated the R43 was to use he talker because R4 stated she just hawere able to tell if told them "I cant hwore the headpho R43 hardly ever to didn't have her he what's going on in her headphones F say, "I cant hear y On 04/23/2015, at (RN)-A confirmed was not on R43's added it "today." I interventions for F and check her ear would expect R43 all activities or ma check the batterie knew when the batterie knew when the batterie knew the cant hear. RN quarterly and annu (IDT) assessed ear | 12:57 p.m. NA-B stated we try levice, and sometimes we give stated R43 could not hear talker. She also stated staff neadphones off so R43 did not | F | 311 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` , | | STRUCTION | | E SURVEY PLETED |
|--------------------------|--|--|--------------------|---------|---|------|----------------------------|
| | | 245579 | B. WING | | | 04/: | 23/2015 |
| | PROVIDER OR SUPPLIER IA HEALTH GRACE H | OME | | 116 WES | ADDRESS, CITY, STATE, ZIP CODE ST SECOND STREET EVILLE, MN 56240 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 311 | wax. She stated R4 without the device a without her pocket knew they were suptalker because it was her room. RN-A statknew how to use it how to use the devicenterventions was to checks. She stated a little better. On 04/23/2015, at A R43's hearing was working pretty good He stated R43 did redevice. He stated stalker. FM-A stated could do. FM-A stated could do. FM-A stated rowear the heastill had some interestill had some int | necking the residents ears for 3 would not be able to hear and would not hear activities talker. She stated the staff oposed to use the pocket as kept on her night stand in ted she did not know how staff as they were not educated on ce. RN-A stated R43's hearing of use the device and ear wax the device helped R43 to hear at the device hear him at all without the he always used the pocket it was about the best they are dit would be a good idea for device it would be a good idea for device in some of the activities hass / church. FM-A stated without the headphones. 4:55 p.m. the director of the device hear her. She stated there was exhipt the device batteries and or staff to know they were device if it was not identified the DON confirmed the staff ated on the use or | F 3 | .11 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | IPLE CONSTRUCTION | | | E SURVEY PLETED |
|--------------------------|--|---|--------------------|--|--|-----|----------------------------|
| | | 245579 | B. WING | | | 04/ | 23/2015 |
| | PROVIDER OR SUPPLIER | IOME | | STREET ADDRESS, C 116 WEST SECOND GRACEVILLE, MN | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH COP | R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 311 F 431 SS=F | with Hearing Impair facility would improfor the hearing impalso identified the fathe residents hearing functioning. The facility's "Use of that the care plan is resident's daily care available to staff peresponsibility for prothe residents. The facility's "Compidentified an individing plan that included in timetables in order nursing, mental and developed for each 483.60(b), (d), (e) ELABEL/STORE DR | wed titled, "Communication red or Deaf," identified the ve the care and quality of life aired residents. The policy acility would routinely checking device to insure proper of Care Plan Policy," identified thall be used in developing the eroutine and would be ersonnel who had the oviding care and services to orehensive Care Plan Policy," ualized comprehensive care measurable objectives and to meet the resident's medical, dipsychosocial needs was resident. | F 3 | | | | 5/19/15 |
| | controlled drugs in accurate reconciliate records are in orde controlled drugs is reconciled. Drugs and biological | sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be nee with currently accepted | | | | | |

| - | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---------------------|---|---|--|
| | | 245579 | B. WING | | 04/23/2015 | |
| | PROVIDER OR SUPPLIER | НОМЕ | | STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLÉTION | |
| F 431 | Continued From pa | age 23 | F 431 | | | |
| | appropriate access | oles, and include the sory and cautionary se expiration date when | | | | |
| | facility must store a locked compartme | State and Federal laws, the all drugs and biologicals in nts under proper temperature it only authorized personnel to keys. | | | | |
| | permanently affixed controlled drugs list Comprehensive Dr Control Act of 1976 abuse, except whe package drug distr | rovide separately locked, d compartments for storage of ted in Schedule II of the rug Abuse Prevention and and other drugs subject to in the facility uses single unit ibution systems in which the ninimal and a missing dose can I. | | | | |
| | by: Based on observa review, the facility is medical supplies a 1 of 4 medication s the potential to affe the facility. In addit document the use emergency kit (E-k | tion, interview and document failed to remove expired stock vailable for use by residents in storage rooms/carts which had ect all 39 residents residing in ion the facility failed to of medications from the Kit) which lacked en the padlock was broken / kit | | Broken E-kit locks accounted for documentation was present on the pharmacy reorder sheet and not on correct Emergency drug box record sheet. The emergency drug box record was updated. 4/20/15 Updates to the Emergency Drug Box policy include specific instruction. When an emergency drug, antibiotic stat medication is needed, or lock is removed for any reason, the following should be completed: a) The nurse breaks the Drug Box. | the flow cord ug ons: c or | |

PRINTED: 06/02/2015 FORM APPROVED OMB NO. 0938-0391

| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
|--------------------------|--|--|--------------------|-----|--|--|----------------------------|
| | | 245579 | B. WING | | | 04/2 | 23/2015 |
| | PROVIDER OR SUPPLIER | ОМЕ | | 1 | TREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET GRACEVILLE, MN 56240 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 431 | storage room tour variations from the practical nurse (LP) red, numerically convite the Emergency Record reveled the should have been at the red padlock on 211057. The report medication had been the Kit. After identific correct, LPN-A rem confirmed contents confirm the findings LPN-A confirmed the padlock which security in the security of the padlock which security is not the security of the padlock which security is not the security of the padlock which security is not the security of the padlock which security is not the security of the padlock which security is not the security of the padlock which security is not the security of the padlock which security is not the security of the padlock which security is not the security of the padlock which security is not the security of the padlock which security is not the security of the padlock which security is not the security of the | p.m. the North medication was conducted with licensed N)-A. During the tour, the E-Kit ded padlock was reconciled and Drug Box Record. The red padlock on the E-Kit box 211055. After further review of the E-Kit was noted to be lacked two entries that en removed or replaced from ying the red padlock was not oved the red padlock, and notified the pharmacy to be including and stated the red and stated it was wrong. | FΔ | 131 | medication, (if applicable) b) Place new padlock on the drug c) Record New padlock # on the sheet in the EDB Binder. d) Complete the following steps addirected: I. In the EDB Binder Document th Reason for breaking the lock on the sheet (ie: Lasix IM removed/or repla audit completed, etc., etc.) and fill in other required information as well. II. Complete the pharmacy order sits entirety. Fax copy to the pharmac Lewis drug fax #748-7228. III. Make one copy of the pharmac slip. Copy goes in Pharmacy outboriginal goes to the office with broke padlock attached - Attn: DON or designee. IV. DON or Designee will maintain count of three (3) padlocks available EDB supply at the North Station. | log s ne e log aced; n all slip in acy y order ox. The en | |
| | pharmacist confirm documentation that removed or replace been documented or red padlock was bropharmacist stated to coding system directly padlock with a number when the E-Kit was removed. The phar should have documentation that is the padrock with a number that is the pharmacist confirmation of the pharmacis | 4/20/15, at 3:05 p.m. the ed the report lacked medications had been ad from the E-Kit and had not on the report form of when the oken or replaced. The he red padlock numerical cted staff to replace the erically sequenced manner opened and the lock macist also verified the facility tented each time the padlock he medication accessed or | | | 2. Reviewed Medication- Emerge Drug Box policy and procedure with licensed- staff during meetings held 5/13, 1:1 and standup meetings. 3. DON, Consulting Pharmacist of designee will complete monthly aud Emergency drug box usage/ flow sto ensure policy and procedure was consistently documented and paddo system is used in numerical order. The results will be reviewed with the Quant Assurance Committee for further monitoring recommendations. 5. Expired 2X2 dressings and stead gloves removed immediately from the staff of th | r d 5/11- r dits of neets s ocking These ality | |

During interview on 4/20/15, at 3:30 p.m. the

treatment cart 4/23/15.

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | | E SURVEY PLETED |
|--------------------------|--|---|--------------------|-----|--|--------------------------------|----------------------------|
| | | 245579 | B. WING | | ····· | 04/2 | 23/2015 |
| | PROVIDER OR SUPPLIER | ОМЕ | | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 431 | and verified each ti staff should have d removal or replaced. Review of facility por Medication-Emerge indicated when an estat medication was containers seal (paperscribed medicat nurse records their form kept in the box binder. The facility failed to medical supplies from the supplies from the facility failed to medical supplies from the failed from | DON confirmed the findings me the padlock was broken ocumented the access and ment of the medications. Dlicy titled, ency Drug Box, dated 7/30/09, emergency drug, antibiotic or seneded, the nurse broke the adlock) and removed the ion. As soon as possible, the nediation used on the triplicate of and on the log sheet in the example of the treatment cart. Do a.m. the medication storage ducted with registered nurse four, the treatment cart had a difference of twenty nine Kendal 2 x 2 in a expiration date of 1/15, of Anseel Derma Prene Iso es with an expiration date of ges of Anseel Derma Prene Iso es | F 4 | 131 | 6. All contents in the treatment can checked for expiration dates. As we supply room. Completed 4/25/15. 7. DON or designee will review expiration dates of products in treatment cart monthly. Tracking log is located the treatment cart. Started 4/25/15. 8. Quality Assurance Committee review tracking log for any further recommendations. | ell as tment ed on 5. | |
| | | expired medical supplies in | | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | FIPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
|--------------------------|--|--|---|---|---------|----------------------------|
| | | 245579 | B. WING _ | | 04 | /23/2015 |
| | PROVIDER OR SUPPLIER | OME | STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 431 | been removed, repl followed the facility | nd stated they should have aced and staff should have policy and removed them. | F 4: | 31 | | |
| F 441 SS=D | was not provided. | n 4/23/15, at 11:00 and one | F 44 | 41 | | 5/13/15 |
| | Infection Control Pr safe, sanitary and c | tablish and maintain an ogram designed to provide a omfortable environment and development and transmission otion. | | | | |
| | Program under whice (1) Investigates, continuous in the facility; (2) Decides what proshould be applied to | tablish an Infection Control ch it - ntrols, and prevents infections ocedures, such as isolation, o an individual resident; and ord of incidents and corrective | | | | |
| | determines that a reprevent the spread isolate the resident. (2) The facility must communicable dise from direct contact direct contact will track (3) The facility must | ion Control Program esident needs isolation to of infection, the facility must reprohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. require staff to wash their rect resident contact for which | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION NG | | E SURVEY PLETED |
|--------------------------|--|--|---------------------|--|---|----------------------------|
| | | 245579 | B. WING | | 04/ | 23/2015 |
| | PROVIDER OR SUPPLIER | OME | | STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 441 | professional practic (c) Linens Personnel must ha | | F 4 | 41 | | |
| | by: Based on observareview the facility fahygiene during the | NT is not met as evidenced tion, interview and document, alled to ensure adequate hand provision of personal cares for observed during and after | | Reviewed and updated the H washing / Hand hygiene policy 5/ Updates to the policy includadding the procedure/ steps for completing appropriate hand was Policy also specificly lists after prassistance with bathing. Staff re-educated on appropriate than the practical state. | 8/15. ed hing. oviding | |
| | During observation nursing assistant (Na whirlpool bath. For observed to donne up, apply barrier concerned the gloves. Stand by assistance bedroom with a four room, NA-A was obtain the dentures with water dentures and place NA-A removed the applied lipstick to Fistand by assistance dining room, NA-A dining room, NA-A | on 4/22/15, at 8:36 a.m. NA)-A was observed giving R8 ollowing the bath NA-A was gloves, instruct R8 to stand eam to R8's buttocks and NA-A proceeded to provide as R8 ambulated back to her r wheeled walker. Once in the observed to enter R8's pair of gloves, rinse R8's r, apply Fixodent cream on the d the dentures in R8's mouth. gloves, combed R8's hair and the dentures in R8's mouth. It is she walker. Once seated in the placed a clothing protector on banana and handed it to R8. | | washing. Reviewed Hand washin hygiene policy at meetings 5/11-5 1:1, standup meetings. 3. Hand sanitizer dispensers ace each tub rooms 5/13/15. 4. DON or designee with complication observational hand wash audits on nursing staff on all shift review results with infection contraction committee and Quality Assurance further recommendations. | ng/ Hand n/13/15, ded to ete ing s and ol | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION NG | | E SURVEY IPLETED |
|--------------------------|--|---|---------------------|---|------------------------------|----------------------------|
| | | 245579 | B. WING | | 04/ | 23/2015 |
| | PROVIDER OR SUPPLIER | OME | | STREET ADDRESS, CITY, STATE, ZIP 116 WEST SECOND STREET GRACEVILLE, MN 56240 | <u> </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 441 | station and washed between the provisi gloves did NA-A wa -At 8:56 a.m. NA-A hands after removin provision of R8's ca have washed her ha | ing room, went to the nurses her hands. At no time on of cares or removal of the | F 4 | 41 | | |
| | On 4/23/15, at 10:4 (DON) stated staff shefore and after wo completing cares at The DON stated NA hands each time she especially after app | Hygiene reviewed 12/17/09, | | | | |
| | | sh their hands after removal of use of gloves did not replace d hygiene. | | | | |

PRINTED: 05/20/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE SURVEY COMPLETED

245579

B. WING

04/21/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| | IA HEALTH GRACE HOME | | RACEVILLE, MN 56240 | |
|------------------------|--|---------------------|--|----------------------------|
| X4) ID REFIX 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 |
| 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 CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. | | | |
| | UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT 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 substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. | | | |
| | PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS | | EPOC | |
| | STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or | | | |

Electronically Signed

05/15/2015

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.

Facility ID: 00762

PRINTED: 05/20/2015 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION 01 - MAIN BUILDING 01 | V / | E SURVEY PLETED |
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PRINTED: 05/20/2015 FORM APPROVED OMB NO. 0938-0391

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| | PROVIDER OR SUPPLIER IA HEALTH GRACE H SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From pa NOT MET as evide NFPA 101 LIFE SA Generators are insunder load for 30 n accordance with N This STANDARD NFPA 101 (2000) REGULATION - Go weekly and exercis 30% of the EPS na per month and sha 99 (1999 edition) a This STANDARD is Based upon a staff available records, for the exercis document weekly i May 2014 for the exercise or other emergence | PROVIDER OR SUPPLIER TA HEALTH GRACE HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in | PROVIDER OR SUPPLIER TA HEALTH GRACE HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 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Facility ID: 00762



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered May 6, 2015

Mr. Kevin Gish, Administrator Essentia Health Grace Home 116 West Second Street Graceville, Minnesota 56240

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5579025

Dear Mr. Gish:

The above facility was surveyed on April 20, 2015 through April 23, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Essentia Health Grace Home May 6, 2015 Page 2

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 Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 06/02/2015 FORM APPROVED

(X6) DATE

Minnesota Department of Health

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | 144A.10, this correspursuant to a surver found that the deficiency herein are not correspond to corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess | nether a violation has been | | | | |
| | that may result fron orders provided tha the Department with notice of assessment | hearing on any assessments non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance. | | | | |
| | receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s | participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are | | | | |

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 05/15/15

TITLE

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
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Minnesota Department of Health

STATE FORM 88VH11 If continuation sheet 2 of 33

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
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| | PLAN OF CORREC | QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES. | | | | |
| 2 302 | MN State Statute 1 or related disorder | 44.6503 Alzheimer's disease train | 2 302 | | | 5/11/15 |
| | ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144 | | | | | |
| | Alzheimer's disease or related of segregated or gene care staff | ity serves persons with disorders, whether in a eral unit, the facility's direct rs must be trained in dementia | | | | |
| | related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, the trained, the frequent topics covered. | of Alzheimer's disease and activities of daily living; with challenging behaviors; | | | | |
| | This MN Requireme | ent is not met as evidenced | | | | |

Minnesota Department of Health

STATE FORM 88VH11 If continuation sheet 3 of 33

| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240 CAN ID CAN | STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| by: Based on interview and document review, the facility failed to ensure consumers were provided in a written or electronic form, a description of facility staff training for the care of residents with demential/Alzheimer's, categories of staff trained, frequency of training and topics covered in the training. This had the potential to affect all 39 residents residing in the facility and / or resident representatives/families. Findings include: The facility's current admission packet was reviewed, which included facility services provided and multiple documents given to a new resident upon admission. The admission packet did not include information regarding the Alzheimer's disease training program. During interview on 4/23/15, at 10:00 a.m. the director of nursing confirmed the facility had not informed their consumers of the Alzheimer's training information regarding the Alzheimer's training information regarding the Alzheimer's disease by the Alzheimer's disease to the addinistrator or designee could add information regarding the Alzheimer's disease | PREFIX | (EACH DEFICIENCY | / MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO | D BE | COMPLETE |
| admission packet for consumer information. The quality assurance committee could design a monitoring system to ensure compliance. | 2 302 | by: Based on interview facility failed to ensin a written or electricality staff training dementia/Alzheime frequency of trainin training. This had the residents residing in representatives/fam. Findings include: The facility's curren reviewed, which incorprovided and multiperesident upon admidid not include infor Alzheimer's disease. During interview on director of nursing of informed their constraining information. SUGGESTED MET The Administrator of information regarding and dementia required admission packet for quality assurance of the constraining information. | and document review, the ure consumers were provided ronic form, a description of for the care of residents with r's, categories of staff trained, g and topics covered in the repotential to affect all 39 in the facility and / or resident nilies. It admission packet was eluded facility services ble documents given to a new ssion. The admission packet reation regarding the retraining program. 4/23/15, at 10:00 a.m. the confirmed the facility had not umers of the Alzheimer's in written or electronic form. THOD OF CORRECTION: or designee could adding the Alzheimer's disease rements into the resident or consumer information. The ommittee could design a | 2 302 | 1. A Notice to Residents and Far has been developed informing res responsible parties of the requiren provide all direct care staff training explains Alzheimer's Disease/ Der assistance with activities of daily li problem- solving challegnging behand communicatin skills. 2. The Notice to Residents and Fis now included in every admission as of 5/4/15. The same notice wil mailed to the responsible party for current residents. Completed 5/13. The Notice to Residents and Fis was given annually to each reside responsible party at every care concluded between January 1 and Marce each calendar year, or as an altern will be mailed to the responsible party at every care concluded between January 1 and Marce each calendar year, or as an altern will be mailed to the responsible party at every care concluded between January 1 and Marce each calendar year, or as an altern will be mailed to the responsible party at every care concluded by the Social Dept. 4. The Social Service Dept. will a report annually to the Quality Assucommittee identifying the percent compliance for giving the Notice to Residnts and Families to all new admissions and the responsible party and mailed to all new admissions and the responsible party and mailed to all new admissions. The goal is 1000 | idents/ nent to g which mentia, ving, naviors, families n pack I be fall I/15. families nt/ nference h 31 of native it arty at Service submit a urance of o | |

Minnesota Department of Health

STATE FORM 88VH11 If continuation sheet 4 of 33

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| | (21) days. | | | | | |
| 2 560 | MN Rule 4658.0409 Plan of Care; Conte | 5 Subp. 2 Comprehensive ents | 2 560 | | | 5/13/15 |
| | comprehensive plate objectives and time long- and short-term and mental and psylidentified in the contassessment. The compassion of the contast include the includ | of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, rchosocial needs that are aprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b). | | | | |
| | by: Based on interview facility failed to deve plan that included the (anti-coagulant) for reviewed for non-praddition, the facility comprehensive car assistive hearing dereviewed for comm | and document review, the elop a comprehensive care ne daily use of Coumadin 1 of 3 resident (R7) who was ressure related skin issues. In failed to develop a e plan for the use of an evice for 1 of 1 resident (R43) unication and observed liker hearing device. | | 1. R7 care plan was immediately updated for anticoagulant medicat These medications increase the rispotential side effects such as bruisbleeding. Completed 4/23/15 2. Reviewed Care plan policy wit management and staff during mee 5/11-5/13/15, 1:1, standup meeting 3. Reviewed medication list of all residents and identified everyone medications with anticoagulant typ | ion use. sk for sing/ h etings gs. I receiving | |
| | Finding include: | | | properties, and then reviewed that appropriate care plans were in pladocumented these results on a spreadsheet. Completed 5/7/15 | | |
| | Anticoagulant: | | | 4. Nurses completing monthly I Rounds will audit the Anticoagulan | | |
| | indicated R7 was diabetes and deme | er Report dated, 4/16/15, lagnosed with atrial fibrillation, ntia. The report also indicated a anti-coagulant medication | | medication use spreadsheet to sec care plans are in place for all resid receiving anticoagulant medication ensure appropriate care plan chan | e that lents ns and | |

Minnesota Department of Health

| AND DIAN OF CORRECTION INDENTIFICATION NUMBER: | | ` , | LE CONSTRUCTION | (X3) DATE : COMPI | | |
|--|---|--|--|--|---|--------------------------|
| | | 00762 | B. WING | | 04/2 | 3/2015 |
| | PROVIDER OR SUPPLIER | OME 116 WEST | DRESS, CITY, S SECOND S LLE, MN 56 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRES OF THE APPROPRIED TO THE A | D BE | (X5) COMPLETE DATE |
| 2 560 | p.m. and 7:00 p.m. Review of R7's care identify the use of a fibrillation nor did the effects and monitor related to the medic Coumadin was not During interview on of nursing confirme Coumadin for atrial medication was not DON also stated "a developed when sh During interview on registered nurse (R currently receiving and verified the me R7's care plan. RN-had been a care pla Coumadin and their bruising and bleedin Hearing Device: R43's quarterly Min 2/12/15, identified F impairment, modera hearing aides, had | rams (MG) daily between 5:00 for atrial fibrillation. e plan, dated 1/14/15, did not an anti-coagulant for the atrial e plan include potential side ing of bruising/bleeding cation use. The use of addressed on the care plan. 4/22/15, at 3:58 p.m. director d R7 was currently receiving fibrillation and verified the addressed on R7's care plan. care plan should have been e went on Coumadin." 4/23/15, at 4:16 p.m. N)-A confirmed R7 was Coumadin for atrial fibrillation dication was not addressed on A also stated "there should an developed for the use of r would be monitoring for | 2 560 | have been made. This will be start next scheduled rounds on 5/14/15. 5. Anticoagulant care plan added admission packets to see that anticoagulant care plan is put in pladmission of all new admissions of all new admissions of anticoagulant medications. Comple 4/28/15. 6. Quarterly the audit results will reviewed with Quality Assurance Committee for any further recommendatins. 7. R43 care plan was immediate updated to include the use of a communication device 4/23/15. 8. Activity staff reviewed care plase that hearing devices are approximate approximate approximate planned. Activity manager of designee will continue quarterly most care plan documentation for activity manager. | d to ace on ecciving eted be ly ans to oppriately onitoring | |

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Minnesota Department of Health STATE FORM

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | | D 14/11/0 | | | |
| | | 00762 | B. WING | | 04/2 | 3/2015 |
| NAME OF | PROVIDER OR SUPPLIER | | , , | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH GRACE H | OME | SECOND S LLE, MN 56 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 560 | Continued From pa | ge 6 | 2 560 | | | |
| | was at risk for a de impaired hearing. T required moderate to comprehend and related to her heari R43's assistive head device and any pre | ated 4/15/15, indicated R43 cline in socialization related to The plan identified R43 assistance from activity staff I participate in group activities ng. The facility failed to identify uring device, correct use of the ventative maintenance 143's hearing device on her | | | | |
| | dining room during headphones off her R43 was seated at residents. R43 repended coffle," "Some told registered nurs ache and wanted to what was wrong an am not understand remained around h | p.m. R43 was observed in the the evening meal with her head and around her neck. the table with 5 other female eatedly called out "Nurse, I bebody," for 10 minutes. R43 to (RN)-B she had a stomach to go to bed. RN-B asked R43 d R43 responded by saying "I ing you." R43's headphones er neck. R43 continued to sit N-B continued to assist th their meal. | | | | |
| | the dining room wit by R43's clothing p from hearing. R43 | 31 a.m. R43 was observed in h the speaker box covered up rotector that prevented R43 was unable to hear me. RN-B u use her pocket talker, R43 | | | | |
| | observed in the hal with R43 seated in | ity staff person (A)-A was lway outside of R43's room the wheelchair. A-A was phones and speaker (talk) box | | | | |

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED | |
|--|---|--|------------------------|--|-----------------|--------------------------|
| | | 00762 | B. WING | | 04/2 | 3/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH GRACE H | OME | SECOND S LLE, MN 56 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 2 560 | in her hand and tell dead, we need to g R43 to the day roor speaker box and he -At 10:07 a.m. R43 during a group ball group. R43 did not Before A-A tossed t "Ready [R43's nam proceeded to toss t reacted in a surpris ball away. | ing R43, "The batteries are et these fixed." A-A wheeled in and left the area with the eadphones in hand. was observed in the day room activity. A-A was leading the have the headphones on. The ball to R43 she stated, e]?" R43 did not respond. A-A he ball to R43 in which R43 ed manner and swatted the | 2 560 | | | |
| | their rooms. R43 restaring at the wall. It to her. R43 stated, hear today." When the music, R43 state entered the day rool like to go with her a R43 did not hear he R43 to the activity ractivity. -At 10:35 a.m. R43 end of a long table headphones on. Ot members were prewith or to R43. R43 and no one respondaughing with each resident seated new understand what the | wheel other residents back to emained in the activity room, Polka music was playing next "For some reason, I can't R43 was asked if she liked and get her fingernails painted, ar or respond. She wheeled soom for the nail painting was observed seated at the in the activity room without her her residents and staff sent however, no one spoke asked if the wind was blowing ded. Staff were observed other when R43 asked a kt to her if she could e staff were saying, the e did not. R43 stated I cant | | | | |

Minnesota Department of Health

STATE FORM 88VH11 If continuation sheet 8 of 33

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---|--|-------------------------------|--------------------------|
| | | 00762 | B. WING | | 04/2 | 23/2015 |
| | PROVIDER OR SUPPLIER | OME 116 WEST | DRESS, CITY, S F SECOND S ILLE, MN 56 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| 2 560 | hear anymore and not the only one." | the resident responded, "your | 2 560 | | | |
| | this." | stated "I don't appreciate | | | | |
| | headphones. Nine the activity. At this to brought the headph stated he would set R43 stated "I can't head phones from placed them on R4 around her neck or | remained without her other residents were noted in time, another employee had nones to the activity room and them on top of the fridge. See or hear." A-A grabbed the the top of the fridge and 3's head and the speaker box a lanyard saying, "They es." R43 stated, "You get used | | | | |
| | room. The speaker R43's quilted jacke | 143 was observed in the dining box was observed tucked into t and was also covered up with did not respond to this s. | | | | |
| | day area in front of headphones in plac her lap along with t | was observed in the south the TV without her se. The headphones were on the speaker box. R43 was ow and not watching the TV. | | | | |
| | the table sorting so covered by her quil pushed up to the ta | vas observed in day area at cks. R43's speaker box was ted jacket and she was ble. The speaker box was voice. The speaker box | | | | |

Minnesota Department of Health

STATE FORM 88VH11 If continuation sheet 9 of 33

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| | | | | | | |
| | | 00762 | B. WING | | 04/2 | 3/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH GRACE H | OME | r SECOND S LLE, MN 56 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 2 560 | hung from the lanyadid not detect voice the table or it was on R43 repeatedly start you." After the surve spoke directly into the liked the earphones R43 stated, "I don't ear phones on, and wear them either." On 4/23/2015, at 12 (NA)-C stated R43 headphones and posterior beautifized for R43. She stated R during the day. On 4/23/2015, at 12 used the pocket tall R43's left ear was astated if R43 could understanding them device otherwise, the everyone uses it." 04/23/2015 2:49:54 (LPN)-A stated the R43 was to use her talker and that R43 talker. She stated woran't hear and will sunderstand you." | ard to R43's abdomen and it as when R43 was pushed up to covered by clothing or napkins. Ited to the surveyor "I cant hear eyor picked up the device and the talk box, R43 stated she and they were comfortable. The hear that good even with the lit just doesn't work to not a lit just doesn't work to not hear staff or had trouble and they would use the hearing ney did not use it, "not a licensed practical nurse best way to communicate with a lit just doesn't hear better with her pocket without her headphones R43 say, "I cant hear you, or I cant licensed practical nurse say, "I cant hear you, or I cant literation and pocket without her headphones R43 say, "I cant hear you, or I cant literation and pocket without her headphones R43 say, "I cant hear you, or I cant literation and pocket without her headphones R43 say, "I cant hear you, or I cant literation and pocket without her headphones R43 say, "I cant hear you, or I cant | 2 560 | | | |
| | On 04/23/2015, at 3 | 3:25 p.m. RN-A confirmed | | | | |

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STATE FORM 88VH11 If continuation sheet 10 of 33

| STATEMEN | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER | | COME | | (X3) DATE | SURVEY LETED |
|--------------------------|---|--|------------------------|---|-----------|--------------------------|
| | | | A. BUILDING: | | | |
| | | 00762 | B. WING | | 04/2 | 3/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH GRACE H | OME | SECOND S LLE, MN 56 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 560 | Continued From page 10 | | 2 560 | | | |
| | was not on the care it. RN-A stated the R43 was to use the | ecket talker / hearing device e plan and she had just added only hearing interventions for pocket talker and check her stated R43 would not be able device. | | | | |
| | | 4:55 p.m. the director of ed she would have expected R43's care plan. | | | | |
| | The facility's "Use of Care Plan Policy," identified that the care plan shall be used in developing the resident's daily care routine and would be available to staff personnel who have the responsibility for providing care and services to the residents. | | | | | |
| | identified an individ plan that included n timetables to meet | prehensive Care Plan Policy," ualized comprehensive care neasurable objectives and the resident's medical, d psychosocial needs would be resident. | | | | |
| | administrator or des policies and provide development of cor administrator or des | THOD OF CORRECTION: The signee could review and revise e staff education related to the imprehensive care plans. The signee could develop and order to ensure compliance. | | | | |
| | TIME PERIOD FOR | R CORRECTION: Twenty-One | | | | |

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| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | E CONSTRUCTION (| (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|--------------------------|---|-------------------------------|--------------------------|
| | | 00762 | B. WING | | 04/23/2015 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, | STATE, ZIP CODE | | |
| ESSENT | TA HEALTH GRACE H | OME | T SECOND S LLE, MN 56 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETE DATE |
| 2 560 | Continued From pa | ge 11 | 2 560 | | | |
| | (21) days. | | | | | |
| 2 915 | MN Rule 4658.052 | 5 Subp. 6 A Rehab - ADLs | 2 915 | | | 5/13/15 |
| | comprehensive res home must ensure A. a resident is treatments and ser abilities in activities deterioration is a not the resident's condipart, activities of da resident's ability to: (1) bathe, dres (2) transfer an (3) use the toil (4) eat; and (5) use speech | given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of ition. For purposes of this illy living includes the as, and groom; d ambulate; | | | | |
| | by: Based on observati review the facility fa assistive hearing de enhance 1 of 1 resi communicate. Findings include: R43's quarterly Min | ent is not met as evidenced on, interview and document ailed to provide the use of an evice in order to maintain or dent's (R43) ability to hear / | | 1. R43 care plan was immediately updated to include the use of a communication device. 4/23/15 2. Replacement batteries for communication devices will be store the nurse s stations and in the actir room for easy access for staff to encommunication device is functioning appropriately. Completed 5/13/15. 3. Staff was in-serviced on the use maintenance of the Communication device and will ensure that resident | ed at vity sure g | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|-----------------------|--|---|--------------------------|
| | | 00762 | B. WING | | 04/2 | 3/2015 |
| | PROVIDER OR SUPPLIER | OME 116 WEST | DRESS, CITY, SECOND S | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 915 | impairment, modera hearing aides, had by others and was a trisk for a decimpaired hearing. Trequired moderate to comprehend and related to her hearing identify any assistiv improve R43's hear On 4/20/15, at 5:25 dining room during headphones off her R43 was seated at residents. R43 repended coffle," "Some R43's tablemate's van Reuben and a chifor R43 who was serenced coffle," "Some R43's tablemate's van Reuben and a chifor R43 who was serenced coffle," "Some R43's tablemate's van Reuben and a chifor R43 who was serenced coffle," "Some R43's tablemate's van Reuben and a chifor R43 who was serenced by sunderstanding you." around her neck. Fitable while RN-B coresident with their nor the dining room with | ate difficulty hearing, utilized clear speech, was understood usually understood by others. Ited 4/15/15, indicated R43 cline in socialization related to the plan identified R43 assistance from activity staff participate in group activities ng. R43's care plan failed to e devices to maintain or ring and communication. p.m. R43 was observed in the the evening meal with her head and around her neck. The table with 5 other female eatedly called out "Nurse, I body," for 10 minutes. All of were offered a choice between tecken salad sandwich except erved a pureed meal. R43 told of a R43 what was wrong and saying "I am not" R43's headphones remained R43 continued to assist another | 2 915 | communication device is functioning properly, put on and placed on the of garments worn and blankets be used. 4. Activity manager or designee that the communication device is functioning and in place daily for on and weekly for one month and revithese results with Quality Assurant committee for further monitoring recommendations. | e outside eing will audit one week view | |
| | hear the surveyor s | n hearing. R43 was unable to peak to her. RN-B stated, r pocket talker, [R43] can't | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|-----------------------------|---|-------------------------------|--------------------------|
| | | 00762 | B. WING | | 04/2 | 23/2015 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | |
| ESSENT | IA HEALTH GRACE H | OME | T SECOND S' ILLE, MN 562 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETE DATE |
| 2 915 | Continued From pa | ge 13 | 2 915 | | | |
| | observed in the hall with R43 seated in R43's headphones and telling R43, "Th to get these fixed." | y (A)-A staff member was way outside of R43's room wheelchair. A-A was holding and speaker box in her hand be batteries are dead, we need A-A proceeded to wheel R43 ave the area with speaker box her hands. | | | | |
| | during a group ball group. R43 did not Before ball was tos "Ready [R43's nam proceeded to toss t | was observed in the day room activity. A-A was leading the have the headphones on. sed to R43, A-A stated to R43, e]?" R43 did not respond. A-A he ball to R43 in which R43 ction and swatted the ball | | | | |
| | A-A proceeded to we their rooms. R43 restaring at the wall. It to her. R43 stated, hear today." When the music, R43 statentered the day roollike to go with her adid not hear her or the state of the st | group ball activity was over. wheel other residents back to mained in the activity room, Polka music was playing next "For some reason, I can't R43 was asked if she liked ed "I can't hear you." A-B m and asked R43 if she would nd get her nails painted, R43 respond. A-B wheeled R43 to r the nail painting activity. | | | | |
| | end of a long table headphones on. Ot members were pres | was observed seated at the in the activity room without her her residents and staff sent however, no one spoke asked if the wind was blowing | | | | |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | | | (3) DATE SURVEY COMPLETED | |
|---|--|---|--------------------------|---|-------|------------------------------|--|
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| | | 00762 | B. WING | | 04/2 | 3/2015 | |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | | |
| ESSENT | IA HEALTH GRACE H | OME | r SECOND S LLE, MN 56 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE | |
| 2 915 | and no one respond laughing with each resident seated new understand what the resident replied, she hear anymore and the not the only one." -At 10:43 a.m. R43 this." -At 10:46 a.m. R43 theadphones. Nine of the activity. At this the brought the headphones from the placed them on R44 around her neck on needed new batterito not hearing." -At 12:15:45 p.m. Recommended in the placed them on R44 around her neck on needed new batterito not hearing." -At 12:15:45 p.m. Recommended in the placed in the plac | ded. Staff were observed other when R43 asked a kt to her if she could e staff were saying, the e did not. R43 stated I cant the resident responded, "your stated "I don't appreciate remained without her other residents were noted in ime, another employee had iones to the activity room and them on top of the fridge. See or hear." A-A grabbed the the top of the fridge and 3's head and the speaker box a lanyard and stated, "They es." R43 stated, "You get used the did not respond to this see." A43 was observed in the dining box was observed tucked into a and was also covered up with did not respond to this se. | 2 915 | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | |) DATE SURVEY COMPLETED | |
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| | | | | | | | |
| | | 00762 | B. WING | | 04/2 | 3/2015 | |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | | |
| ESSENT | IA HEALTH GRACE H | OME | r SECOND S LLE, MN 56 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE | |
| 2 915 | Continued From page 15 | | 2 915 | | | | |
| | table sorting socks. covered by her quilt pushed up to the ta unable to detect my hanging from the la abdomen and did n was pushed up to t clothing or napkins surveyor "I cant heapicked up the device R43 stated she like were comfortable. I | vas observed in day area at a . R43's speaker box was ted jacket and she was .ble. The speaker box was y voice. The speaker box anyard hung just to R43's not detect voices when she he table, or it was covered by . R43 repeatedly told the ar you." After the surveyor se and spoke directly into it, d the earphones and they R43 stated, "I don't hear that ear phones on, and it just wear them either." | | | | | |
| | On 4/23/2015, at 12:42 p.m. nursing assistant (NA)-C stated R43 could not hear without the headphones and pocket talker. She stated the headphones/pocket talker were the only adaptive devices utilized for enhanced communication with R43. She confirmed R43 attended activities at times, but could only hear the activity when she was wearing the devices. She stated R43 always utilized the devices during the day. On 4/23/2015, at 12:54 p.m. D-A stated R43 used the pocket talker device, read lips and that R43's left ear was better than her right. She also stated R43 was able to state her likes and was offered food choices. She also stated if R43 could not hear staff or had trouble understanding them they would use the hearing device otherwise, they did not use it, "not everyone uses it." | | | | | | |
| | On 4/23/2015, at 12 | 2:57 p.m. NA-B stated we try | | | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|---------------------|--|-------|--------------------------|
| | | 00762 | B. WING | | 04/2 | 3/2015 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| FSSENT | IA HEALTH GRACE H | OME | SECOND S | | | |
| | TATILALITI GITAGE II | GRACEVI | LLE, MN 56 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 2 915 | Continued From pa | ge 16 | 2 915 | | | |
| | her a motion. She s without the pocket t | evice, and sometimes we give stated R43 could not hear alker. She also stated staff eadphones off so R43 did not on. | | | | |
| | (LPN)-A stated the R43 was to use her talker because R43 stated she just had were able to tell if the told them "I cant he wore the headphon R43 hardly ever too didn't have her head what's going on in a her headphones R44 | p.m. licensed practical nurse best way to communicate with head phones and pocket heard better with them. She pocket talker to use and staff ne battery was dead when R43 ar you." LPN-A stated R43 e most of the time. She stated ok them off. She stated if R43 dphones on she couldn't hear activities. She added, without 13 couldn't hear and would u, or I cant understand you." | | | | |
| | (RN)-A confirmed F was not on R43's candded it "today." R interventions for R4 and check her ears would expect R43 tall activities or massischeck the batteries knew when the batt wearing the device she cant hear. RN-quarterly and annual (IDT) assessed earstated they assessed to the resident or chwax. She stated R4 | 8:25 p.m. registered nurse R43's use of the hearing device are plan and that she had just N-A stated the only hearing 3 was to use the pocket talker for wax. RN-A stated she o have the device on when at s. She stated staff did not on R43's device because they ery was dead when R43 was and would respond by saying A stated on admission, ally the interdisciplinary team the residents hearing. RN-A ed resident hearing by talking necking the residents ears for 3 would not be able to hear and would not hear activities | | | | |

Minnesota Department of Health

STATE FORM 88VH11 If continuation sheet 17 of 33

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|--|--|-------|--------------------------|
| | | 00762 | B. WING | | 04/2 | 23/2015 |
| | PROVIDER OR SUPPLIER | OME 116 WEST | DRESS, CITY, S SECOND S LLE, MN 56 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 915 | without her pocket knew they were sup talker because it was her room. RN-A staknew how to use it how to use the devinterventions was to | ge 17 talker. She stated the staff oposed to use the pocket as kept on her night stand in ted she did not know how staff as they were not educated on ce. RN-A stated R43's hearing o use the device and ear wax the device helped R43 to hear | 2 915 | | | |
| | On 04/23/2015, at 4:04:34 p.m. FM-A stated R43's hearing was very bad and the device was working pretty good, better than hearing aides. He stated R43 did not hear him at all without the device. He stated she always used the pocket talker. FM-A stated it was about the best they could do. FM-A stated it would be a good idea for her to wear the headphones to activities as R43 still had some interest in some of the activities and also enjoyed mass / church. FM-A stated R43 could not gear without the headphones. | | | | | |
| | nursing (DON) state the device to be on she has tried to talk and R43 could not no process for chec there was no way for suppose to use the | | | | | |
| | with Hearing Impair | wed titled, "Communication red or Deaf," identified the ve the care and quality of life | | | | |

Minnesota Department of Health

STATE FORM 88VH11 If continuation sheet 18 of 33

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|--|--|------|--------------------------|
| | | 00762 | B. WING | | 04/2 | 3/2015 |
| | PROVIDER OR SUPPLIER | OME 116 WEST | DRESS, CITY, S SECOND S LLE, MN 56 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 915 | for the hearing impa also identified the fa the residents hearing functioning. The facility's "Use of that the care plan so resident's daily care available to staff pe | ge 18 aired residents. The policy acility would routinely checking device to insure proper of Care Plan Policy," identified thall be used in developing the eroutine and would be rounded the poviding care and services to | 2 915 | | | |
| | identified an individ plan that included n timetables in order | orehensive Care Plan Policy," ualized comprehensive care neasurable objectives and to meet the resident's medical, d psychosocial needs was resident. | | | | |
| | The director of nursinservice staff regalmaintenance of assensure complaince perform routine obs | THOD OF CORRECTION: sing (DON), or designee, could rding the use and sistive hearing devices. To the DON or designee could servational audits to ensure the opropriatly and are in working | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | |

6899

| Minneso | finnesota Department of Health | | | | | | |
|--------------------------|--|--|--|---|-------------------------------|--------------------------|--|
| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
| | | 00762 | B. WING | | 04/23/2015 | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, § | STATE, ZIP CODE | | | |
| | | 116 WEST | SECOND S | | | | |
| ESSENT | ESSENTIA HEALTH GRACE HOME GRACE | | | 240 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDENCY) | D BE | (X5) COMPLETE DATE | |
| 21375 | Continued From pa | ige 19 | 21375 | | | | |
| 21375 | MN Rule 4658.0800 Subp. 1 Infection Control; Program | | 21375 | | | 5/13/15 | |
| | home must establis control program de sanitary environme | | | | | | |
| | by: Based on observati review the facility fa hygiene during the | ent is not met as evidenced ion, interview and document, ailed to ensure adequate hand provision of personal cares for observed during and after | | Reviewed and updated the Hand washing / Hand hygiene policy 5/8/15. Staff re-educated on appropriate hand washing. Reviewed Hand washing/ Hand hygiene policy at meetings 5/11-5/13/15, 1:1, standup meetings. Hand sanitizer dispensers added to | | | |
| | Findings include: | | | each tub rooms 5/13/15.4. DON or designee with comple | te | | |
| | During observation on 4/22/15, at 8:36 a.m. nursing assistant (NA)-A was observed giving R8 a whirlpool bath. Following the bath NA-A was observed to donne gloves, instruct R8 to stand up, apply barrier cream to R8's buttocks and remove the gloves. NA-A proceeded to provide stand by assistance as R8 ambulated back to her bedroom with a four wheeled walker. Once in the room, NA-A was observed to enter R8's bathroom, donne a pair of gloves, rinse R8's dentures with water, apply Fixodent cream on the dentures and placed the dentures in R8's mouth. NA-A removed the gloves, combed R8's hair and applied lipstick to R8 lips. NA-A provided R8 stand by assistance as she ambulated to the dining room with the walker. Once seated in the dining room, NA-A placed a clothing protector on R8's lap, pealed a banana and handed it to R8. NA-A exited the dining room, went to the nurses | | | each tub rooms 5/13/15. 4. DON or designee with complete random observational hand washing audits on nursing staff on all shifts a review results with infection control committee and Quality Assurance for further recommendations. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|---------------------|--|------|--------------------------|
| | | 00762 | B. WING | | 04/2 | 3/2015 |
| NAME OF | PROVIDER OR SUPPLIER | | DRESS, CITY, S | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH GRACE H | OME | LLE, MN 56 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21375 | Continued From pa | ge 20 | 21375 | | | |
| | | her hands. At no time ion of cares or removal of the ish her hands. | | | | |
| | hands after removing provision of R8's can have washed her half gloves and confirm wash their hands be | verified she did not wash her ng the gloves following the ares. NA-A stated she should ands after removing the ed staff were instructed to efore and after working with with each glove change. | | | | |
| | (DON) stated staff | 4 a.m. the director of nursing should wash their hands orking with a resident, after and when they remove gloves. A-A should have washed her ne removed her gloves olying the barrier cream. | | | | |
| | directed staff to was | Hygiene reviewed 12/17/09, sh their hands after removal of use of gloves did not replace | | | | |
| | The director of nurs educate staff on ap the provison of care | THOD OF CORRECTION: sing (DON) or designee could propriate hand hygiene during es. The DON or designee om observational audits to | | | | |
| | TIME PERIOD FOR | R CORRECTION: Twenty-one | | | | |

6899

| Minnesota Department of Health | | | | | | |
|--------------------------------|--|--|---------------------|--|--|--------------------------|
| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 00762 | B. WING | | 04/2 | 3/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH GRACE H | IC)ME | SECOND S | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21375 | Continued From pa | ige 21 | 21375 | | | |
| | (21) days | | | | | |
| 21600 | MN Rule 4658.1335 Subp. 2 Stock Medications; Emergency Supply | | 21600 | | | 5/13/15 |
| | nursing home may medication supply the QAA committee | have an emergency which must be approved by e. The contents, maintenance, ergency medication supply eart 6800.6700. | | | | |
| | by: Based on observation review, the facility for the use of medication emergency kit (E-K documentation when | ent is not met as evidenced ion, interview and document ailed to document and track ons from and access of the (it) which lacked en the padlock was broken / kit wo separate occasions. | | 1. Broken E-kit locks accounted documentation was present on the pharmacy reorder sheet and not o correct Emergency drug box recorsheet. The emergency drug box r was updated. 4/20/15 2. Reviewed Medication- Emergency drug box records a support of the control of | e in the rd flow ecord ency | |
| | Findings include: | | | Drug Box policy and procedure willicensed-staff during meetings he 5/13, 1:1 and standup meetings. 3. DON, Consulting Pharmacist | ld 5/11- | |
| | storage room tour variations (LPI red, numerically cowith the Emergency Record reveled the should have been 2 the red padlock on 211057. The report medication had been the Kit. After identific correct, LPN-A rem confirmed contents | ip.m. the North medication was conducted with licensed N)-A. During the tour, the E-Kit ded padlock was reconciled y Drug Box Record. The red padlock on the E-Kit box 211055. After further review of the E-Kit was noted to be lacked two entries that en removed or replaced from ying the red padlock was not oved the red padlock, and notified the pharmacy to s. During this observation, | | designee will complete random au Emergency drug box usage/ flow sensure policy and procedure was consistently documented and pad system is used in numerical order results will be reviewed with the Q Assurance Committee for further monitoring recommendations. 5. Expired 2X2 dressings and stegloves removed immediately from treatment cart 4/23/15. 6. All contents in the treatment contected for expiration dates. As we supply room. Completed 4/25/15. | dits of sheets to locking. These uality erile the art were vell as | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|-----------------------|---|-------------------------------|--------------------------|
| | | 00762 | B. WING | | 04/2 | 3/2015 |
| | PROVIDER OR SUPPLIER | OMF 116 WEST | DRESS, CITY, SECOND S | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 21600 | LPN-A confirmed the padlock which secumatched the report. During interview on pharmacist confirm documentation that removed or replace been documented or red padlock was bropharmacist stated tooding system direct padlock with a num when the E-Kit was removed. The phar should have docum was removed and to replaced. During interview on director of nursing I and verified each timestaff should have do removal or replacer. Review of facility portion Medication-Emergent indicated when an estat medication was containers seal (paperscribed medication was records the medication was containers seal (paperscribed medication was containers to the medication was contained to the medication was con | ne findings and stated the redured the E-Kit should have and stated it was wrong. 4/20/15, at 3:05 p.m. the ed the report lacked medications had been ed from the E-Kit and had not on the report form of when the oken or replaced. The he red padlock numerical cted staff to replace the erically sequenced manner opened and the lock macist also verified the facility tented each time the padlock he medication accessed or 4/20/15, at 3:30 p.m. the DON confirmed the findings me the padlock was broken ocumented the access and ment of the medications. | 21600 | 7. DON or designee will review expiration dates of products in tre cart monthly. Tracking log is loca the treatment cart. Started 4/25/18. Quality Assurance Committee review tracking log for any further recommendations. | ited on 15. will | |

Minnesota Department of Health

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE | SURVEY LETED |
|--------------------------|--|--|------------------------|---|-----------|--------------------------|
| 7.1.12 . 27.11 | o. co20 | | A. BUILDING: | | | |
| | | 00762 | B. WING | | 04/2 | 3/2015 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH GRACE H | OME | SECOND S LLE, MN 56 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21600 | The administrator, of designee could reviprocedures to ensumedication use was the padlock locking numerically coding administrator, conscould perform rand ensure compliance | consultant pharmacist or iew and revise policies and re E-Kit access and s consistently documented and system was utilized in the fashion as directed. The ultant pharmacist or designee om observational audits to | 21600 | | | |
| 21980 | (21) days. | .557 Subd. 3 Reporting - | 21980 | | | 5/26/15 |
| | reporter who has revulnerable adult is lead or who has knowled has sustained a phyreasonably explained information to the condividual is a vulned the individual is addreporter is not required. | of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult ysical injury which is not ed shall immediately report the ommon entry point. If an erable adult solely because mitted to a facility, a mandated ired to report suspected e individual that occurred prior is: | | | | |
| | another facility and believe the vulneral previous facility; or (2) the reporter k that the individual is in section 626.5572 | as admitted to the facility from the reporter has reason to ble adult was maltreated in the mows or has reason to believe a vulnerable adult as defined 2, subdivision 21, clause (4). required to report under the | | | | |

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|---|---|------------------------------|---|-------------------------|--|
| | | 00762 | B. WING | | 04/23/2015 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | ORESS, CITY, S | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH GRACE H | OME | SECOND S LLE, MN 56 | | | |
| (X4) ID PREFIX TAG | RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLETE | |
| 21980 | as described above (c) Nothing in this known or suspected knows or has reason been made to the condition (d) Nothing in this reporter from also reason to believe the 626.5572, subdivisi (5), occurred must subdivision. If the retime believes that a agency will determine the reported error with the criteria under set 17, paragraph (c), of acility may provided directly to the lead a how the event mee 626.5572, subdivisi (5). The lead ager information when more than the report under sufficient with the report under sufficient | ection may voluntarily report expection requires a report of dispersion requires a report of dispersion to know that a report has sommon entry point. It is section shall preclude a reporting to a law enforcement reporter who knows or has reporter who knows or has reporter who knows or has reporter or under section on 17, paragraph (c), clause make a report under this reporter or a facility, at any an investigation by a lead reporter or a facility, at any an investigation by a lead reporter or expected for the common entry point or reporter | 21980 | 1. When made aware of the un-rinjury of suspicious origin, a Vulne Adult Incident report was filed with and the facility administrator was in on 4.22.14. 2. A subsequent internal investig. | rable MDH nformed | |
| | Finding include: | - | | was conducted and the report filed MDH, CEP, APS, and the Ombuds 5.1.15. 3. It was the conclusion of the | l with | |

Minnesota Department of Health

STATE FORM 88VH11 If continuation sheet 25 of 33

| IVIIIIIICSC | Minnesota Department of Health | | | | | | |
|--------------------------|---|--|--|---|--|--|--|
| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
| | | 00762 | B. WING | | | | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| ESSENT | IA HEALTH GRACE H | IOME 116 WEST | SECOND S | TREET | | | |
| LOOLINI | GRACE | | | 240 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLETE | | |
| 21980 | Continued From pa | ge 25 | 21980 | | | | |
| | (MDS) dated 1/27/1 cognitively intact, refor bed mobility, lim transfers and exten | nange Minimum Data Set 15, identified R31 was equired supervision of one staff lited assistance of one staff for asive assistance of one staff for and personal hygiene. | | investigator was not able to say will certainty what or who, if anybody, was ource of the injury, nor how the injury, nor how the injury event report fell through the cracks was not reviewed by the IDP team Corrective action included coaching nursing regarding behaviors and particularly how best to assist residence the risk of bruises or skin to | was the itial s and . g dents to | | |
| | "bruise to forearm s symptoms of infecti present." 4/4/15, re forearm have nearly | ogress note dated 3/5/15, read still visible. No signs and ion and no open areas ad bruised area on right y faded with no defined larker area of skin noted on rm. No open areas. | | The IDP team now have available computer generated report that list events occurring since the they las which enables them to better spot incident of abuse or neglect. This reviewed by the IDP Team daily exweek-ends and holidays. 4. Notice was received from MDI no further action was needed at the | a ts ts tr met possible report is cept for | | |
| | Review of R31's ev 2:44 p.m. revealed to his right arm whice centimeters (cm) are with slight swelling. origin of the bruise "he got it (bruise) from the night." Further more measures were response, the physical and the car report also indicate medical doctor immedical doctor immedical doctor immedical doctor immedical systems. | re plan dated, 3/3/14, revealed in right forearm. ent report dated, 3/3/15, at R31 had a bruise on forearm ch measured 16 x 13 and was reddish/blue in color. The report also indicated the was unknown and R31 stated om 2 women in the middle of review of the report revealed taken to the residents ician nor R31's family was the plan was not reviewed. The distaff would notify the nediately by phone or beeper ving: bruising of unknown ciated with moderate to severe or loss of range of motion and ated with known incident. | | on 5.7.15. 5. Licensed staff was re-educat Vulnerable Adult policy and reporti process during scheduled meeting 5/11-5/13/15, stand up meetings, a meetings followed by competency evaluations. 5. Vulnerable Adult Policy was reviewed 5/8/15. 6. IDP team will review weekly month (5/26/15) for any incidents t should have been reported under to policy, but were not these results were viewed by Quality Assurance Co for further monitoring recommendations. | for one hat the VA will be mmittee | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|---|------------------------|--|-------------------|--------------------------|
| | | | 71. BOILDING. | | | |
| | | 00762 | B. WING | | 04/2 | 3/2015 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH GRACE H | IC)ME | SECOND S LLE, MN 56 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21980 | Continued From pa | age 26 | 21980 | | | |
| | director of nursing was of unknown or SA nor investigated recall the injury and reported. At 12:13 a resident had a signification or signification of the SA and report and thorough been competed and that no one was no | A 4/22/15, at 12:10 p.m. the (DON) confirmed the bruise igin and was not reported to d. The DON stated she did not d assumed it did not get p.m. the DON confirmed when gnificant bruise of unknown immediately reported." The dministrator should have been oft, a report should have been d was not and an incident in investigation should have d was not. The DON confirmed tified and that she did not even lise to R31's right forearm. | | | | |
| | social worker (SW) the bruise of unkno not get reported to confirmed that he w right away if there w | 1 4/22/15, at 12:13 p.m. the stated she "vaguely" recalled own origin and confirmed it did the SA. The SW also would have reported the bruise was no explanation of how it also reported as a vulnerable | | | | |
| | registered nurse (Rabout the bruise an reported to the adm and they all should | A 4/22/15, at 12:54 p.m. RN)-A stated she did not know and confirmed it did not get ministrator, DON, SW nor SA have been notified. When lation was completed RN-A now of." | | | | |
| | assistant (NA)-D co | n 4/22/15, at 1:25 p.m. nursing onfirmed R31 had a large forearm and stated "I cant | | | | |

Minnesota Department of Health

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| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|---------------------|---|-------------------|--------------------------|
| | | 00762 | B. WING | | 04/2 | 3/2015 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | 1 0 ./- | 0,2010 |
| ESSENT | IA HEALTH GRACE H | OME | SECOND S | | | |
| 0/0.15 | CLIMMA DV CTA | TEMENT OF DEFICIENCIES | LLE, MN 56 | | ONI | ()(5) |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| 21980 | Continued From pa | ge 27 | 21980 | | | |
| | recall what they said happened or how he got it." NA-D also verified that she would report any bruising to the nurse right away. | | | | | |
| | confirmed R31 had forearm and stated | 4/22/15, at 1:21 p.m. NA-E a large bruise on his right "I was told about it in report." hat she would have reported it y. | | | | |
| | practical nurse (LPI large bruise on his did not know how h it happened. LPN-A suspicious bruise o ask the resident who will be the suspicious bruise of the suspicious bru | 4/22/15, at 1:45 p.m. licensed N)-A confirmed R31 had a right forearm and stated she e got it nor anyone saying how a stated if she found a f unknown origin she would at happened, talk to the report it to the DON and report. | | | | |
| | Vulnerable Adult Podirected staff to repincident of actual or resident or of any reinjury which was not be reported in accostatute. The policy any suspected abus vulnerable adult impropersion who was | olicy titled, Grace Home olicy, reviewed on 4/3/14, ort and investigate any resident who had sustained and treasonably explained shall rd with MN. Vulnerable Adult also directed staff to report se, neglect, exploitation of a mediately to his /her responsible to report the ately to the administrator or | | | | |
| | | HOD OF CORRECTION: director of nursing or social | | | | |

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | | SURVEY LETED | | |
|--|---|--|------------------------|--|--------------------|--------------------------|--|
| | | | A. BUILDING: | A. Bollbird. | | | |
| | | 00762 | B. WING | | 04/2 | 3/2015 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | | |
| ESSENT | IA HEALTH GRACE H | OME | SECOND S LLE, MN 56 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETE DATE | |
| 21980 | policies and proced investigating allegatinjuries of unknown director of nursing of incident reports to e thorough investigation | ge 28 all staff members on the ures for reporting and tions of mistreatment and / or origin. The administrator, or social worker could audit ensure timely reporting and ons were completed. | 21980 | | | | |
| 21995 | Maltreatment of Vul Subd. 4a. Interna (a) Each facility sho ongoing written pro applicable licensing of suspected maltre facility has an internal mandated reporter requirements of this internally. However responsible for come reporting requirements. This MN Requirements of this internally in the same policy and procedure facility failed to impose policy and procedure notifying the administrand thoroughly investigations. | reporting of maltreatment. all establish and enforce an ocedure in compliance with rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting section by reporting r, the facility remains uplying with the immediate | 21995 | Vulnerable Adult Policy reviewe 5/8/15. Nursing staff re-educated on Vulnerable Adult policy and reportin process during scheduled meeting 5/11-5/13/15, stand up meetings, a meetings followed by competency evaluations The IDP team now have availa | ng s ınd 1:1 | 5/13/15 | |

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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | |
|--------------------------|--|--|------------------------|--|---|--------------------------|
| | | | A. BUILDING. | | | |
| | | 00762 | B. WING | | 04/2 | 3/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH GRACE H | OME | SECOND S LLE, MN 56 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21995 | Vulnerable Adult Podirected staff to repincident of actual or resident or of any reinjury which was not be reported in accostatute. The policy any suspected abust vulnerable adult imsupervisor who was information immedidesignee. R31's significant ch (MDS) dated 1/27/1 cognitively intact, refor bed mobility, limit transfers, extensive toileting, dressing at Review of R31's prestated "bruise to for and symptoms of in present." 4/4/14 staforearm have nearly discoloration, just do most of outer foreat Review of R31's car R31 had a bruise of the residual resi | policy titled, Grace Home policy, reviewed on 4/3/14, nort and investigate any resuspected maltreatment of a resident who had sustained an at reasonably explained shall and with MN. Vulnerable Adult also directed staff to report see, neglect, exploitation of a mediately to his /her responsible to report the ately to the administrator or an ange Minimum Data Set 15, identified R31 was required supervision of one staff for reasonal hygiene. Sogress note dated 3/5/15 rearm still visible. No signs affection and no open areas ated "Bruised area on right y faded with no defined larker, are of skin noted on rm. No open areas." | 21995 | computer generated report that lise events occurring since they last menables them to better spot possilincident of abuse or neglect. This reviewed by the IDP Team daily exweek-ends and holidays. 4. DON, Social Service, or design audit event and incident reports to timely reporting and thorough investigations were completed and review results with Quality Assura Committee for further recommendations. | net which oble report is except for gnee will o ensure d will nce | |
| | | R31 had a bruise on forearm | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|---------------------|--|------|--------------------------|
| | | 00762 | B. WING | | 04/2 | 3/2015 |
| NAME OF | PROVIDER OR SUPPLIER | | DRESS, CITY, S | STATE, ZIP CODE | 04/2 | .5/2015 |
| | IA HEALTH GRACE H | OME 116 WEST | SECOND S | TREET | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21995 | to his right arm whicentimeters (cm) at with slight swelling. origin of the bruise "he got it (bruise) from the night." Further more measures were response, the physical notified and the car report also indicate medical doctor immore for any of the follow origin, bruise associated as welling, and all large bruise associated by the follow origin, and instruction or follows of unknown or stated she did not get reported administrator should not, a report should and was not and ar investigation should was not. The DON | ch measured 16 x 13 and was reddish/blue in color. The report also indicated the was unknown and R31 stated om 2 women in the middle of review of the report revealed taken to the residents ician nor R31's family was a plan was not reviewed. The d staff would notify the nediately by phone or beeper ring: bruising of unknown stated with moderate to severe or loss of range of motion and atted with known incident. 4/22/15, at 12:10 p.m. the (DON) confirmed the bruise gin and was not reported to nor investigated. The DON ecall the injury and assumed it d. At 12:13 p.m. the DON esident had a significant origin, it should be ed." The DON verified the d have been notified and was a have been made to the SA incident report and thorough d have been competed and confirmed that no one was e did not even know about the | 21995 | | | |
| | social worker (SW) the bruise of unkno not get reported to | 4/22/15, at 12:13 p.m. the stated she "vaguely" recalled wn origin and confirmed it did the SA. The SW also yould have reported the bruise | | | | |

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| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--|--|-------|--------------------------|
| | | 00762 | B. WING | | 04/2 | 3/2015 |
| | PROVIDER OR SUPPLIER | OME 116 WEST | DRESS, CITY, S SECOND S LLE, MN 56 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| 21995 | right away if there was acquired and a adult. During interview on registered nurse (Rabout the bruise an reported to the admand that they all show When asked if an in RN-A stated "not the During interview on assistant (NA)-D cobruise on his right for recall what they said NA-D also verified to bruising to the nurs. During interview on confirmed R31 had forearm and stated NA-E also verified to (bruising) right away. During interview on practical nurse (LPI large bruise on his indid not know how hit happened. LPN-Asuspicious bruise or ask the resident who | vas no explanation of how it also reported as a vulnerable 4/22/15, at 12:54 p.m. N)-A stated she did not know d confirmed it did not get hinistrator, DON, SW nor SA bould have been notified. Investigation was completed at I know of." 4/22/15, at 1:25 p.m. nursing performed R31 had a large orearm and stated "I cant d happened or how he got it." that she would report any e right away. 4/22/15, at 1:21 p.m. NA-E a large bruise on his right "I was told about it in report." hat she would have reported it | 21995 | DEFICIENCY) | | |
| | complete an event | | | | | |

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

| STATEMENT OF DEFICIENCIES | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|----------------------------|--|-------------------------------|--------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NOWBER. | A. BUILDING: | | COMP | LETED |
| | | 00762 | B. WING | | 04/2 | 3/2015 |
| 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLETE | |
| 21995 | Continued From page 32 | | 21995 | | | |
| | The director of nursing develop and implementated to timely repailegations of mistrounknown origin. The assurance committed audits to ensure committed to the committed of the c | THOD FOR CORRECTION: sing (DON) or designee could nent policies and procedures corting and investigating eatment and injuries of e quality assessment and ee could perform random mpliance. R CORRECTION: Twenty (21) | | | | |

Minnesota Department of Health