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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 88VH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00762

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245579**
2.STATE VENDOR OR MEDICAID NO.
(L2) **030525100**

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

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/14/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE NEII 07/20/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/19/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/02/2015
(L33)

DETERMINATION APPROVAL

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 Meath

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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.

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 Meath

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 Meath

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245579	A. Building B. Wing	7/14/2015

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0441** Reg. # **483.65** LSC	**07/13/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GA/mm	07/21/2015	32600	07/14/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/23/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00762	A. Building B. Wing	7/14/2015

Name of Facility	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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp. 1** LSC	**07/13/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GA/mm	08/19/2015	32600	07/14/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/23/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Protecting, Maintaining and Improving the Health of Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On July 14, 2015,

I, _____, _____, received
(Name)(Please Print) (Title)(Please Print)
the Notice of Penalty Assessment dated July 16, 2015 and licensing orders issued to:

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

The Penalty Assessments and licensing orders attached hereto have been corrected as of July 14, 2015.

Signed: _____, _____, Date _____
(Name)(Please Print) (Title)(Please Print)

DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE

On July 14, 2015,

I, _____, _____, of the Division of
(Name)(Please Print) (Title)(Please Print)
Compliance Monitoring, Minnesota Department of Health, delivered the Notice of Penalty Assessment dated July 16, 2015 and issued to:

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

The Notice of Penalty Assessment was handed to _____,
(Name)(Please Print)
_____, Date _____
(Title)(Please Print)

Signed: _____, _____, Date _____
(Name)(Please Print) (Title)(Please Print)

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 88VH

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

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

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

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

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/17/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Denise Erickson, HFE NEII — 07/09/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 07/09/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/15/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/02/2015
(L33)

DETERMINATION APPROVAL

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.

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

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:

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245579	A. BUILDING _____ B. WING _____	R 06/17/2015

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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 6/17/15. The certification tags that were corrected can be found on the CMS2567B. Also there are tag/s that were not found corrected and/or new tags were issued at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}	GA 07/09/15 mm	
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	{F 441}		7/13/15

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

Electronically Signed | 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245579	A. BUILDING _____ B. WING _____	R 06/17/2015

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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 1 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. 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.	{F 441}	It is current Policy and Procedure for all Essentia Health Grace Home nursing assistants to follow proper infection control procedures including proper hand hygiene at the appropriate times. NA-A and NA-B were educated on proper hand hygiene. All Nursing Assistants will be educated at mandatory meetings 7/8/15 regarding proper hand hygiene. An Audit of nursing assistants will occur regarding 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245579	A. BUILDING _____ B. WING _____	R 06/17/2015

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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 2 -At 1:44 p.m. NA-A donned gloves to both hands, while NA-B proceeded to put the transfer belt around R14's waist. NA-A or NA-B did not perform hand hygiene prior starting cares for R14. -At 1:46 p.m. with the use of the transfer belt and wheeled walker, NA-A and NA-B assisted R14 to a standing position and proceeded to assist her to ambulate into the bathroom. R14 stood in front of the toilet, NA-A reached down and pulled R14's pants and dirty incontinent product down her legs and assisted R14 to sit on the toilet. -At 1:48 p.m. with R14 was seated on the toilet, NA-A removed the dirty incontinent product from around R14's knees and placed the incontinent product in the garbage can while NA-B donned gloves on both hands. NA-B applied gloved to her hands, removed a new incontinent product from a nearby cupboard and handed it to NA-A. With the same dirty gloved hands, NA-A immediately reached over and applied the incontinent product to R14's perineal area. NA-A wore the same soiled gloved during the entire observation. -At 1:51 p.m. NA-A and NA-B assisted R14 to stand up from the toilet using the transfer belt around her waist and the front wheeled walker. NA-A proceeded to complete perineal cares for R14 with her left gloved hand and stated R14 had a bowel movement smear. NA-A continued to clean R14's perineal area, then immediately pulled up R14's incontinent product and pants with the same 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 procedure. -At 1:54 p.m. NA-A and NA-B removed their gloves, threw them in the garbage located in the	{F 441}	7/13/15. DON will report these auditing findings to Quality Assurance Performance Improvement committee on 7/20/15. With assured compliance the frequency of audits will decrease to 2X/ wk for 1 month. Then monthly X 2 months and report to Quality Assurance Performance Improvement committee on 10/19/15 for any further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245579	A. BUILDING _____ B. WING _____	R 06/17/2015

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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 3	{F 441}		

bathroom, then NA-A proceeded to wheel R14 out into the hallway to the south nurses station. NA-A and NA-B then walked behind the south nurses station and proceeded to wash their hands.
NA-A wore the same dirty gloves during the entire observation while toileting and perineal cares were performed for R14.

During interview on 6/17/15 at 1:59 p.m. NA-A confirmed she wore the same gloves the entire time while performing perineal cares for R14 and stated "I usually take them off after is do peri cares, I should have removed my gloves and washed my hands." NA-A also verified she should of taking her gloves off before handling R14's walker, transfer belt and clothing and stated "no this is not good infection control."

During interview on 6/17/25 at 2:04 p.m. director of nursing (DON) confirmed she expected staff to remove their gloves after performing perineal cares and to wash their hands before performing any other tasks with the resident and stated "the gloves should have been removed, this is not good infection control practice."

Review of facility policy titled, Hand Washing And Hand Hygiene, revised on 5/8/15, directed staff to wash their hands before and after direct contact with residents/patients, after contact with blood, body fluids, secretions, mucous membranes, or non intact skin, after removing gloves and after handling items potentially contaminated with blood, body fluids, or secretions.

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245579	A. Building B. Wing	6/17/2015

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA 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	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **05/26/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **05/29/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **05/13/2015**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **05/13/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **05/26/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GA/mm	06/25/2015	31256	06/17/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/23/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245579	A. Building / B. Wing: 01 - MAIN BUILDING 01	5/21/2015

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0144	05/14/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/mm	Date: 06/25/2015	Signature of Surveyor: 34764	Date: 05/21/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 4/21/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

Gail Anderson, Unit Supervisor
Licensing and Certification Program
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**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 88VH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00762

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245579**
2.STATE VENDOR OR MEDICAID NO.
(L2) **030525100**

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

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/23/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE NEII 05/26/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/02/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

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

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

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

DEPARTMENT CONTACT

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245579	A. BUILDING _____ B. WING _____	04/23/2015

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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		5/26/15

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

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.

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the administrator and Stage agency (SA) and complete a thorough investigation for injuries of unknown origin for 1 of 1 resident (R31) with a significant bruise of unknown origin. Finding include: R31's significant change Minimum Data Set (MDS) dated 1/27/15, identified R31 was cognitively intact, required supervision of one staff for bed mobility, limited assistance of one staff for transfers and extensive assistance of one staff for toileting, dressing and personal hygiene. Review of R31's progress note dated 3/5/15, read "bruise to forearm still visible. No signs and	F 225	1. When made aware of the un-reported bruise of suspicious origin, a Vulnerable Adult Incident report was filed immediately with MDH and the faciltiy administrator was informed on 4.22.14. 2. A subsequent internal investigation was conducted and the report filed with MDH, CEP, APS, and the Ombudsman on 5.1.15. 3. It was the conclusion of the investigator was not able to say with any certainty what or who, if anybody, was the source of the injury, nor how the initial event report fell through the cracks and was not reviewed by the IDP team. Corrective action included coaching nursing regarding behaviors and particularly how best to assist residents to reduce the risk of bruises or skin tears. The IDP team now have available a computer generated report that lists	

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F 225	Continued From page 2 symptoms of infection and no open areas present." 4/4/15, read bruised area on right forearm have nearly faded with no defined discoloration, just darker area of skin noted on most of outer forearm. No open areas. Review of R31's care plan dated, 3/3/14, revealed R31 had a bruise on right forearm. Review of R31's event report dated, 3/3/15, at 2:44 p.m. revealed R31 had a bruise on forearm to his right arm which measured 16 x13 centimeters (cm) and was reddish/blue in color with slight swelling. The report also indicated the origin of the bruise was unknown and R31 stated "he got it (bruise) from 2 women in the middle of the night." Further review of the report revealed no measures were taken to the residents response, the physician nor R31's family was notified and the care plan was not reviewed. The report also indicated staff would notify the medical doctor immediately by phone or beeper for any of the following: bruising of unknown origin, bruise associated with moderate to severe pain swelling, and /or loss of range of motion and large bruise associated with known incident. During interview on 4/22/15, at 12:10 p.m. the director of nursing (DON) confirmed the bruise was of unknown origin and was not reported to SA nor investigated. The DON stated she did not recall the injury and assumed it did not get reported. At 12:13 p.m. the DON confirmed when a resident had a significant bruise of unknown origin, it should be immediately reported." The DON verified the administrator should have been	F 225	events/ incidents to better spot possible incident of abuse or neglect. This report is reviewed by the IDP Team daily except for week-ends and holidays this will be reviewed by the DON, or On-Call Charge Nurse to see that VA reports are being filed immediately and timely. 4. Notice was received from MDH that no further action was needed at this time on 5.7.15. 5. Licensed staff was re-educated on Vulnerable Adult policy and reporting process during scheduled meetings 5/11-5/13/15, stand up meetings, and 1:1 meetings followed by competency evaluations. 6. Vulnerable Adult Policy was reviewed 5/22/15. VA policy was revised to include that all suspected incidence of abuse or maltreatment will be reported immediately of being made aware on the incident. Nursing staff will be re-educated on this revision in the policy. 7. Nurses stations computers have Vulnerable Adult file icon placed on them with VA policy and report filing process in them for ease in submitting a report. 8. Laminated VA reporting process reference sheet has been placed in each Charge Nurse book at both Nurses stations to allow easy access to the procedure for reporting. 9. Ombudsman is scheduled to be here 6/9/15 for yearly education for all staff to review Vulnerable Adult and Rights Rights. 10. To ensure that all reports are being filed in a timely manner, DON, Social Service or designee will monitor daily any	

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F 225	Continued From page 3 notified and was not, a report should have been made to the SA and was not and an incident report and thorough investigation should have been competed and was not. The DON confirmed that no one was notified and that she did not even know about the bruise to R31's right forearm. During interview on 4/22/15, at 12:13 p.m. the social worker (SW) stated she "vaguely" recalled the bruise of unknown origin and confirmed it did not get reported to the SA. The SW also confirmed that he would have reported the bruise right away if there was no explanation of how it was acquired and also reported as a vulnerable adult. During interview on 4/22/15, at 12:54 p.m. registered nurse (RN)-A stated she did not know about the bruise and confirmed it did not get reported to the administrator, DON, SW nor SA and they all should have been notified. When asked if an investigation was completed RN-A stated "not that I know of." During interview on 4/22/15, at 1:25 p.m. nursing assistant (NA)-D confirmed R31 had a large bruise on his right forearm and stated "I cant 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. During interview on 4/22/15, at 1:21 p.m. NA-E confirmed R31 had a large bruise on his right forearm and stated "I was told about it in report." NA-E also verified that she would have reported it	F 225	incident reports with the IDP team and audit reports for one quarter and submit these findings for review to Quality Assurance Committee and further monitoring recommendations at the next scheduled QA meeting to ensure that all reports are being filed immediately and timely.	

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F 225	Continued From page 4 (bruising) right away. During interview on 4/22/15, at 1:45 p.m. licensed practical nurse (LPN)-A confirmed R31 had a large bruise on his right forearm and stated she did not know how he got it nor anyone saying how it happened. LPN-A stated if she found a suspicious bruise of unknown origin she would ask the resident what happened, talk to the nursing assistants, report it to the DON and complete an event report. Review of facility policy titled, Grace Home Vulnerable Adult Policy, reviewed on 4/3/14, directed staff to report and investigate any incident of actual or suspected maltreatment of a resident or of any resident who had sustained an injury which was not reasonably explained shall be reported in accord with MN. Vulnerable Adult Statute. The policy also directed staff to report any suspected abuse, neglect, exploitation of a vulnerable adult immediately to his /her supervisor who was responsible to report the information immediately to the administrator or designee.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced	F 226		5/29/15

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F 226	Continued From page 5 by: Based on interview and document review, the facility failed to implement their abuse prevention policy and procedures related to immediately notifying the administrator, the State agency (SA) and thoroughly investigating 1 of 1 resident (R31) with a significant bruise of unknown origin. Finding include: Review of facility policy titled, Grace Home Vulnerable Adult Policy, reviewed on 4/3/14, directed staff to report and investigate any incident of actual or suspected maltreatment of a resident or of any resident who had sustained an injury which was not reasonably explained shall be reported in accord with MN. Vulnerable Adult Statute. The policy also directed staff to report any suspected abuse, neglect, exploitation of a vulnerable adult immediately to his /her supervisor who was responsible to report the information immediately to the administrator or designee. R31's significant change Minimum Data Set (MDS) dated 1/27/15, identified R31 was cognitively intact, required supervision of one staff for bed mobility, limited assistance of one staff for transfers, extensive assistance of one staff for toileting, dressing and personal hygiene. Review of R31's progress note dated 3/5/15 stated "bruise to forearm still visible. No signs and symptoms of infection and no open areas present." 4/4/14 stated "Bruised area on right	F 226	1. Vulnerable Adult Policy reviewed 5/8/15. 2. Nursing staff re-educated on Vulnerable Adult policy and reporting process during scheduled meetings 5/11-5/13/15, stand up meetings, and 1:1 meetings followed by competency evaluations. 5/22/15 VA policy was revised to include that all suspected incidence of abuse or maltreatment will be reported immediately of being made aware on the incident. Staff will be re-educated on this revision of the policy. 3. The IDP team now have available a computer generated report that lists events/ incidents. This report is reviewed by the IDP Team daily except for week-ends and holidays the DON, On-Call Charge nurse or designee will review these reports to see that VA reports are being filed immediately and timely. 4. Ombudsman is scheduled to be here 6/9/15 for yearly education for all staff to review Vulnerable Adult and Rights Rights. 5. Nurses stations computers have Vulnerable Adult file icon placed on them with VA policy and report filing process in them for ease in submitting a report. 6. Laminated VA reporting process reference sheet has been placed in each Charge Nurse book at both Nurses stations to allow easy access to the procedure for reporting. 5. To ensure that all reports are being filed in a timely manner, DON, Social Service or designee will monitor daily any	

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F 226	Continued From page 6 forearm have nearly faded with no defined discoloration, just darker, are of skin noted on most of outer forearm. No open areas." Review of R31's care plan dated, 3/3/14, revealed R31 had a bruise on right forearm. Review of R31's event report dated, 3/3/15, at 2:44 p.m. revealed R31 had a bruise on forearm to his right arm which measured 16 x 13 centimeters (cm) and was reddish/blue in color with slight swelling. The report also indicated the origin of the bruise was unknown and R31 stated "he got it (bruise) from 2 women in the middle of the night." Further review of the report revealed no measures were taken to the residents response, the physician nor R31's family was notified and the care plan was not reviewed. The report also indicated staff would notify the medical doctor immediately by phone or beeper for any of the following: bruising of unknown origin, bruise associated with moderate to severe pain swelling, and /or loss of range of motion and large bruise associated with known incident. During interview on 4/22/15, at 12:10 p.m. the director of nursing (DON) confirmed the bruise was of unknown origin and was not reported to SA / administrator nor investigated. The DON stated she did not recall the injury and assumed it did not get reported. At 12:13 p.m. the DON confirmed when a resident had a significant bruise of unknown origin, it should be immediately reported." The DON verified the administrator should have been notified and was not, a report should have been made to the SA	F 226	incident reports with the IDP team and audit reports for one quarter and submit these findings for review to Quality Assurance Committee and further monitoring recommendations at the next scheduled QA meeting to ensure that all reports are being filed immediately and timely.	

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F 226	Continued From page 7	F 226		

and was not and an incident report and thorough investigation should have been competed and was not. The DON confirmed that no one was notified and that she did not even know about the bruise to R31's right forearm.

During interview on 4/22/15, at 12:13 p.m. the social worker (SW) stated she "vaguely" recalled the bruise of unknown origin and confirmed it did not get reported to the SA. The SW also confirmed that he would have reported the bruise right away if there was no explanation of how it was acquired and also reported as a vulnerable adult.

During interview on 4/22/15, at 12:54 p.m. registered nurse (RN)-A stated she did not know about the bruise and confirmed it did not get reported to the administrator, DON, SW nor SA and that they all should have been notified. When asked if an investigation was completed RN-A stated "not that I know of."

During interview on 4/22/15, at 1:25 p.m. nursing assistant (NA)-D confirmed R31 had a large bruise on his right forearm and stated "I cant 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.

During interview on 4/22/15, at 1:21 p.m. NA-E confirmed R31 had a large bruise on his right forearm and stated "I was told about it in report." NA-E also verified that she would have reported it (bruising) right away.

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F 226	Continued From page 8 During interview on 4/22/15, at 1:45 p.m. licensed practical nurse (LPN)-A confirmed R31 had a large bruise on his right forearm and stated she did not know how he got it nor anyone saying how it happened. LPN-A stated if she found a suspicious bruise of unknown origin she would ask the resident what happened, talk to the nursing assistants, report it to the DON and complete an event report.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279		5/13/15

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F 279	Continued From page 9 Based on interview and document review, the facility failed to develop a comprehensive care plan that included the daily use of Coumadin (anti-coagulant) for 1 of 3 resident (R7) who was reviewed for non-pressure related skin issues. In addition, the facility failed to develop a comprehensive care plan for the use of an assistive hearing device for 1 of 1 resident (R43) reviewed for communication and observed utilizing a pocket talker hearing device. Finding include: Anticoagulant: R7's Physician Order Report dated, 4/16/15, indicated R7 was diagnosed with atrial fibrillation, diabetes and dementia. The report also indicated R7 was prescribed a anti-coagulant medication (Coumadin) 3 milligrams (MG) daily between 5:00 p.m. and 7:00 p.m. for atrial fibrillation. Review of R7's care plan, dated 1/14/15, did not identify the use of an anti-coagulant for the atrial fibrillation nor did the plan include potential side effects and monitoring of bruising/bleeding related to the medication use. The use of Coumadin was not addressed on the care plan. During interview on 4/22/15, at 3:58 p.m. director of nursing confirmed R7 was currently receiving Coumadin for atrial fibrillation and verified the medication was not addressed on R7's care plan. DON also stated "a care plan should have been developed when she went on Coumadin."	F 279	1. R7 care plan was immediately updated for anticoagulant medication use. These medications increase the risk for potential side effects such as bruising/ bleeding. Completed 4/23/15 2. Reviewed Care plan policy with management and staff during meetings 5/11-5/13/15, 1:1, standup meetings. 3. Reviewed medication list of all residents and identified everyone receiving medications with anticoagulant type properties, and then reviewed that appropriate care plans were in place, and 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 that care plans are in place for all residents receiving anticoagulant medications and ensure appropriate care plan changes have been made. This will be starting next scheduled rounds on 5/14/15. 5. Anticoagulant care plan added to admission packets to see that anticoagulant care plan is put in place on admission of all new admissions receiving anticoagulant medications. Completed 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 plans to see that hearing devices are appropriately care planned.	

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F 279	Continued From page 10 During interview on 4/23/15, at 4:16 p.m. registered nurse (RN)-A confirmed R7 was currently receiving Coumadin for atrial fibrillation and verified the medication was not addressed on R7's care plan. RN-A also stated "there should had been a care plan developed for the use of Coumadin and their would be monitoring for bruising and bleeding." Hearing Device: R43's quarterly Minimum Data Set (MDS) dated 2/12/15, identified R43 had severe cognitive impairment, moderate difficulty hearing, utilized hearing aides, had clear speech, was understood by others and was 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. On 4/20/15, at 5:25 p.m. R43 was observed in the dining room during the evening meal with her headphones off her head and around her neck. R43 was seated at the table with 5 other female	F 279	9. Activity manager or designee will audit monthly that hearing devies are care planned accurately and ensure that appropriate changes have been made in a timely manner. 10. Activity department wa educated on care plan documentation and communication device usage. 11. DON or designee will audit care plan accuracy monthly for one quarter and review results with Quality Assurance Committee for further recommendations.	

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residents. R43 repeatedly called out "Nurse, I need coffle," "Somebody," for 10 minutes. R43 told registered nurse (RN)-B she had a stomach ache and wanted to go to bed. RN-B asked R43 what was wrong and R43 responded by saying "I am not understanding you." R43's headphones remained around her neck. R43 continued to sit at the table while RN-B continued to assist another resident with their meal.

On 4/23/2015, at 8:31 a.m. R43 was observed in the dining room with the speaker box covered up by R43's clothing protector that prevented R43 from hearing. R43 was unable to hear me. RN-B stated, " Unless you use her pocket talker, R43 can't hear you. "

-At 9:50 a.m. activity staff person (A)-A was observed in the hallway outside of R43's room with R43 seated in the wheelchair. A-A was holding R43's headphones and speaker (talk) box in her hand and telling R43, "The batteries are dead, we need to get these fixed." A-A wheeled R43 to the day room and left the area with the speaker box and headphones in hand.

-At 10:07 a.m. R43 was observed in the day room during a group ball activity. A-A was leading the group. R43 did not have the headphones on. Before A-A tossed the ball to R43 she stated, "Ready [R43's name]?" R43 did not respond. A-A proceeded to toss the ball to R43 in which R43 reacted in a surprised manner and swatted the ball away.

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F 279	Continued From page 12 -At 10:25 a.m. the group ball activity was over. A-A proceeded to wheel other residents back to their rooms. R43 remained in the activity room, staring at the wall. Polka music was playing next to her. R43 stated, "For some reason, I can't hear today." When R43 was asked if she liked the music, R43 stated "I can't hear you." A-B entered the day room and asked R43 if she would like to go with her and get her fingernails painted, R43 did not hear her or respond. She wheeled R43 to the activity room for the nail painting activity. -At 10:35 a.m. R43 was observed seated at the end of a long table in the activity room without her headphones on. Other residents and staff members were present however, no one spoke with or to R43. R43 asked if the wind was blowing and no one responded. Staff were observed laughing with each other when R43 asked a resident seated next to her if she could understand what the staff were saying, the resident replied, she did not. R43 stated I cant hear anymore and the resident responded, "your not the only one." -At 10:43 a.m. R43 stated "I don't appreciate this." -At 10:46 a.m. R43 remained without her headphones. Nine other residents were noted in the activity. At this time, another employee had brought the headphones to the activity room and stated he would set them on top of the fridge. R43 stated "I can't see or hear." A-A grabbed the head phones from the top of the fridge and	F 279		

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placed them on R43's head and the speaker box around her neck on a lanyard saying, "They needed new batteries." R43 stated, "You get used to not hearing."

-At 12:15:45 p.m. R43 was observed in the dining room. The speaker box was observed tucked into R43's quilted jacket and was also covered up with a cloth napkin. R43 did not respond to this surveyors questions.

-At 12:49 p.m. R43 was observed in the south day area in front of the TV without her headphones in place. The headphones were on her lap along with the speaker box. R43 was looking at the window and not watching the TV.

-At 2:30 p.m. R43 was observed in day area at the table sorting socks. R43's speaker box was covered by her quilted jacket and she was pushed up to the table. The speaker box was unable to detect my voice. The speaker box hung from the lanyard to R43's abdomen and it did not detect voices when R43 was pushed up to the table or it was covered by clothing or napkins. R43 repeatedly stated to the surveyor "I cant hear you." After the surveyor picked up the device and spoke directly into the talk box, R43 stated she liked the earphones and they were comfortable. R43 stated, "I don't hear that good even with the ear phones on, and it just doesn't work to not wear them either."

On 4/23/2015, at 12:42 p.m. nursing assistant (NA)-C stated R43 could not hear without the

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F 279	Continued From page 14 headphones and pocket talker. She stated the headphones/pocket talker were the only adaptive devices utilized for enhanced communication with R43. She stated R43 always utilized the devices during the day. On 4/23/2015, at 12:54 p.m. NA-D stated R43 used the pocket talker device, read lips and that R43's left ear was better than her right. 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." 04/23/2015 2:49:54 p.m. licensed practical nurse (LPN)-A stated the best way to communicate with R43 was to use her head phones and pocket talker and that R43 heard better with her pocket talker. She stated without her headphones R43 can't hear and will say, "I cant hear you, or I cant understand you." On 04/23/2015, at 3:25 p.m. RN-A confirmed R43's use of the pocket talker / hearing device was not on the care plan and she had just added it. RN-A stated the only hearing interventions for R43 was to use the pocket talker and check her ears for wax. RN-A stated R43 would not be able to hear without the device. On 04/23/2015, at 4:55 p.m. the director of nursing (DON) stated she would have expected the device to be on R43's care plan.	F 279		

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F 279	Continued From page 15 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. The facility's "Comprehensive Care Plan Policy," identified an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs would be developed for each resident.	F 279		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the use of an assistive hearing device in order to maintain or enhance 1 of 1 resident's (R43) ability to hear / communicate. Findings include: R43's quarterly Minimum Data Set (MDS) dated 2/12/15, identified R43 had severe cognitive impairment, moderate difficulty hearing, utilized hearing aides, had clear speech, was understood	F 311	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 stored at the nurse□s stations and in the activity room for easy access for staff to ensure communication device is functioning appropriately. Completed 5/13/15. 3. Staff was in-serviced on the use and maintenance of the Communication device and will ensure that resident□s communication device is functioning properly, put on and placed on the outside	5/13/15

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F 311	Continued From page 16 by others and was 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. R43's care plan failed to identify any assistive devices to maintain or improve R43's hearing and communication. On 4/20/15, at 5:25 p.m. R43 was observed in the dining room during the evening meal with her headphones off her head and around her neck. R43 was seated at the table with 5 other female residents. R43 repeatedly called out "Nurse, I need coffle," "Somebody," for 10 minutes. All of R43's tablemate's were offered a choice between a Reuben and a chicken salad sandwich except for R43 who was served a pureed meal. R43 told RN-B she had a stomach ache and wanted to go to bed. RN-B asked R43 what was wrong and R43 responded by saying "I am not understanding you." R43's headphones remained around her neck. R43 continued to sit at the table while RN-B continued to assist another resident with their meal. On 4/23/2015, at 8:31 a.m. R43 was observed in the dining room with the speaker (talk) box covered up by the clothing protector which prevented R43 from hearing. R43 was unable to hear the surveyor speak to her. RN-B stated, "Unless you use her pocket talker, [R43] can't hear you. "	F 311	of garments worn and blankets being used. 4. Activity staff was educated on the importance of communication devies and the use and maintenance of communication devies. 5. Activity staff reivewed all care plans for accuracy for all residents using communication devies. 5. Activity manager or designee will audit that the communication device is functioning and in place daily for one week and weekly for one month and review these results with Quality Assurance committee for further monitoring recommendations.	

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F 311	Continued From page 17 -At 9:50 a.m. activity (A)-A staff member was observed in the hallway outside of R43's room with R43 seated in wheelchair. A-A was holding R43's headphones and speaker box in her hand and telling R43, "The batteries are dead, we need to get these fixed." A-A proceeded to wheel R43 to day room and leave the area with speaker box and headphones in her hands. -At 10:07 a.m. R43 was observed in the day room during a group ball activity. A-A was leading the group. R43 did not have the headphones on. Before ball was tossed to R43, A-A stated to R43, "Ready [R43's name]?" R43 did not respond. A-A proceeded to toss the ball to R43 in which R43 had a surprised reaction and swatted the ball away. -At 10:25 a.m. the group ball activity was over. A-A proceeded to wheel other residents back to their rooms. R43 remained in the activity room, staring at the wall. Polka music was playing next to her. R43 stated, "For some reason, I can't hear today." When R43 was asked if she liked the music, R43 stated "I can't hear you." A-B entered the day room and asked R43 if she would like to go with her and get her nails painted, R43 did not hear her or respond. A-B wheeled R43 to the activity room for the nail painting activity. -At 10:35 a.m. R43 was observed seated at the end of a long table in the activity room without her headphones on. Other residents and staff members were present however, no one spoke with or to R43. R43 asked if the wind was blowing	F 311		

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and no one responded. Staff were observed laughing with each other when R43 asked a resident seated next to her if she could understand what the staff were saying, the resident replied, she did not. R43 stated I cant hear anymore and the resident responded, "your not the only one."

-At 10:43 a.m. R43 stated "I don't appreciate this."

-At 10:46 a.m. R43 remained without her headphones. Nine other residents were noted in the activity. At this time, another employee had brought the headphones to the activity room and stated he would set them on top of the fridge. R43 stated "I can't see or hear." A-A grabbed the head phones from the top of the fridge and placed them on R43's head and the speaker box around her neck on a lanyard and stated, "They needed new batteries." R43 stated, "You get used to not hearing."

-At 12:15:45 p.m. R43 was observed in the dining room. The speaker box was observed tucked into R43's quilted jacket and was also covered up with a cloth napkin. R43 did not respond to this surveyors questions.

-At 12:49 p.m. R43 was observed in the south day area in front of the TV without her headphones in place. The headphones were observed on her lap along with the speaker box. R43 was looking at the window and not watching the TV.

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-At 2:30 p.m. R43 was observed in day area at a table sorting socks. R43's speaker box was covered by her quilted jacket and she was pushed up to the table. The speaker box was unable to detect my voice. The speaker box hanging from the lanyard hung just to R43's abdomen and did not detect voices when she was pushed up to the table, or it was covered by clothing or napkins. R43 repeatedly told the surveyor "I cant hear you." After the surveyor picked up the device and spoke directly into it, R43 stated she liked the earphones and they were comfortable. R43 stated, "I don't hear that good even with the ear phones on, and it just doesn't work to not 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."

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F 311	Continued From page 20 On 4/23/2015, at 12:57 p.m. NA-B stated we try to speak into her device, and sometimes we give her a motion. She stated R43 could not hear without the pocket talker. She also stated staff would take R43's headphones off so R43 did not always have them on. 04/23/2015 2:49:54 p.m. licensed practical nurse (LPN)-A stated the best way to communicate with R43 was to use her head phones and pocket talker because R43 heard better with them. She stated she just had pocket talker to use and staff were able to tell if the battery was dead when R43 told them "I cant hear you." LPN-A stated R43 wore the headphone most of the time. She stated R43 hardly ever took them off. She stated if R43 didn't have her headphones on she couldn't hear what's going on in activities. She added, without her headphones R43 couldn't hear and would say, "I cant hear you, or I cant understand you." On 04/23/2015, at 3:25 p.m. registered nurse (RN)-A confirmed R43's use of the hearing device was not on R43's care plan and that she had just added it "today." RN-A stated the only hearing interventions for R43 was to use the pocket talker and check her ears for wax. RN-A stated she would expect R43 to have the device on when at all activities or mass. She stated staff did not check the batteries on R43's device because they knew when the battery was dead when R43 was wearing the device and would respond by saying she cant hear. RN-A stated on admission, quarterly and annually the interdisciplinary team (IDT) assessed each residents hearing. RN-A stated they assessed resident hearing by talking	F 311		

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F 311	Continued From page 21 to the resident or checking the residents ears for wax. She stated R43 would not be able to hear without the device and would not hear activities without her pocket talker. She stated the staff knew they were supposed to use the pocket talker because it was kept on her night stand in her room. RN-A stated she did not know how staff knew how to use it as they were not educated on how to use the device. RN-A stated R43's hearing interventions was to use the device and ear wax checks. She stated the device helped R43 to hear a little better. 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. On 04/23/2015, at 4:55 p.m. the director of nursing (DON) stated she would have expected the device to be on R43's care plan. She stated she has tried to talk to R43 without her device and R43 could not hear her. She stated there was no process for checking the device batteries and there was no way for staff to know they were suppose to use the device if it was not identified on R43' care plan. The DON confirmed the staff had not been educated on the use or maintenance of the device.	F 311		

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	245579	A. BUILDING _____ B. WING _____	04/23/2015

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

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F 311	Continued From page 22 Facility policy reviewed titled, "Communication with Hearing Impaired or Deaf," identified the facility would improve the care and quality of life for the hearing impaired residents. The policy also identified the facility would routinely check the residents hearing device to insure proper functioning. 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 had the responsibility for providing care and services to the residents. The facility's "Comprehensive Care Plan Policy," identified an individualized comprehensive care plan that included measurable objectives and timetables in order to meet the resident's medical, nursing, mental and psychosocial needs was developed for each resident.	F 311		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		5/19/15

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F 431	Continued From page 23 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to remove expired stock medical supplies available for use by residents in 1 of 4 medication storage rooms/carts which had the potential to affect all 39 residents residing in the facility. In addition the facility failed to document the use of medications from the emergency kit (E-Kit) which lacked documentation when the padlock was broken / kit was accessed. Findings include:	F 431	1. Broken E-kit locks accounted for and documentation was present on the pharmacy reorder sheet and not on the correct Emergency drug box record flow sheet. The emergency drug box record was updated. 4/20/15 2. Updates to the Emergency Drug Box policy include specific instructions: When an emergency drug, antibiotic or stat medication is needed, or lock is removed for any reason, the following should be completed: a) The nurse breaks the Drug Box padlock; removes the prescribed	

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F 431	Continued From page 24 Emergency Kit: On 4/20/15, at 2:55 p.m. the North medication storage room tour was conducted with licensed practical nurse (LPN)-A. During the tour, the E-Kit red, numerically coded padlock was reconciled with the Emergency Drug Box Record. The Record reveled the red padlock on the E-Kit box should have been 211055. After further review of the red padlock on the E-Kit was noted to be 211057. The report lacked two entries that medication had been removed or replaced from the Kit. After identifying the red padlock was not correct, LPN-A removed the red padlock, confirmed contents and notified the pharmacy to confirm the findings. During this observation, LPN-A confirmed the findings and stated the red padlock which secured the E-Kit should have matched the report and stated it was wrong. During interview on 4/20/15, at 3:05 p.m. the pharmacist confirmed the report lacked documentation that medications had been removed or replaced from the E-Kit and had not been documented on the report form of when the red padlock was broken or replaced. The pharmacist stated the red padlock numerical coding system directed staff to replace the padlock with a numerically sequenced manner when the E-Kit was opened and the lock removed. The pharmacist also verified the facility should have documented each time the padlock was removed and the medication accessed or replaced. During interview on 4/20/15, at 3:30 p.m. the	F 431	medication, (if applicable) b) Place new padlock on the drug box. c) Record New padlock # on the log sheet in the EDB Binder. d) Complete the following steps as directed: I. In the EDB Binder Document the Reason for breaking the lock on the log sheet (ie: Lasix IM removed/or replaced; audit completed, etc., etc.) and fill in all other required information as well. II. Complete the pharmacy order slip in its entirety. Fax copy to the pharmacy Lewis drug fax #748-7228. III. Make one copy of the pharmacy order slip. Copy goes in Pharmacy outbox. The original goes to the office with broken padlock attached - Attn: DON or designee. IV. DON or Designee will maintain a count of three (3) padlocks available in EDB supply at the North Station. 2. Reviewed Medication- Emergency Drug Box policy and procedure with licensed- staff during meetings held 5/11-5/13, 1:1 and standup meetings. 3. DON, Consulting Pharmacist or designee will complete monthly audits of Emergency drug box usage/ flow sheets to ensure policy and procedure was consistently documented and padlocking system is used in numerical order. These results will be reviewed with the Quality Assurance Committee for further monitoring recommendations. 5. Expired 2X2 dressings and sterile gloves removed immediately from the treatment cart 4/23/15.	

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F 431	Continued From page 25 director of nursing DON confirmed the findings and verified each time the padlock was broken staff should have documented the access and removal or replacement of the medications. Review of facility policy titled, Medication-Emergency Drug Box, dated 7/30/09, indicated when an emergency drug, antibiotic or stat medication was needed, the nurse broke the containers seal (padlock) and removed the prescribed medication. As soon as possible, the nurse records the mediation used on the triplicate form kept in the box and on the log sheet in the binder. The facility failed to remove expired stock medical supplies from the treatment cart. On 4/23/15 at 10:06 a.m. the medication storage room tour was conducted with registered nurse (RN)-B During the tour, the treatment cart had a box which contained twenty nine Kendal 2 x 2 gauze sponges with a expiration date of 1/15, thirteen packages of Anseel Derma Prene Iso Touch surgical gloves with an expiration date of 11/14, nine packages of Anseel Derma Prene Iso Touch surgical gloves with an expiration date of 10/14, and 6 packages of Anseel Derma Prene Iso Touch surgical gloves with an expiration date of 9/14. RN-B confirmed the findings and stated they should have been taken out of circulation and replaced with new supplies. During interview on 4/23/15, at 11;00 a.m. the DON confirmed the expired medical supplies in	F 431	6. All contents in the treatment cart were checked for expiration dates. As well as supply room. Completed 4/25/15. 7. DON or designee will review expiration dates of products in treatment cart monthly. Tracking log is located on the treatment cart. Started 4/25/15. 8. Quality Assurance Committee will review tracking log for any further recommendations.	

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F 431	Continued From page 26 the treatment cart and stated they should have been removed, replaced and staff should have followed the facility policy and removed them. Requested policy on 4/23/15, at 11:00 and one was not provided.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		5/13/15

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F 441	Continued From page 27 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document, review the facility failed to ensure adequate hand hygiene during the provision of personal cares for 1 of 1 resident (R8) observed during and after bathing services. Findings include: 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.	F 441	1. Reviewed and updated the Hand washing / Hand hygiene policy 5/8/15. Updates to the policy included adding the procedure/ steps for completing appropriate hand washing. Policy also specificly lists after providing assistance with bathing. 2. Staff re-educated on appropriate hand washing. Reviewed Hand washing/ Hand hygiene policy at meetings 5/11-5/13/15, 1:1, standup meetings. 3. Hand sanitizer dispensers added to each tub rooms 5/13/15. 4. DON or designee with complete random observational hand washing audits on nursing staff on all shifts and review results with infection control committee and Quality Assurance for any further recommendations.	

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F 441	Continued From page 28 NA-A exited the dining room, went to the nurses station and washed her hands. At no time between the provision of cares or removal of the gloves did NA-A wash her hands. -At 8:56 a.m. NA-A verified she did not wash her hands after removing the gloves following the provision of R8's cares. NA-A stated she should have washed her hands after removing the gloves and confirmed staff were instructed to wash their hands before and after working with the residents and with each glove change. On 4/23/15, at 10:44 a.m. the director of nursing (DON) stated staff should wash their hands before and after working with a resident, after completing cares and when they remove gloves. The DON stated NA-A should have washed her hands each time she removed her gloves especially after applying the barrier cream. The facility policy and procedure titled, Handwashing Hand Hygiene reviewed 12/17/09, directed staff to wash their hands after removal of gloves and that the use of gloves did not replace hand washing / hand hygiene.	F 441		

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	245579	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/21/2015**

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K 000	INITIAL COMMENTS 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 STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

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

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.

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Essentia Health - Grace Home is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1976 and was determined to be of Type II(111) construction. In 1998, 3 additions were added to the southeast, northeast and northwest that were determined to be of Type II(111)construction. Because the original building and the addition meet the construction types allowed for existing buildings, the facility was surveyed as one building. The building is protected by a complete fire sprinkler system. The facility has a fire alarm system with smoke detection by the smoke barrier doors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 45 beds and had a census of 39 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is	K 000		

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	245579	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/21/2015**

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 144 SS=F	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. This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - Generators must be inspected weekly and exercised under load at not less than 30% of the EPS nameplate rating, for 30 minutes per month and shall be in accordance with NFPA 99 (1999 edition) and NFPA 110 (1999 edition). This STANDARD is not met as evidenced by: Based upon a staff interview and review of available records, the facility did not properly document weekly inspections for the month of May 2014 for the emergency generator. In a fire or other emergency, this deficient practice could adversely affect all residents, staff and visitors.	K 144	Emergency Generators will be inspected weekly, and a load test will be done yearly. The Maintenance Supervisior will be responsible to see that the work is completed. The recorder information will be submitted to the safety committee and Quality Assurance Committee for review.	5/14/15

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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.

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00762	A. BUILDING: _____ B. WING _____	04/23/2015

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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	00762	A. BUILDING: _____ B. WING _____	04/23/2015

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On April 20th, 21st, 22nd and 23rd 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced	2 302		5/11/15

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2 302	Continued From page 3 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 dementia/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 in written or electronic form. SUGGESTED METHOD OF CORRECTION: The Administrator or designee could add information regarding the Alzheimer's disease and dementia requirements into the resident admission packet for consumer information. The quality assurance committee could design a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 302	1. A Notice to Residents and Families has been developed informing residents/ responsible parties of the requirement to provide all direct care staff training which explains Alzheimer's Disease/ Dementia, assistance with activities of daily living, problem- solving challegnging behaviors, and communicatin skills. 2. The Notice to Residents and Families is now included in every admission pack as of 5/4/15. The same notice will be mailed to the responsible party for all current residents. Completed 5/11/15. 3. The Notice to Residents and Families was given annually to each resident/ responsible party at every care conference held between January 1 and March 31 of each calendar year, or as an alternative it will be mailed to the responsible party at the time designated by the Social Service Dept. 4. The Social Service Dept. will submit a report annually to the Quality Assurance committee identifying the percent of compliance for giving the Notice to Residnts and Families to all new admissions and the responsible parties of current residents. The goal is 100% compliance.	

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2 302	Continued From page 4 (21) days.	2 302		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan that included the daily use of Coumadin (anti-coagulant) for 1 of 3 resident (R7) who was reviewed for non-pressure related skin issues. In addition, the facility failed to develop a comprehensive care plan for the use of an assistive hearing device for 1 of 1 resident (R43) reviewed for communication and observed utilizing a pocket talker hearing device. Finding include: Anticoagulant: R7's Physician Order Report dated, 4/16/15, indicated R7 was diagnosed with atrial fibrillation, diabetes and dementia. The report also indicated R7 was prescribed a anti-coagulant medication	2 560	1. R7 care plan was immediately updated for anticoagulant medication use. These medications increase the risk for potential side effects such as bruising/ bleeding. Completed 4/23/15 2. Reviewed Care plan policy with management and staff during meetings 5/11-5/13/15, 1:1, standup meetings. 3. Reviewed medication list of all residents and identified everyone receiving medications with anticoagulant type properties, and then reviewed that appropriate care plans were in place, and 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 that care plans are in place for all residents receiving anticoagulant medications and ensure appropriate care plan changes	5/13/15

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2 560	Continued From page 5 (Coumadin) 3 milligrams (MG) daily between 5:00 p.m. and 7:00 p.m. for atrial fibrillation. Review of R7's care plan, dated 1/14/15, did not identify the use of an anti-coagulant for the atrial fibrillation nor did the plan include potential side effects and monitoring of bruising/bleeding related to the medication use. The use of Coumadin was not addressed on the care plan. During interview on 4/22/15, at 3:58 p.m. director of nursing confirmed R7 was currently receiving Coumadin for atrial fibrillation and verified the medication was not addressed on R7's care plan. DON also stated "a care plan should have been developed when she went on Coumadin." During interview on 4/23/15, at 4:16 p.m. registered nurse (RN)-A confirmed R7 was currently receiving Coumadin for atrial fibrillation and verified the medication was not addressed on R7's care plan. RN-A also stated "there should had been a care plan developed for the use of Coumadin and their would be monitoring for bruising and bleeding." Hearing Device: R43's quarterly Minimum Data Set (MDS) dated 2/12/15, identified R43 had severe cognitive impairment, moderate difficulty hearing, utilized hearing aides, had clear speech, was understood by others and was usually understood by others.	2 560	have been made. This will be starting next scheduled rounds on 5/14/15. 5. Anticoagulant care plan added to admission packets to see that anticoagulant care plan is put in place on admission of all new admissions receiving anticoagulant medications. Completed 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 care plans to see that hearing devices are appropriately care planned. Activity manager or designee will continue quarterly monitoring of care plan documentation for accuracy.	

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2 560	Continued From page 6 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. On 4/20/15, at 5:25 p.m. R43 was observed in the dining room during the evening meal with her headphones off her head and around her neck. R43 was seated at the table with 5 other female residents. R43 repeatedly called out "Nurse, I need coffle," "Somebody," for 10 minutes. R43 told registered nurse (RN)-B she had a stomach ache and wanted to go to bed. RN-B asked R43 what was wrong and R43 responded by saying "I am not understanding you." R43's headphones remained around her neck. R43 continued to sit at the table while RN-B continued to assist another resident with their meal. On 4/23/2015, at 8:31 a.m. R43 was observed in the dining room with the speaker box covered up by R43's clothing protector that prevented R43 from hearing. R43 was unable to hear me. RN-B stated, " Unless you use her pocket talker, R43 can't hear you. " -At 9:50 a.m. activity staff person (A)-A was observed in the hallway outside of R43's room with R43 seated in the wheelchair. A-A was holding R43's headphones and speaker (talk) box	2 560		

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2 560	Continued From page 7 in her hand and telling R43, "The batteries are dead, we need to get these fixed." A-A wheeled R43 to the day room and left the area with the speaker box and headphones in hand. -At 10:07 a.m. R43 was observed in the day room during a group ball activity. A-A was leading the group. R43 did not have the headphones on. Before A-A tossed the ball to R43 she stated, "Ready [R43's name]?" R43 did not respond. A-A proceeded to toss the ball to R43 in which R43 reacted in a surprised manner and swatted the ball away. -At 10:25 a.m. the group ball activity was over. A-A proceeded to wheel other residents back to their rooms. R43 remained in the activity room, staring at the wall. Polka music was playing next to her. R43 stated, "For some reason, I can't hear today." When R43 was asked if she liked the music, R43 stated "I can't hear you." A-B entered the day room and asked R43 if she would like to go with her and get her fingernails painted, R43 did not hear her or respond. She wheeled R43 to the activity room for the nail painting activity. -At 10:35 a.m. R43 was observed seated at the end of a long table in the activity room without her headphones on. Other residents and staff members were present however, no one spoke with or to R43. R43 asked if the wind was blowing and no one responded. Staff were observed laughing with each other when R43 asked a resident seated next to her if she could understand what the staff were saying, the resident replied, she did not. R43 stated I cant	2 560		

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2 560	Continued From page 8 hear anymore and the resident responded, "your not the only one." -At 10:43 a.m. R43 stated "I don't appreciate this." -At 10:46 a.m. R43 remained without her headphones. Nine other residents were noted in the activity. At this time, another employee had brought the headphones to the activity room and stated he would set them on top of the fridge. R43 stated "I can't see or hear." A-A grabbed the head phones from the top of the fridge and placed them on R43's head and the speaker box around her neck on a lanyard saying, "They needed new batteries." R43 stated, "You get used to not hearing." -At 12:15:45 p.m. R43 was observed in the dining room. The speaker box was observed tucked into R43's quilted jacket and was also covered up with a cloth napkin. R43 did not respond to this surveyors questions. -At 12:49 p.m. R43 was observed in the south day area in front of the TV without her headphones in place. The headphones were on her lap along with the speaker box. R43 was looking at the window and not watching the TV. -At 2:30 p.m. R43 was observed in day area at the table sorting socks. R43's speaker box was covered by her quilted jacket and she was pushed up to the table. The speaker box was unable to detect my voice. The speaker box	2 560		

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2 560	Continued From page 9 hung from the lanyard to R43's abdomen and it did not detect voices when R43 was pushed up to the table or it was covered by clothing or napkins. R43 repeatedly stated to the surveyor "I cant hear you." After the surveyor picked up the device and spoke directly into the talk box, R43 stated she liked the earphones and they were comfortable. R43 stated, "I don't hear that good even with the ear phones on, and it just doesn't work to not 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 stated R43 always utilized the devices during the day. On 4/23/2015, at 12:54 p.m. NA-D stated R43 used the pocket talker device, read lips and that R43's left ear was better than her right. 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." 04/23/2015 2:49:54 p.m. licensed practical nurse (LPN)-A stated the best way to communicate with R43 was to use her head phones and pocket talker and that R43 heard better with her pocket talker. She stated without her headphones R43 can't hear and will say, "I cant hear you, or I cant understand you." On 04/23/2015, at 3:25 p.m. RN-A confirmed	2 560		

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2 560	Continued From page 10 R43's use of the pocket talker / hearing device was not on the care plan and she had just added it. RN-A stated the only hearing interventions for R43 was to use the pocket talker and check her ears for wax. RN-A stated R43 would not be able to hear without the device. On 04/23/2015, at 4:55 p.m. the director of nursing (DON) stated she would have expected the device to be on 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. The facility's "Comprehensive Care Plan Policy," identified an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs would be developed for each resident. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies and provide staff education related to the development of comprehensive care plans. The administrator or designee could develop and auditing system in order to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One	2 560		

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2 560	Continued From page 11 (21) days.	2 560		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the use of an assistive hearing device in order to maintain or enhance 1 of 1 resident's (R43) ability to hear / communicate. Findings include: R43's quarterly Minimum Data Set (MDS) dated 2/12/15, identified R43 had severe cognitive	2 915	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 stored at the nurse□s stations and in the activity room for easy access for staff to ensure communication device is functioning appropriately. Completed 5/13/15. 3. Staff was in-serviced on the use and maintenance of the Communication device and will ensure that resident□s	5/13/15

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2 915	Continued From page 12 impairment, moderate difficulty hearing, utilized hearing aides, had clear speech, was understood by others and was 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. R43's care plan failed to identify any assistive devices to maintain or improve R43's hearing and communication. On 4/20/15, at 5:25 p.m. R43 was observed in the dining room during the evening meal with her headphones off her head and around her neck. R43 was seated at the table with 5 other female residents. R43 repeatedly called out "Nurse, I need coffle," "Somebody," for 10 minutes. All of R43's tablemate's were offered a choice between a Reuben and a chicken salad sandwich except for R43 who was served a pureed meal. R43 told RN-B she had a stomach ache and wanted to go to bed. RN-B asked R43 what was wrong and R43 responded by saying "I am not understanding you." R43's headphones remained around her neck. R43 continued to sit at the table while RN-B continued to assist another resident with their meal. On 4/23/2015, at 8:31 a.m. R43 was observed in the dining room with the speaker (talk) box covered up by the clothing protector which prevented R43 from hearing. R43 was unable to hear the surveyor speak to her. RN-B stated, "Unless you use her pocket talker, [R43] can't hear you. "	2 915	communication device is functioning properly, put on and placed on the outside of garments worn and blankets being used. 4. Activity manager or designee will audit that the communication device is functioning and in place daily for one week and weekly for one month and review these results with Quality Assurance committee for further monitoring recommendations.	

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2 915	Continued From page 13	2 915		

-At 9:50 a.m. activity (A)-A staff member was observed in the hallway outside of R43's room with R43 seated in wheelchair. A-A was holding R43's headphones and speaker box in her hand and telling R43, "The batteries are dead, we need to get these fixed." A-A proceeded to wheel R43 to day room and leave the area with speaker box and headphones in her hands.

-At 10:07 a.m. R43 was observed in the day room during a group ball activity. A-A was leading the group. R43 did not have the headphones on. Before ball was tossed to R43, A-A stated to R43, "Ready [R43's name]?" R43 did not respond. A-A proceeded to toss the ball to R43 in which R43 had a surprised reaction and swatted the ball away.

-At 10:25 a.m. the group ball activity was over. A-A proceeded to wheel other residents back to their rooms. R43 remained in the activity room, staring at the wall. Polka music was playing next to her. R43 stated, "For some reason, I can't hear today." When R43 was asked if she liked the music, R43 stated "I can't hear you." A-B entered the day room and asked R43 if she would like to go with her and get her nails painted, R43 did not hear her or respond. A-B wheeled R43 to the activity room for the nail painting activity.

-At 10:35 a.m. R43 was observed seated at the end of a long table in the activity room without her headphones on. Other residents and staff members were present however, no one spoke with or to R43. R43 asked if the wind was blowing

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	00762	A. BUILDING: _____ B. WING _____	04/23/2015

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

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2 915	Continued From page 14 and no one responded. Staff were observed laughing with each other when R43 asked a resident seated next to her if she could understand what the staff were saying, the resident replied, she did not. R43 stated I cant hear anymore and the resident responded, "your not the only one." -At 10:43 a.m. R43 stated "I don't appreciate this." -At 10:46 a.m. R43 remained without her headphones. Nine other residents were noted in the activity. At this time, another employee had brought the headphones to the activity room and stated he would set them on top of the fridge. R43 stated "I can't see or hear." A-A grabbed the head phones from the top of the fridge and placed them on R43's head and the speaker box around her neck on a lanyard and stated, "They needed new batteries." R43 stated, "You get used to not hearing." -At 12:15:45 p.m. R43 was observed in the dining room. The speaker box was observed tucked into R43's quilted jacket and was also covered up with a cloth napkin. R43 did not respond to this surveyors questions. -At 12:49 p.m. R43 was observed in the south day area in front of the TV without her headphones in place. The headphones were observed on her lap along with the speaker box. R43 was looking at the window and not watching the TV.	2 915		

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2 915	Continued From page 15 -At 2:30 p.m. R43 was observed in day area at a table sorting socks. R43's speaker box was covered by her quilted jacket and she was pushed up to the table. The speaker box was unable to detect my voice. The speaker box hanging from the lanyard hung just to R43's abdomen and did not detect voices when she was pushed up to the table, or it was covered by clothing or napkins. R43 repeatedly told the surveyor "I cant hear you." After the surveyor picked up the device and spoke directly into it, R43 stated she liked the earphones and they were comfortable. R43 stated, "I don't hear that good even with the ear phones on, and it just doesn't work to not 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 12:57 p.m. NA-B stated we try	2 915		

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2 915	Continued From page 16 to speak into her device, and sometimes we give her a motion. She stated R43 could not hear without the pocket talker. She also stated staff would take R43's headphones off so R43 did not always have them on. 04/23/2015 2:49:54 p.m. licensed practical nurse (LPN)-A stated the best way to communicate with R43 was to use her head phones and pocket talker because R43 heard better with them. She stated she just had pocket talker to use and staff were able to tell if the battery was dead when R43 told them "I cant hear you." LPN-A stated R43 wore the headphone most of the time. She stated R43 hardly ever took them off. She stated if R43 didn't have her headphones on she couldn't hear what's going on in activities. She added, without her headphones R43 couldn't hear and would say, "I cant hear you, or I cant understand you." On 04/23/2015, at 3:25 p.m. registered nurse (RN)-A confirmed R43's use of the hearing device was not on R43's care plan and that she had just added it "today." RN-A stated the only hearing interventions for R43 was to use the pocket talker and check her ears for wax. RN-A stated she would expect R43 to have the device on when at all activities or mass. She stated staff did not check the batteries on R43's device because they knew when the battery was dead when R43 was wearing the device and would respond by saying she cant hear. RN-A stated on admission, quarterly and annually the interdisciplinary team (IDT) assessed each residents hearing. RN-A stated they assessed resident hearing by talking to the resident or checking the residents ears for wax. She stated R43 would not be able to hear without the device and would not hear activities	2 915		

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2 915	Continued From page 17 without her pocket talker. She stated the staff knew they were supposed to use the pocket talker because it was kept on her night stand in her room. RN-A stated she did not know how staff knew how to use it as they were not educated on how to use the device. RN-A stated R43's hearing interventions was to use the device and ear wax checks. She stated the device helped R43 to hear a little better. 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. On 04/23/2015, at 4:55 p.m. the director of nursing (DON) stated she would have expected the device to be on R43's care plan. She stated she has tried to talk to R43 without her device and R43 could not hear her. She stated there was no process for checking the device batteries and there was no way for staff to know they were suppose to use the device if it was not identified on R43' care plan. The DON confirmed the staff had not been educated on the use or maintenance of the device. Facility policy reviewed titled, "Communication with Hearing Impaired or Deaf," identified the facility would improve the care and quality of life	2 915		

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2 915	Continued From page 18 for the hearing impaired residents. The policy also identified the facility would routinely check the residents hearing device to insure proper functioning. 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 had the responsibility for providing care and services to the residents. The facility's "Comprehensive Care Plan Policy," identified an individualized comprehensive care plan that included measurable objectives and timetables in order to meet the resident's medical, nursing, mental and psychosocial needs was developed for each resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could inservice staff regarding the use and maintenance of assistive hearing devices. To ensure complaince, the DON or designee could perform routine observational audits to ensure the devices are used appropriatly and are in working order. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		

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21375	Continued From page 19	21375		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document, review the facility failed to ensure adequate hand hygiene during the provision of personal cares for 1 of 1 resident (R8) observed during and after bathing services. Findings include: 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	21375	1. Reviewed and updated the Hand washing / Hand hygiene policy 5/8/15. 2. Staff re-educated on appropriate hand washing. Reviewed Hand washing/ Hand hygiene policy at meetings 5/11-5/13/15, 1:1, standup meetings. 3. Hand sanitizer dispensers added to each tub rooms 5/13/15. 4. DON or designee with complete random observational hand washing audits on nursing staff on all shifts and review results with infection control committee and Quality Assurance for any further recommendations.	5/13/15

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21375	Continued From page 20 station and washed her hands. At no time between the provision of cares or removal of the gloves did NA-A wash her hands. -At 8:56 a.m. NA-A verified she did not wash her hands after removing the gloves following the provision of R8's cares. NA-A stated she should have washed her hands after removing the gloves and confirmed staff were instructed to wash their hands before and after working with the residents and with each glove change. On 4/23/15, at 10:44 a.m. the director of nursing (DON) stated staff should wash their hands before and after working with a resident, after completing cares and when they remove gloves. The DON stated NA-A should have washed her hands each time she removed her gloves especially after applying the barrier cream. The facility policy and procedure titled, Handwashing Hand Hygiene reviewed 12/17/09, directed staff to wash their hands after removal of gloves and that the use of gloves did not replace hand washing / hand hygiene. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate staff on appropriate hand hygiene during the provison of cares. The DON or designee could perform random observational audits to ensure complaince. TIME PERIOD FOR CORRECTION: Twenty-one	21375		

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21375	Continued From page 21 (21) days	21375		
21600	MN Rule 4658.1335 Subp. 2 Stock Medications; Emergency Supply Subp. 2. Emergency medication supply. A nursing home may have an emergency medication supply which must be approved by the QAA committee. The contents, maintenance, and use of the emergency medication supply must comply with part 6800.6700. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to document and track the use of medications from and access of the emergency kit (E-Kit) which lacked documentation when the padlock was broken / kit was accessed on two separate occasions. Findings include: On 4/20/15, at 2:55 p.m. the North medication storage room tour was conducted with licensed practical nurse (LPN)-A. During the tour, the E-Kit red, numerically coded padlock was reconciled with the Emergency Drug Box Record. The Record reveled the red padlock on the E-Kit box should have been 211055. After further review of the red padlock on the E-Kit was noted to be 211057. The report lacked two entries that medication had been removed or replaced from the Kit. After identifying the red padlock was not correct, LPN-A removed the red padlock, confirmed contents and notified the pharmacy to confirm the findings. During this observation,	21600	1. Broken E-kit locks accounted for and documentation was present on the pharmacy reorder sheet and not on the correct Emergency drug box record flow sheet. The emergency drug box record was updated. 4/20/15 2. Reviewed Medication- Emergency Drug Box policy and procedure with licensed- staff during meetings held 5/11-5/13, 1:1 and standup meetings. 3. DON, Consulting Pharmacist or designee will complete random audits of Emergency drug box usage/ flow sheets to ensure policy and procedure was consistently documented and padlocking system is used in numerical order. These results will be reviewed with the Quality Assurance Committee for further monitoring recommendations. 5. Expired 2X2 dressings and sterile gloves removed immediately from the treatment cart 4/23/15. 6. All contents in the treatment cart were checked for expiration dates. As well as supply room. Completed 4/25/15.	5/13/15

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21600	Continued From page 22 LPN-A confirmed the findings and stated the red padlock which secured the E-Kit should have matched the report and stated it was wrong. During interview on 4/20/15, at 3:05 p.m. the pharmacist confirmed the report lacked documentation that medications had been removed or replaced from the E-Kit and had not been documented on the report form of when the red padlock was broken or replaced. The pharmacist stated the red padlock numerical coding system directed staff to replace the padlock with a numerically sequenced manner when the E-Kit was opened and the lock removed. The pharmacist also verified the facility should have documented each time the padlock was removed and the medication accessed or replaced. During interview on 4/20/15, at 3:30 p.m. the director of nursing DON confirmed the findings and verified each time the padlock was broken staff should have documented the access and removal or replacement of the medications. Review of facility policy titled, Medication-Emergency Drug Box, dated 7/30/09, indicated when an emergency drug, antibiotic or stat medication was needed, the nurse broke the containers seal (padlock) and removed the prescribed medication. As soon as possible, the nurse records the mediation used on the triplicate form kept in the box and on the log sheet in the binder. SUGGESTED METHOD OF CORRECTION:	21600	7. DON or designee will review expiration dates of products in treatment cart monthly. Tracking log is located on the treatment cart. Started 4/25/15. 8. Quality Assurance Committee will review tracking log for any further recommendations.	

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21600	Continued From page 23 The administrator, consultant pharmacist or designee could review and revise policies and procedures to ensure E-Kit access and medication use was consistently documented and the padlock locking system was utilized in the numerically coding fashion as directed. The administrator, consultant pharmacist or designee could perform random observational audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21600		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the	21980		5/26/15

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21980	Continued From page 24 provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the administrator and Stage agency (SA) and complete a thorough investigation for injuries of unknown origin for 1 of 1 resident (R31) with a significant bruise of unknown origin. Finding include:	21980	1. When made aware of the un-reported injury of suspicious origin, a Vulnerable Adult Incident report was filed with MDH and the faciltiy administrator was informed on 4.22.14. 2. A subsequent internal investigation was conducted and the report filed with MDH, CEP, APS, and the Ombudsman on 5.1.15. 3. It was the conclusion of the	

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21980	Continued From page 25 R31's significant change Minimum Data Set (MDS) dated 1/27/15, identified R31 was cognitively intact, required supervision of one staff for bed mobility, limited assistance of one staff for transfers and extensive assistance of one staff for toileting, dressing and personal hygiene. Review of R31's progress note dated 3/5/15, read "bruise to forearm still visible. No signs and symptoms of infection and no open areas present." 4/4/15, read bruised area on right forearm have nearly faded with no defined discoloration, just darker area of skin noted on most of outer forearm. No open areas. Review of R31's care plan dated, 3/3/14, revealed R31 had a bruise on right forearm. Review of R31's event report dated, 3/3/15, at 2:44 p.m. revealed R31 had a bruise on forearm to his right arm which measured 16 x 13 centimeters (cm) and was reddish/blue in color with slight swelling. The report also indicated the origin of the bruise was unknown and R31 stated "he got it (bruise) from 2 women in the middle of the night." Further review of the report revealed no measures were taken to the residents response, the physician nor R31's family was notified and the care plan was not reviewed. The report also indicated staff would notify the medical doctor immediately by phone or beeper for any of the following: bruising of unknown origin, bruise associated with moderate to severe pain swelling, and /or loss of range of motion and large bruise associated with known incident.	21980	investigator was not able to say with any certainty what or who, if anybody, was the source of the injury, nor how the initial event report fell through the cracks and was not reviewed by the IDP team. Corrective action included coaching nursing regarding behaviors and particularly how best to assist residents to reduce the risk of bruises or skin tears. The IDP team now have available a computer generated report that lists events occurring since the they last met which enables them to better spot possible incident of abuse or neglect. This report is reviewed by the IDP Team daily except for week-ends and holidays. 4. Notice was received from MDH that no further action was needed at this time on 5.7.15. 5. Licensed staff was re-educated on Vulnerable Adult policy and reporting process during scheduled meetings 5/11-5/13/15, stand up meetings, and 1:1 meetings followed by competency evaluations. 5. Vulnerable Adult Policy was reviewed 5/8/15. 6. IDP team will review weekly for one month (5/26/15) for any incidents that should have been reported under the VA policy, but were not these results will be reviewed by Quality Assurance Committee for further monitoring recommendations.	

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	00762	A. BUILDING: _____ B. WING _____	04/23/2015

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

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21980	Continued From page 26 During interview on 4/22/15, at 12:10 p.m. the director of nursing (DON) confirmed the bruise was of unknown origin and was not reported to SA nor investigated. The DON stated she did not recall the injury and assumed it did not get reported. At 12:13 p.m. the DON confirmed when a resident had a significant bruise of unknown origin, it should be immediately reported." The DON verified the administrator should have been notified and was not, a report should have been made to the SA and was not and an incident report and thorough investigation should have been competed and was not. The DON confirmed that no one was notified and that she did not even know about the bruise to R31's right forearm. During interview on 4/22/15, at 12:13 p.m. the social worker (SW) stated she "vaguely" recalled the bruise of unknown origin and confirmed it did not get reported to the SA. The SW also confirmed that he would have reported the bruise right away if there was no explanation of how it was acquired and also reported as a vulnerable adult. During interview on 4/22/15, at 12:54 p.m. registered nurse (RN)-A stated she did not know about the bruise and confirmed it did not get reported to the administrator, DON, SW nor SA and they all should have been notified. When asked if an investigation was completed RN-A stated "not that I know of." During interview on 4/22/15, at 1:25 p.m. nursing assistant (NA)-D confirmed R31 had a large bruise on his right forearm and stated "I cant	21980		

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21980	Continued From page 27 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. During interview on 4/22/15, at 1:21 p.m. NA-E confirmed R31 had a large bruise on his right forearm and stated "I was told about it in report." NA-E also verified that she would have reported it (bruising) right away. During interview on 4/22/15, at 1:45 p.m. licensed practical nurse (LPN)-A confirmed R31 had a large bruise on his right forearm and stated she did not know how he got it nor anyone saying how it happened. LPN-A stated if she found a suspicious bruise of unknown origin she would ask the resident what happened, talk to the nursing assistants, report it to the DON and complete an event report. Review of facility policy titled, Grace Home Vulnerable Adult Policy, reviewed on 4/3/14, directed staff to report and investigate any incident of actual or suspected maltreatment of a resident or of any resident who had sustained an injury which was not reasonably explained shall be reported in accord with MN. Vulnerable Adult Statute. The policy also directed staff to report any suspected abuse, neglect, exploitation of a vulnerable adult immediately to his /her supervisor who was responsible to report the information immediately to the administrator or designee. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing or social	21980		

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21980	Continued From page 28 worker could train all staff members on the policies and procedures for reporting and investigating allegations of mistreatment and / or injuries of unknown origin. The administrator, director of nursing or social worker could audit incident reports to ensure timely reporting and thorough investigations were completed. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21980		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse prevention policy and procedures related to immediately notifying the administrator, the State agency (SA) and thoroughly investigating 1 of 1 resident (R31) with a significant bruise of unknown origin. Finding include:	21995	1. Vulnerable Adult Policy reviewed 5/8/15. 2. Nursing staff re-educated on Vulnerable Adult policy and reporting process during scheduled meetings 5/11-5/13/15, stand up meetings, and 1:1 meetings followed by competency evaluations 3. The IDP team now have available a	5/13/15

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21995	Continued From page 29 Review of facility policy titled, Grace Home Vulnerable Adult Policy, reviewed on 4/3/14, directed staff to report and investigate any incident of actual or suspected maltreatment of a resident or of any resident who had sustained an injury which was not reasonably explained shall be reported in accord with MN. Vulnerable Adult Statute. The policy also directed staff to report any suspected abuse, neglect, exploitation of a vulnerable adult immediately to his /her supervisor who was responsible to report the information immediately to the administrator or designee. R31's significant change Minimum Data Set (MDS) dated 1/27/15, identified R31 was cognitively intact, required supervision of one staff for bed mobility, limited assistance of one staff for transfers, extensive assistance of one staff for toileting, dressing and personal hygiene. Review of R31's progress note dated 3/5/15 stated "bruise to forearm still visible. No signs and symptoms of infection and no open areas present." 4/4/14 stated "Bruised area on right forearm have nearly faded with no defined discoloration, just darker, are of skin noted on most of outer forearm. No open areas." Review of R31's care plan dated, 3/3/14, revealed R31 had a bruise on right forearm. Review of R31's event report dated, 3/3/15, at 2:44 p.m. revealed R31 had a bruise on forearm	21995	computer generated report that lists events occurring since they last met which enables them to better spot possible incident of abuse or neglect. This report is reviewed by the IDP Team daily except for week-ends and holidays. 4. DON, Social Service, or designee will audit event and incident reports to ensure timely reporting and thorough investigations were completed and will review results with Quality Assurance Committee for further recommendations.	

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21995	Continued From page 30	21995		

to his right arm which measured 16 x 13 centimeters (cm) and was reddish/blue in color with slight swelling. The report also indicated the origin of the bruise was unknown and R31 stated "he got it (bruise) from 2 women in the middle of the night." Further review of the report revealed no measures were taken to the residents response, the physician nor R31's family was notified and the care plan was not reviewed. The report also indicated staff would notify the medical doctor immediately by phone or beeper for any of the following: bruising of unknown origin, bruise associated with moderate to severe pain swelling, and /or loss of range of motion and large bruise associated with known incident.

During interview on 4/22/15, at 12:10 p.m. the director of nursing (DON) confirmed the bruise was of unknown origin and was not reported to SA / administrator nor investigated. The DON stated she did not recall the injury and assumed it did not get reported. At 12:13 p.m. the DON confirmed when a resident had a significant bruise of unknown origin, it should be immediately reported." The DON verified the administrator should have been notified and was not, a report should have been made to the SA and was not and an incident report and thorough investigation should have been competed and was not. The DON confirmed that no one was notified and that she did not even know about the bruise to R31's right forearm.

During interview on 4/22/15, at 12:13 p.m. the social worker (SW) stated she "vaguely" recalled the bruise of unknown origin and confirmed it did not get reported to the SA. The SW also confirmed that he would have reported the bruise

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21995	Continued From page 31 right away if there was no explanation of how it was acquired and also reported as a vulnerable adult. During interview on 4/22/15, at 12:54 p.m. registered nurse (RN)-A stated she did not know about the bruise and confirmed it did not get reported to the administrator, DON, SW nor SA and that they all should have been notified. When asked if an investigation was completed RN-A stated "not that I know of." During interview on 4/22/15, at 1:25 p.m. nursing assistant (NA)-D confirmed R31 had a large bruise on his right forearm and stated "I cant 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. During interview on 4/22/15, at 1:21 p.m. NA-E confirmed R31 had a large bruise on his right forearm and stated "I was told about it in report." NA-E also verified that she would have reported it (bruising) right away. During interview on 4/22/15, at 1:45 p.m. licensed practical nurse (LPN)-A confirmed R31 had a large bruise on his right forearm and stated she did not know how he got it nor anyone saying how it happened. LPN-A stated if she found a suspicious bruise of unknown origin she would ask the resident what happened, talk to the nursing assistants, report it to the DON and complete an event report.	21995		

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21995	Continued From page 32 SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures related to timely reporting and investigating allegations of mistreatment and injuries of unknown origin. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21995		