



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 30, 2025

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

RE: CCN: 245579
Cycle Start Date: January 15, 2025

Dear Administrator:

On January 15, 2025, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 15, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by July 15, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

Essentia Health Grace Home

January 30, 2025

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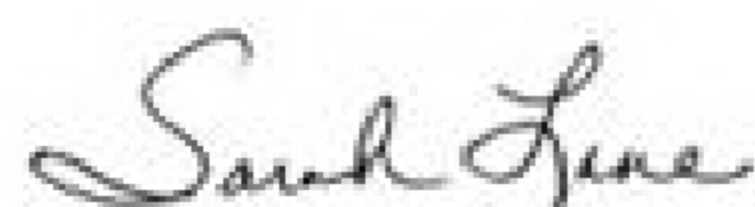
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



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January 30, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: CPYI11

Dear Administrator:

The above facility was surveyed on January 13, 2025 through January 15, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

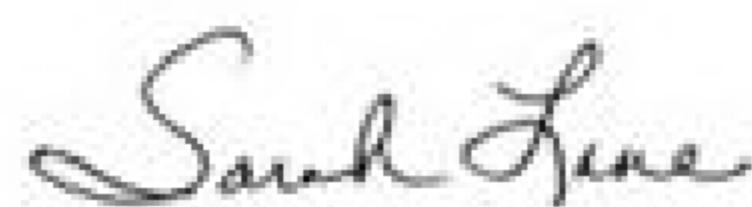
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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

PRINTED: 02/12/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245579	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/15/2025
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH GRACE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments On 1/13/25 to 1/15/25, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance.	E 000			
F 000	INITIAL COMMENTS On 1/13/25 to 1/15/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaint was reviewed: The following complaints were reviewed with no deficiency issued. H55794600C (MN00109366). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the	F 000			

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

TITLE

(X6) DATE

Electronically Signed

02/07/2025

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 000 F 760 SS=D	<p>Continued From page 1 regulations has been attained.</p> <p>Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)</p> <p>The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure professional standards of practice were followed during medication set-up and administration of insulin with a Novolog insulin pen (rapid-acting insulin, used to improve blood sugar control in people with diabetes mellitus) for 1 of 2 residents (R12) who received insulin without the pen primed according to manufacturer's recommendations.</p> <p>Findings include:</p> <p>R12's quarterly Minimum Data Set (MDS) dated 11/25/24, identified R12 had intact cognition and had a diagnosis of diabetes mellitus (DM) and received injections of insulin.</p> <p>R12's care plan revised 12/1/24, identified staff were to administer medications as prescribed.</p> <p>R12's Order Summary Report signed 12/11/24, identified Novolog Flex Pen U-100 inject 5 units Subcutaneously (an injection just under the skin into the fatty tissue) three times daily for DM.</p> <p>During an observation of medication pass on 1/14/25 at 5:30 p.m., registered nurse (RN)-A prepared R12's medication which included her 5:00 p.m., Novolog insulin. RN-A removed the</p>	F 000 F 760	<p>Corrective Action</p> <ul style="list-style-type: none"> - RN-A received immediate retraining for priming insulin pen with demonstration to ensure there would be no further instances in which resident R12 or other residents who use insulin pens would receive an injection without priming of the insulin pen. - The facility developed a standardized training checklist for insulin pen administration and competency that will be completed by all nurses no later than 2/20/25 at meeting, 1:1, via teams mtg or phone. - Audits in place for random checks on all residents receiving insulin within the facility to ensure proper priming is completed prior to insulin administration.-Ongoing <p>Staff Education Plan: Completion-2/20/25</p> <ul style="list-style-type: none"> - Mandatory in-service training for ALL nursing staff on: <ul style="list-style-type: none"> * Training on insulin pen priming. * Potential clinical risks of improper insulin administration. 	2/28/25

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F 760	<p>Continued From page 2</p> <p>Novolog insulin pen from the medication cart, removed the tip, attached a needle to the end of the pen, dialed the dose to the ordered 5 units, picked up an alcohol wipe, went to R12's room and administered the 5 units of insulin to R12. RN-A then removed the needle from the end of the pen, placed it in the sharps container and sanitized her hands. RN-A did not prime the pen (waste 2 units of insulin to remove the air bubbles) per manufacturer's instructions prior to drawing up the 5 units of insulin.</p> <p>During an interview on 1/14/25 at 5:324 p.m., RN-A verified she had not primed the insulin pen prior to dialing up the 5 units of Novolog for R12 per manufacturer's recommendations. RN-A stated she was aware the insulin pen should have been primed prior to dialing up the insulin to ensure the accurate dosage of insulin was administered.</p> <p>During an interview on 1/15/25 at 9:15 a.m., consultant pharmacist (CP) stated it was important to always prime an insulin pen prior to drawing up the dosage to ensure the residents received the correct dosage of insulin.</p> <p>During an interview on 1/15/25 at 9:23 a.m., director of nursing (DON) stated her expectation was that the insulin pen would have been primed prior to dialing up the insulin dose for R12 to ensure the proper dose of insulin was administered.</p> <p>Review of the Novolog insulin manufacture's package insert dated 2023, identified the need to perform an airshot before each injection to ensure the any air bubbles were removed. The process directed: Attach a new needle, Select a</p>	F 760	<p>* Create visual aids demonstrating correct priming procedure.</p> <p>Monitoring Mechanism</p> <ul style="list-style-type: none"> - Auditing for proper priming of insulin pen prior to administration x 4 weeks. - Monthly insulin medication error trend analysis. - Ongoing quality assurance monitoring to include random audits and competency checks x2 quarters 	

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F 760	Continued From page 3 dose of 2 units on the dosage selector, hold the pen with the needle pointing upward, tap the insulin reservoir to move any air bubbles to the top of the reservoir, press the injection button all the way in, and check to see if insulin comes out of the needle tip. Repeat if no insulin comes from the needle, then dial the selector to the ordered insulin dose and administer as ordered. Review of a facility policy titled Medication Administration revised 7/23, identified staff would follow appropriate standards and protocols when administering medications.	F 760		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		2/28/25

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F 880	<p>Continued From page 4</p> <p>and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which 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; and</p> <p>(vi) The hand hygiene procedures to be followed</p>	F 880		

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F 880	<p>Continued From page 5 by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement appropriate donning/doffing of personal protective equipment (PPE) practices to prevent the spread of infection for 1 of 3 residents (R21) observed for enhanced barrier precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). This deficient practice had the potential to affect all 22 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of Centers for Disease Control and Prevention (CDC) guidance dated 4/1/24, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions included: dressing,</p>	F 880	<p>Corrective Action</p> <p>1. PPE Accessibility-Completed, 2/14/2025</p> <ul style="list-style-type: none"> - Immediately placed gowns and gloves in all rooms in which MDRO guidelines were in effect including resident R21 Completed - 2/14/2025 - Immediate reeducation to clinical staff on use of gowns with resident R21 in regards to Enhanced Barrier Precautions (EBP)completed during survey. <p>2. Staff Intervention</p> <ul style="list-style-type: none"> - Install wall-mounted PPE dispensers in all rooms for gown placement.- Completion date 2/28/2025. - Direct observation of PPE use of gown in R21's room completed during survey and ongoing for all MDRO precautions in place within the facility. <p>3. Review of Infection Control Policy for</p>	

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F 880	<p>Continued From page 6</p> <p>bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing.</p> <p>R21's significant change Minimum Data Set (MDS) dated 12/28/24, identified R21 had moderate cognitive impairment and diagnoses which included diabetes mellitus (DM), renal insufficiency, and hypertension (elevated blood pressure). Identified R21 required extensive assistance with activities of daily living (ADL's) which included toileting, transferring, and dressing.</p> <p>R21's care plan revised 12/20/24, indicated R21 had a catheter related to bladder outlet obstruction. Care plan directed staff to assist with emptying catheter every shift.</p> <p>During an observation on 1/13/25 at 11:02 a.m., there was a sign on R21's door that stated Enhanced Barrier Precautions; Everyone must clean their hands, including before entering and when leaving the room. Wear gloves and gown for the following high contact resident activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. In addition, the sign contained a picture of hand sanitizer, a gown, and gloves. There were no gowns located inside or outside R21's room.</p> <p>During an observation on 1/13/25 at 1:01 p.m.,</p>	F 880	<p>inclusion of Enhanced Barrier Precautions and expected PPE during high contact activities <input type="checkbox"/> Completed, 2/14/2025.</p> <p>Comprehensive Staff Education Plan - Completion Date 2/20/25.</p> <ul style="list-style-type: none"> - Mandatory training for ALL staff on: <ul style="list-style-type: none"> * Review of Infection Control Policy * Education/Training on high-contact care activities requiring PPE for enhanced barrier precautions <p>Monitoring Mechanism</p> <ul style="list-style-type: none"> - PPE compliance with weekly audits for 4 weeks. - Monthly infection control trend analysis for proper Enhanced Barrier Precaution protocol use. - Ongoing quality assurance monitoring to include random audits and competency checks x2 quarters and as needed 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245579	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/15/2025
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH GRACE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240		
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F 880	<p>Continued From page 7</p> <p>occupational therapy assistant (OTA) entered R21's bathroom, sanitized hands, applied gloves and informed R21 she was there to assist her off the toilet. OTA used toilet paper to wipe R21's perineal area, removed gloves, pulled up R21's pants and washed hands. OTA proceeded to walk along side of R21 in to the therapy room. The only PPE OTA wore while assisting R21 off the toilet was gloves.</p> <p>During an observation on 1/13/25 at 2:56 p.m., nursing assistant (NA)-A entered R21's room, sanitized hands, applied a gait belt around R21's waist and walked with R21 to the bathroom while holding on to the gait belt. NA-A applied gloves and pulled R21's pants down as R21 sat down on the toilet. NA-A used toilet paper to wipe R21's perineal area, removed gloves, pulled up R21's pants and washed hands. NA-A walked with R21 to her recliner while holding on to the gait belt. The only PPE NA-A was wearing while assisting R21 on the toilet was gloves.</p> <p>During an interview on 1/13/25 at 3:01 p.m., NA-A verified the only PPE she had used while toileting R21 was gloves. NA-A stated the only time she needed to wear a gown was when she was working with R21's catheter.</p> <p>During an interview on 1/14/25 at 11:42 a.m., OTA verified the only PPE she had used while toileting R21 was gloves. OTA stated her understanding of EBP was that she only needed to wear a gown when she was working with R21's catheter.</p> <p>During an interview on 1/15/25 at 8:30 a.m., infection preventionist (IP) verified R21 had a catheter and was on EBP. IP stated her understanding of EBP had been that staff only</p>	F 880		

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

PRINTED: 02/12/2025
FORM APPROVED
OMB NO. 0938-0391

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F 880	<p>Continued From page 8</p> <p>needed to wear a gown if they were caring for R21's catheter. IP stated now that she was aware of when a gown should be used, her expectation was that staff would wear a gown when indicated per Centers for Disease Control (CDC) guidance while caring for any resident who was on EBP.</p> <p>During an interview on 1/15/25 at 9:21 a.m., director of nursing (DON) stated her expectation was that PPE would have been readily available to use for any residents in EBP and staff would have worn a gown and gloves while caring for R21.</p> <p>Review of a facility policy titled Standard and Transmission Based Precautions (TBP) revised 11/2/23, identified TBP were special precautions for the care of patients with diseases or conditions of epidemiological significance that are transmitted by contact. Identified gowns were to be worn to protect skin and prevent soiling of clothing during patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions or causing soiling of clothing.</p>	F 880		

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NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH GRACE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240
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K 000	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/14/2025. At the time of this survey, Essentia Health Grace Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.</p> <p>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.</p> <p>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/07/2025
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	<p>Continued From page 1</p> <p>Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR</p> <p>By email to: FM.HC.Inspections@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"> 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. <p>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.</p>	K 000		

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K 000	Continued From page 2 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 capacity of 40 beds and had a census of 23 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			

Minnesota Department of Health

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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 1/13/25 to 1/15/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). A complaint survey was also conducted. Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/07/25
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2 000	<p>Continued From page 1</p> <p>correction you have reviewed these orders and identify the date when they will be completed.</p> <p>The following complaint was reviewed during the survey: H55794600C (MN00109366). No licensing orders were issued.</p> <p>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.</p> <p>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota 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.</p>	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of	21390		2/21/25

Minnesota Department of Health

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21390	<p>Continued From page 3</p> <p>current standards of practice in infection control.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement appropriate donning/doffing of personal protective equipment (PPE) practices to prevent the spread of infection for 1 of 3 residents (R21) observed for enhanced barrier precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). This deficient practice had the potential to affect all 22 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of Centers for Disease Control and Prevention (CDC) guidance dated 4/1/24, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions included: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing.</p> <p>R21's significant change Minimum Data Set (MDS) dated 12/28/24, identified R21 had moderate cognitive impairment and diagnoses which included diabetes mellitus (DM), renal insufficiency, and hypertension (elevated blood</p>	21390	Corrected, 2/15/2025.	

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21390	<p>Continued From page 4</p> <p>pressure). Identified R21 required extensive assistance with activities of daily living (ADL's) which included toileting, transferring, and dressing.</p> <p>R21's care plan revised 12/20/24, indicated R21 had a catheter related to bladder outlet obstruction. Care plan directed staff to assist with emptying catheter every shift.</p> <p>During an observation on 1/13/25 at 11:02 a.m., there was a sign on R21's door that stated Enhanced Barrier Precautions; Everyone must clean their hands, including before entering and when leaving the room. Wear gloves and gown for the following high contact resident activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. In addition, the sign contained a picture of hand sanitizer, a gown, and gloves. There were no gowns located inside or outside R21's room.</p> <p>During an observation on 1/13/25 at 1:01 p.m., occupational therapy assistant (OTA) entered R21's bathroom, sanitized hands, applied gloves and informed R21 she was there to assist her off the toilet. OTA used toilet paper to wipe R21's perineal area, removed gloves, pulled up R21's pants and washed hands. OTA proceeded to walk along side of R21 in to the therapy room. The only PPE OTA wore while assisting R21 off the toilet was gloves.</p> <p>During an observation on 1/13/25 at 2:56 p.m., nursing assistant (NA)-A entered R21's room, sanitized hands, applied a gait belt around R21's</p>	21390		

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21390	<p>Continued From page 5</p> <p>waist and walked with R21 to the bathroom while holding on to the gait belt. NA-A applied gloves and pulled R21's pants down as R21 sat down on the toilet. NA-A used toilet paper to wipe R21's perineal area, removed gloves, pulled up R21's pants and washed hands. NA-A walked with R21 to her recliner while holding on to the gait belt. The only PPE NA-A was wearing while assisting R21 on the toilet was gloves.</p> <p>During an interview on 1/13/25 at 3:01 p.m., NA-A verified the only PPE she had used while toileting R21 was gloves. NA-A stated the only time she needed to wear a gown was when she was working with R21's catheter.</p> <p>During an interview on 1/14/25 at 11:42 a.m., OTA verified the only PPE she had used while toileting R21 was gloves. OTA stated her understanding of EBP was that she only needed to wear a gown when she was working with R21's catheter.</p> <p>During an interview on 1/15/25 at 8:30 a.m., infection preventionist (IP) verified R21 had a catheter and was on EBP. IP stated her understanding of EBP had been that staff only needed to wear a gown if they were caring for R21's catheter. IP stated now that she was aware of when a gown should be used, her expectation was that staff would wear a gown when indicated per Centers for Disease Control (CDC) guidance while caring for any resident who was on EBP.</p> <p>During an interview on 1/15/25 at 9:21 a.m., director of nursing (DON) stated her expectation was that PPE would have been readily available to use for any residents in EBP and staff would have worn a gown and gloves while caring for R21.</p>	21390		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	<p>Continued From page 6</p> <p>Review of a facility policy titled Standard and Transmission Based Precautions (TBP) revised 11/2/23, identified TBP were special precautions for the care of patients with diseases or conditions of epidemiological significance that are transmitted by contact. Identified gowns were to be worn to protect skin and prevent soiling of clothing during patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions or causing soiling of clothing.</p> <p>SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could assure clear directions for staff to follow regarding infection control practices, specific to isolation processes when providing cares to residents to minimize the spread of infection. The Director of nursing or designee could assure staff are trained, randomly monitored, supervised and systems evaluated to assure good infection control practice.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	21390		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 13, 2025

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

RE: CCN: 245579
Cycle Start Date: January 15, 2025

Dear Administrator:

On January 30, 2025, we notified you a remedy may be imposed. On March 12, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 28, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 15, 2025 did not go into effect. (42 CFR 488.417 (b))

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 13, 2025

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

Re: Reinspection Results
Event ID: CPYI12

Dear Administrator:

On March 12, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 15, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us