CENTERS FOR MEDICARE & MEDICAID SERVICES

WEDICARE/WEDICALD CERTIFICATION AND TRANSWITTAL	
PART I - TO RE COMPLETED BY THE STATE SURVEY ACENCY	

ID: ZWHB Facility ID: 00762

MEDICARE/MEDICAID PROVIDER (L1) 245579 2.STATE VENDOR OR MEDICAID NO (L2) 030525100		3. NAME AND AL (L3) ESSENTIA 1 (L4) 116 WEST S (L5) GRACEVIL	HEALTH GRA SECOND STRE	СЕ НОМЕ	(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		
5. EFFECTIVE DATE CHANGE OF O' (L9) 6. DATE OF SURVEY 11/0' 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	7/2017 (L34)(L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	PPLIER CATEGO 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	RY 09 ESRD 10 NF 11 ICF/IID 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30		
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	40 (L18) 40 (L17)	Complian1.		gram	And/Or Approved Waivers Of The2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF)5. Life Safety Code * Code: A	6. Scope of Services Limit 7. Medical Director		
14. LTC CERTIFIED BED BREAKDOV 18 SNF 18/19 SNF 40 (L37) (L38) 16. STATE SURVEY AGENCY REMA	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)		
17. SURVEYOR SIGNATURE Date : Gail Anderson, Unit Supervisor 11/17/2017 (L19)				(L19)	18. STATE SURVEY AGENCY APPROVAL Date: Joanne Simon, Enforcement Specialist 12/01/2017 (L2)			
I	PART II - TO BE	COMPLETED	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE STA	ATE AGENCY		
DETERMINATION OF ELIGIBILE 1. Facility is Eligible to F 2. Facility is not Eligible	Participate		MPLIANCE WITH GHTS ACT:	CIVIL	 Statement of Finan Ownership/Control Both of the Above 	l Interest Disclosure Stmt (HCFA-1513)		
22. ORIGINAL DATE OF PARTICIPATION 07/08/1991 (L24) 25. LTC EXTENSION DATE: (L27)	23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV A. Suspensior B. Rescind Sus	DATE VE SANCTIONS of Admissions:	4. LTC AGREEM ENDING DAT (L25)		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	05-Fail to Meet Health/Safety nt 06-Fail to Meet Agreement		
			(L45)					
28. TERMINATION DATE:	(L28)	03001	UARRIER NO.	(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION 11/08/2017	OF APPROVAL D	ATE				
	(L32)	11/00/2017		(L33)	DETERMINATION APPR	OVAL		



Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245579

November 17, 2017

Ms. Julie Rosenberg, Administrator Essentia Health Grace Home 116 West Second Street Graceville, MN 56240

Dear Ms. Rosenberg:

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 October 24, 2017 the above facility is recommended for:

40 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 17, 2017

Ms. Julie Rosenberg, Administrator Essentia Health Grace Home 116 West Second Street Graceville, MN 56240

RE: Project Number S5579027

Dear Ms. Rosenberg:

On September 29, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 14, 2017. 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 November 7, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 3, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 14, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 24, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 14, 2017, effective October 24, 2017 and therefore remedies outlined in our letter to you dated September 29, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: ZWHB

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

PART I	- TO BE COMPLETED BY THE S	TATE SURVEY AGENCY	Facility ID: 00762			
MEDICARE/MEDICAID PROVIDER NO. (L1)	3. NAME AND ADDRESS OF FACILITY (L3) ESSENTIA HEALTH GRACE HO (L4) 116 WEST SECOND STREET (L5) GRACEVILLE, MN	OME (L6) 56240	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint			
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ES	(L7) RD 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint			
6. DATE OF SURVEY 09/14/2017 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited	02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 IC 04 SNF 08 OPT/SP 12 RF	F/IID 15 ASC	FISCAL YEAR ENDING DATE: (L35) 09/30			
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 40 (L18) 13.Total Certified Beds 40 (L17)	10.THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On: 1. Acceptable POC X B. Not in Compliance with Program Requirements and/or Applied Waivers:	And/Or Approved Waivers Of TI 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNI 5. Life Safety Code * Code: B *	6. Scope of Services Limit 7. Medical Director			
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 40 (L37) (L38) (L39)	ICF IID (L42) (L43)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)			
6. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): Effective October 1, 2017, the five active nursing home beds are permanently decertified in accordance with the permanent delicensure of these same five beds. Effective October 1, 2017, the number of certified SNF/NF beds are 40. After this change they currently have zero (0) beds on layaway. 7. SURVEYOR SIGNATURE Date: 18. STATE SURVEY AGENCY APPROVAL Date:						
Christina Martinson, HFE-NE II	10/20/2017 (L1	Joanne Simon, Certifica	Joanne Simon, Certificatin Specialist 11/08/2017 (L20)			
PART II - TO B	E COMPLETED BY HCFA REGIO	NAL OFFICE OR SINGLE ST	ATE AGENCY			
DETERMINATION OF ELIGIBILITY X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) :			
22. ORIGINAL DATE 23. LTC AGREEM OF PARTICIPATION BEGINNING 07/08/1991 (L24) (L41)		26. TERMINATION ACTION: VOLUNTARY 01 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem	05-Fail to Meet Health/Safety			
25. LTC EXTENSION DATE: 27. ALTERNATI A. Suspension		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active			
28. TERMINATION DATE: 22 (L28)	O. INTERMEDIARY/CARRIER NO. 03001 (L3	30. REMARKS				
31. RO RECEIPT OF CMS-1539 3:	2. DETERMINATION OF APPROVAL DATE (L3)	3) DETERMINATION APPR	ROVAL			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 29, 2017

Ms. Julie Rosenberg, Administrator Essentia Health Grace Home 116 West Second Street Graceville, MN 56240

RE: Project Number S5579027

Dear Ms. Rosenberg:

On September 14, 2017, 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 electronically delivered CMS-2567 whereby corrections are required.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us

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

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 October 24, 2017, 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 October 24, 2017 the following remedy will be imposed:

• Per instance civil money penalty. (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;

Essentia Health Grace Home September 29, 2017

Page 3

- 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 December 14, 2017 (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 March 14, 2018 (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.

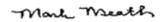
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,



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

Email: mark.meath@state.mn.us

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

cc: Licensing and Certification File

PRINTED: 10/20/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG	COMPLETED		
		245579	B. WING _		09	/14/2017
	PROVIDER OR SUPPLIER	IOME		STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	TS	F 00	00		
	as your allegation of Department's acceptoriolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 ic submission of the POC will tion of compliance.				
F 164 SS=D	on-site revisit of you validate that substate regulations has been your verification. 483.10(h)(1)(3)(i); 4	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with 483.70(i)(2) PERSONAL ENTIALITY OF RECORDS	F 16	54		10/24/17
	medical treatment, communications, p meetings of family	acy includes accommodations, written and telephone ersonal care, visits, and and resident groups, but this e facility to provide a private dent.				
		has a right to secure and al and medical records.				
	of personal and me provided at	s the right to refuse the release edical records except as her applicable federal or state				
		t keep confidential all ed in the resident's records,				
ABORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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

Electronically Signed

10/08/2017

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 A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245579	B. WING			09/14/2017	
	PROVIDER OR SUPPLIER	IOME		1	STREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 164	(ii) To the individual representative whe (iii) Required by Law (iii) For treatment, poperations, as perrwith 45 CFR 164.50 (iv) For public health neglect, or domestiactivities, judicial at law enforcement propurposes, research medical examiners a serious threat to by and in compliant This REQUIREMED by: Based on observativities the facility fainformation was no of 1 residents (R1) Findings include: During afternoon cade (CA) p.m., R1's bath bright, colored pink private care information was no of 1 residents (R1)	orm or storage method of the en release is- , or their resident re permitted by applicable law; v; cayment, or health care nitted by and in compliance	F 1	164	Reviewed the Notice of Privacy Pra policy and is accurate and up to date 9/14/17 Poster that was posted in R room with verbal consent was remor R1 individual care plan was reviewe updated. Future type information widocumented on individual "All about sheets and updated in the care plan This was reviewed at Resident Cour 10/2/17. A facility walk thru to assess all area the building for any other private hea information was posted in view of ot Staff will be re-educated on resident rights and privacy in October by at lease of the following: 1:1 meetings	e. 11 ved. d and ill be me" n. ncil on as of alth thers.	

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245579	B. WING			09/-	14/2017
	PROVIDER OR SUPPLIER	OME		11	TREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET RACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE			
F 164	when R1's bathroor open. On 9/12/17, observed from the I past R1's door. On again at 12:15 p.m. the hallway. R1's care plan date needed an EZ stanwith staff assist relative the staff assist relative the staff assist relative the sheets, the care plareceived updated in the shift during reports assist of one staff at times would swing I transfers. NA-A felt staff to operate the NA-A confirmed the was easily visible to personal care information private place. During interview on nursing assistant (Nathroom wall. Nathroom wall. Natisible to visitors in were in the room. Natical place on the wall the with R1's cares.	m and bedroom door were at 3:44 p.m., the poster was nallway, and visitors walked 9/13/17, at 7:53 a.m and the poster was visible from d 3/16/17, indicated R1 d (mechanical lift) for transfers	F 1	64	stand-ups, or scheduled meetings competency evaluations following education. Yearly staff education on residents with the Ombudsman is scheduled held on 11/9/17. DON or designee will complete Ramonthly facility audits X 3 months tensure compliance. Audit information will be presented Quality Assurance and Performance Improvement Committee.	rights to be ndom o	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		E SURVEY IPLETED
		245579	B. WING		09/	14/2017
	PROVIDER OR SUPPLIER	OME		STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240	, ,	- 11 - 12 - 12
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 164	on the poster regar in the hallway. During interview on director of nursing placed on R1's wall R1 that staff had be explained after the collected, R1 denie clarified she felt stallift too fast when trabathroom. The DOI placed on the wall twhen using the methe posted information and vis and visitor's in R1's stated the information.	ding R1 was visible to visitors 9/14/17, at 12:49 p.m. the (DON) stated the sign was I following an allegation from een rough with her. The DON initial information was d abuse or mistreatment, and off had used the mechanical ansferring her in and out of the N stated the poster was then to remind staff to slow down chanical lift. The DON stated	F 16	4		
F 225 SS=E	9/2013, indicated s privacy while handl information means electronic or paper, by facility and is repayment for the production of the prod	ity must- therwise engage individuals d guilty of abuse, neglect, propriation of property, or	F 22	5		10/24/17

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245579	B. WING _		09/	14/2017	
	PROVIDER OR SUPPLIER A HEALTH GRACE H	ОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 225	Continued From pa	ge 4	F 22	25			
	nurse aide registry	ing entered into the State concerning abuse, neglect, atment of residents or their property; or					
	or her professional body as a result of	ary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or resident property.					
	licensing authorities actions by a court of	ate nurse aide registry or sany knowledge it has of of law against an employee, se unfitness for service as a facility staff.					
		ullegations of abuse, neglect, treatment, the facility must:					
	abuse, neglect, expincluding injuries of misappropriation of reported immediate after the allegation cause the allegation serious bodily injury the events that cau abuse and do not rethe administrator of officials (including tadult protective ser for jurisdiction in londard misappropriate administration of the administrator of officials (including tadult protective ser for jurisdiction in londard misappropriate administration in londard misappropriate administration in londard misappropriate administration in londard misappropriation in londard misappropriation of the londard misappropriation in londard misappropriation misapprop	alleged violations involving ploitation or mistreatment, unknown source and resident property, are ely, but not later than 2 hours is made, if the events that in involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other to the State Survey Agency and vices where state law provides ing-term care facilities) in ate law through established					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245579	B. WING			09/1	14/2017
	NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH GRACE HOME			11	TREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET FRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	thoroughly investigated (3) Prevent further exploitation, or mist investigation is in personal content of the result administrator or his representative and with State law, incluated Agency, within 5 woif the alleged violatic corrective action mand the sale of the alleged violatic corrective action mand the sale of t	that all alleged violations are ated. potential abuse, neglect, reatment while the rogress. Its of all investigations to the or her designated to other officials in accordance uding to the State Survey orking days of the incident, and on is verified appropriate ust be taken. NT is not met as evidenced eview and interview, the facility by report to the state agency by investigate observed 1 of 1 resident (R24), an 1 resident (R48) and a altercation involving 2 of 2 of 1 addition, the facility in allegation of physical abuse of manner for 1 of 1 residents	F 2	.25	SA was notified of all omitted event allegations of abuse and elopement R48, R24, R20 and thoroughly investigated in accordance with statlaws. Reviewed and revised the VA policy Staff will be educated on reporting requirements for alleged violations involving abuse, neglect, or mistreat Licensed staff will be educated regathe requirement to initiate an event when an incident of potential abuse/mistreatment occurs and to alleged violations of abuse/mistreat immediately to the Administrator. Licensed staff will also be re-educatinitiate an OHFC report immediately notification of a potential abuse/neglect/mistreatment report, investigate any allegations, and represults of the investigation and corractions taken to the appropriate offi accordance with state law.	t for te /. atment. arding report report tment ted to y upon oort ective	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245579	B. WING		09/1	4/2017
	PROVIDER OR SUPPLIER	IOME		STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 225	Achilles tendon, an of one staff for ADL the potential for phyothers and infliction adults. R24's care interventions include such behavior at tirprogress note date father. R24's progress not 7/23/17, at 3:48 p.r. was tearful after a freported to the nursabusive" to her. R2 visiting her at the fawishes would be codirected to put her the facility. Staff word dad. R24 agreed to R24 she would spedesignee (SSD) on 7/24/17, at 4:29 p.r. nursing (DON) visit R24 stated she did anymore. R24 stated told her to "shut up her safety. Nursing visitors and R24 waneeded assistance 8/12/17, at 3:35 p.r. that her dad was puwheelchair. When sher, he hit her on towas not hurt. The residence in the stafe in the safety in the safety. When sher, he hit her on towas not hurt. The residence in the stafe in the safety. When sher, he hit her on towas not hurt. The residence in the stafe in the safety in the safety. When sher, he hit her on towas not hurt. The residence in the safety in the sa	d required limited assistance als. R24's care plan indicated spical and verbal abuse by a of abuse on other vulnerable plan listed various ling to encourage R24 to tell of the of occurrence, refer to a 7/24/17 in regards to R24's relephone conversation and the set that her dad was "verbally 4 stated she did not want him accility. The nurse told R24 her to be a the set of the plan. The nurse informed ask with the social service	F 225	Staff education/ training will be by one of the following; 1:1, standup scheduled meetings held in Octo 2017. All new hires will be educated on during orientation and through Sofacility electronic education and there after and PRN. Reviewed at resident council me 10/2/17 VA policy, if any resident unsafe at anytime to report to standling residents have the potential to affected if alleged violations are reported immediately and thorous investigated in accordance with sthrough established procedures. IDP team will review daily events appropriate reporting and on-call review on weekends. Reconciliat 2017 events to VA log was compomissions have since been submithe SA. Social Service or designee will converted to be reviewed with QAPI committee.	VA policy ABA annually eting on s feel off. be not ghly state law, for RN will ion of all leted all nitted to complete chly X 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ОМЕ		11	TREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET FRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	room waiting for dir approached her. R the incident on 8/12 medication cart. WI the medication cart want him to come a stated he didn't card dad was observed arm and then on he and walked away. I talk to the SSD on 8 The allegation of phe facility staff on 8/12 submitted to the SA 1:35 p.m An invest and submitted to the The physical alterca on 8/13/17, at 11:40 father was not reported facility did not the SA veconfirmed R24's rewas submitted to the R24 had an on againer father. R24 dict wanted him to visit SSD identified R24	m.: R24 was in the dining oner when her father 24 was uncomfortable from 2/17. R24 agreed to sit by the nen her father came over to R24 told her dad she didn't around so much. R24's father e, he was still her father. Her to swat R24 on the side of the er thigh. Her dad then laughed the nurse told R24 staff would	F 2	225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245579	B. WING		09	/14/2017
	PROVIDER OR SUPPLIER	IOME		STREET ADDRESS, CITY, STATE, ZIP CO 116 WEST SECOND STREET GRACEVILLE, MN 56240	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 225	was not aware of the 11:40 a.m. until she SSD verified the in a.m. was not report. The SSD said there incident to her, and the vulnerable adu On 9/14/17, at 2:21 (DON) verified all abe reported to the verified the report was late. Further, thave been an ever would have confirm administrator and report aware of the phand her father with 8/13/17, incident aware of the phand her father with 8/13/17, until asked at 2:30 p.m. The Donotes stating she of the 8/13/17, incident visited with the SS to visit. The DONoreport the event from complete a thorough stated the staff me vulnerable adult poon 9/14/17, 2:35 phane heard about both 8/12/17, and 8/13/10 confirmed staff upon soon as they were The administrator or report observed and hours to the SA, af administrator identification.	known. The SSD stated she he incident from 8/13/17, at he got to work on 8/14/17. The cident on 8/13/17, at 11:40 ted to the SA or investigated. It was a delay in reporting the state facility needed to revisit a guidelines. I p.m. the director of nursing alleged abuse incidents should SA within two hours. The DON submitted to the SA on 8/13/17 he DON stated there should at report completed which hed what time the DON, medical doctor were notified of het. The DON stated she was hysical altercation between R24 essed by facility staff on d by the surveyor on 9/14/17, ON then reviewed progress lid not see much follow up of het. The DON reported staff D and directed R24's dad not verified the facility did not hom 8/13/17, to the SA or gh investigation. The DON mber should have followed the	F 2	225		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (V41) PROVIDED (SUBDILITATION AND HUMAN SERVICES

NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH GRACE HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 225 Continued From page 9 vulnerable adult policy. ESSENTIA HEALTH GRACE HOME STREET ADDRESS, CITY, STATE, ZIP COID 116 WEST SECOND STREET GRACEVILLE, MN 56240 10 PROVIDER'S PLAN OF CORRECTIVE ACTION S CROSS-REFERENCED TO THE AFT DEFICIENCY)	DE .)/14/2017		
ESSENTIA HEALTH GRACE HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 225 Continued From page 9 vulnerable adult policy. 116 WEST SECOND STREET GRACEVILLE, MN 56240 PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AFT DEFICIENCY) F 225 vulnerable adult policy.	DE .			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 225 Continued From page 9 vulnerable adult policy. F 225 (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AFTER DEFICIENCY)	===:=:			
vulnerable adult policy.	HOULD BE	(X5) COMPLETION DATE		
The facility's Vulnerable Adult Policy dated 1/19/17, indicated the facility would assure resident safety by assisting staff to recognize, respond and report maltreatment of vulnerable adults, and to establish procedures and responsibilities for protecting all residents dependent upon the facility for their health care services for providing them a safe environment. Reporting/Investigation Procedures for actual or suspected abuse/neglect: 1. Any employee who witnesses, suspects maltreatment or is informed of an event involving a facility employee immediately reports the event to the administrator or designee. 2. The administrator or designee will complete a facility Incident/Event Report within 2 hours if reportable. R48 had an elopement incident on 7/24/17. The facility failed to immediately report to the SA and thoroughly investigate the elopement. Review of R48's progress notes from 7/1/17, through 8/30/17, revealed a progress note dated 7/24/17, describing an unwitnessed, off property elopement by R48. The progress note lacked information related to the administrator or SA notification. Additionally, the progress notes failed to identify completion of a thorough investigation. R48's significant change MDS dated 6/22/17, indicated R48 had diagnoses which included Alzheimer's disease, dementia, anxiety and depression. R48's MDS identified R48 was severely cognitively impaired and ambulated				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245579	B. WING		·····	09/·	14/2017
	PROVIDER OR SUPPLIER	ОМЕ		11	TREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET BRACEVILLE, MN 56240		
(X4) ID PREFIX TAG				Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Assessment (CAA) wandered through to exit the facility. Twore a bracelet on she was leaving the R48's nursing progregistered nurse (Rathe north door alarmursing assistant (National States) north of was located inside accompany NA-F be Safety Events-Essedated 7/24/17, indicated through the north door and entered the house. Staff went of to see her right away to the house immediately. The report in about "getting out of attempted to go out outside. A wanderg properly. R48 was worth to impaired short teach the report did not in of the vulnerable accompany interview on stated she was worth.	Imptoms Care Area dated 6/27/17, indicated R48 but the facility and attempted he CAA also indicated R48 her ankle to alert staff when e building. I wess note created by (N)-A dated 7/24/17, indicated in sounded and when a NA)-F walked outside R48 was the back door to the house of the facility was closing. R48 the house and was reluctant to tack to the facility. I went a Elopement (11/2010), cated R48 exited the facility oor, walked across a parking back door of a neighboring ut to get R48 but was unable ay. Staff noted the back door diately north of the facility was side the house and panied staff back to the indicated R48 often talked of here" and going home. R48 to doors and sometimes made it uard was in place and worked very difficult to redirect related orm memory and inattention. Indicate if the SA was notified	F 2	225			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245579	B. WING		09/	14/2017
	PROVIDER OR SUPPLIER IA HEALTH GRACE H	ОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 225	active that day and R48 walked out the and a nursing assis neighboring house went to the house a could not recall if sl anyone. RN-A confivulnerable adult regelopement. During an interview DON confirmed that on 7/23/17, and wa house. The DON st elopement and dep safety, because R4 The DON confirmed was completed on wanderguard was a was made aware of interdisciplinary me 7/25/17. The DON report was not com DON indicated she report an elopement two hours of the eloidentify if the admin elopement. R20 and R48 had a immediately reported investigated. R20's progress not was hit in the back	ge 11 nent and stated R48 was really she just couldn't settle down. north door, the alarm went off stant saw the back door of the closing. The nursing assistant and returned with R48. RN-A he reported the elopement to rmed she did not make a port with the SA regarding this on 9/14/17, at 2:33 p.m. the st R48 eloped from the building liked into the neighboring stated R48 was at risk for ended on facility staff for 8 lacked safety awareness. It is an elopement assessment R48 upon admission and a supplied. She confirmed she if the elopement on during an eting review of the event on stated a vulnerable adult pleted for this elopement. The would expect nursing staff to at off property to the SA within opement. The DON could not instrator was updated on this an altercation which was not ed to the SA or thoroughly	F 225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245579	B. WING _		09	/14/2017
-	PROVIDER OR SUPPLIER	IOME		STREET ADDRESS, CITY, STATE, ZIP COD 116 WEST SECOND STREET GRACEVILLE, MN 56240		714/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 225	R20's admission M R20 had diagnoses non-displaced fract the right foot, type I diabetic polyneurop nerves that causes burning pain), and indicated R20 was identified she had cher at risk for physi interfered with her seems behavior and Mood Aggressive/Comba 8/19/17, indicated Farea. Prior to R48's behavior R48 was a Day Room. Event refunction varied oveusually on the moverestlessness, and between the report also ind with other residents. The event report in behavior symptoms four to six days a wand other behavior towards others like put others at significant to the report stated FR48 hit her. Progrethe interdisciplinary behavior of R48. The continue to encourain safe areas to attention. It also incontinue to encourain safe areas to attention. It also incontinue to encourain safe areas to attention. It also incontinue to encourain safe areas to attention. It also incontinue to encourain safe areas to attention. It also incontinue to encourain safe areas to attention in behavior in behavio	DS dated 7/3/17, indicated which included a cure of the fifth metatarsal of II Diabetes Mellitus with pathy (damage to peripheral weakness, numbness and depression. R20's MDS cognitively intact. R20's MDS daily verbal behaviors that put cal injury and significantly social interactions.	F 22	25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245579	B. WING _		09/	14/2017
	PROVIDER OR SUPPLIER A HEALTH GRACE H	OME		STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	discussed the event to the kitchen to thr When I stood up she backside. It didn't he [R48] was still by the moves fast." On 9/14/17, at 2:45 event of aggressive 8/19/17, appeared the resident (R20) on the still by the facility to a rewould be to immedie each resident was seen to confirme updated. The DON confirmed updated. The DON resident to resident the administrator at stated R48 was at a rabuse from others of the port, the administration of the still and the still still be still	17, indicated that SSD-A t with R20. R20 stated "I went ow away my ice cream cup. he was behind me and hit my urt it just startled me. I thought e other doors, she sure p.m., the DON stated the elombative behavior on to be R48 hitting another he back. The normal response esident to resident altercation fately intervene to make sure safe and file a vulnerable adult on confirmed a VA report was ident to resident altercation. If the administrator was not identified she would expect a altercation to be reported to ond SA immediately. The DON risk for physical and verbal due to her wandering. p.m., the administrator stated of requiring a vulnerable adult rator would expect to be yellow.	F 22	25		
F 226 SS=E	Adult Abuse Prever Procedures Policy of abuse, neglect and property would be r and state agencies 483.12(b)(1)-(3), 48	•	F 22	6		10/24/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245579	B. WING			09/ ⁻	14/2017
	PROVIDER OR SUPPLIER	OME		11	TREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET RACEVILLE, 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Continued From pa	ge 14	F 2	26			
		t develop and implement procedures that:					
	 (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, (b) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- 						
		constitute abuse, neglect, sappropriation of resident at § 483.12.					
		or reporting incidents of abuse, n, or the misappropriation of					
	(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced						
	facility failed to oper prevention policy fo	r and document review, the rationalize their abuse r 3 of 3 residents ewed for abuse prohibition.			SA was notified of all omitted even allegations of abuse and elopemen R48, R24, R20 and thoroughly investigated in accordance with stalaws.	t for	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		245579	B. WING			09 /1	14/2017
	PROVIDER OR SUPPLIER	ОМЕ	STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE. MN 56240				., = 3
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	The facility's Vulner 1/19/17, indicated to resident safety by a respond and report adults, and to establic responsibilities for pulse dependent upon the services for providing Reporting/Investigates suspected abuse/notes. Any employee with maltreatment or is in a facility employee to the administrator facility Incident/Evereportable. R24's admission M7/24/17, indicated Fassistance with activated in identified mode no behaviors. The Malter depression, anxiety tendon. R24's care plan data a self-care deficit reachilles tendon, and of one staff for ADL the potential for phyothers and infliction adults. R24's care plan data self-care deficit reachilles tendon, and for estaff for ADL the potential for phyothers and infliction adults. R24's care plan data self-care deficit reachilles tendon, and for estaff for ADL the potential for phyothers and infliction adults. R24's care plan data as the potential for phyothers and infliction adults. R24's care plan data as the potential for phyothers and infliction adults. R24's care plan data as the potential for phyothers and infliction adults. R24's care plan data as the potential for phyothers and infliction adults. R24's care plan data as the potential for phyothers and infliction adults. R24's progress note date father.	he facility would assure he facility would assure he facility would assure he facility would assure he facility staff to recognize, maltreatment of vulnerable olish procedures and protecting all residents he facility for their health careing them a safe environment. Action Procedures for actual or health careing them a safe environment. The witnesses, suspects and witnesses, suspects and strained of an event involving himmediately reports the event for designee. The ror designee will complete a not Report within 2 hours if the minimum Data Set (MDS) dated and R24 required limited himmediately living (ADL's), the rately impaired cognition and MDS included diagnoses of and strain of left Achilles and strain of left Achilles hed 8/4/17, indicated R24 had belated to surgery on the left of required limited assistance had been and verbal abuse by the fabuse on other vulnerable had been as a surgery on the ror with the factor of the	F 2	226	Reviewed and revised the VA policy Staff will be educated on reporting requirements for alleged violations involving abuse, neglect, or mistreat Licensed staff will be educated regathe requirement to initiate an event when an incident of potential abuse/mistreatment occurs and to alleged violations of abuse/mistreatimmediately to the Administrator. Licensed staff will also be re-educatinitiate an OHFC report immediately notification of a potential abuse/neglect/mistreatment report, investigate any allegations, and represults of the investigation and corractions taken to the appropriate off accordance with state law. Staff education/ training will be by a one of the following; 1:1, standups scheduled meetings held in Octobe 2017. All new hires will be educated on Voluring orientation and through SAB-facility electronic education and an there after and PRN. Reviewed at resident council meeti 10/2/17 VA policy, if any residents funsafe at anytime to report to staff. Ombudsmen is scheduled to hold education for staff, residents and fain November, 2017. All residents have the potential to be affected if alleged violations are not reported immediately and thorough investigated in accordance with statthrough established procedures.	atment. arding report report tend to y upon ort ective icials in at least or er, A policy A nually ng on eel The amilies e t	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245579	B. WING			00/-	14/2017
NAME OF I	PROVIDER OR SUPPLIER	240070			TREET ADDRESS, CITY, STATE, ZIP CODE	09/	14/2017
10 10 1	THO VIDENT ON CONTINUENT				16 WEST SECOND STREET		
ESSENT	IA HEALTH GRACE H	IOME			GRACEVILLE, MN 56240		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETION DATE
F 226	26 Continued From page 16		F 2	226			
	· ·	4 stated she did not want him			IDP team will review daily events for	ır	
		acility. The nurse told R24 her			appropriate reporting and on-call R		
		ommunicated to staff. R24 was			review on weekends. Reconciliation		
	directed to put her	call light on if her dad came to			2017 events to VA log was complet	ed all	
	the facility. Staff wo	ould could remove her or her			omissions have since been submit		
		the plan. The nurse informed			the SA.		
		ak with the social service			Social Service or designee will com		
	designee (SSD) on				weekly audit X3 weeks and monthl	y X 3	
	7/24/17, at 4:29 p.m.: The SSD and director of				results to be reviewed with QAPI		
		ed with R24 at her request. n't want her dad to visit			committee.		
		ed "he talked mean" to her and					
		". R24 denied being fearful for					
		staff was to observe for					
		as to use call light if she					
		due to an unwanted visitor.					
	8/12/17, at 3:35 p.n	n.: R24 reported to the nurse					
		ushing her outside in the					
		she asked him to stop pushing					
		op of the head. R24 stated she					
		ote identified "nurse will					
		or her dad, at this time her dad					
	is not here."	m . DO4 was in the dining					
		m.: R24 was in the dining nner when her father					
		24 was uncomfortable from					
		2/17. R24 agreed to sit by the					
		hen her father came over to					
		R24 told her dad she didn't					
		around so much. R24's father					
		e, he was still her father. Her					
		to swat R24 on the side of the					
		er thigh. Her dad then laughed					
		The nurse told R24 staff would					
	talk to the SSD on 8						
		nysical abuse reported to					
		1/17, at 3:35 p.m. was					
		A by the facility on 8/13/17, at stigative report was completed					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG		COMPLETED		
		245579	B. WING _		09	/14/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 226	and submitted to the The physical alterdon 8/13/17, at 11:4 father was not reported the facility did not to incident. On 9/14/17, at 1:57 designee (SSD) verified all allegation reported to the SA confirmed R24's rewas submitted to the R24 had an on againer father. R24 did wanted him to visit SSD identified R24 reliable historian, an eeds and desires was not aware of the 11:40 a.m. until she SSD verified the in a.m. was not report the SSD said ther incident to her, and the vulnerable adu On 9/14/17, at 2:22 (DON) verified all abe reported to the verified the report was late. Further, thave been an ever would have confirm administrator and the 8/12/17, incide not aware of the plant of t	re SA on 8/17/17, at 2:27 p.m. reation observed by facility staff 0 a.m. between R24 and her orted to the SA. Additionally, horoughly investigate the regreted she was in charge of the program in the facility. The SSD as of abuse are expected to be within two hours, and reported allegation on 8/12/17 and SA late. The SSD indicated ain off again relationship with tated whether or not she her throughout her stay. The swas alert and oriented, a and capable of making her known. The SSD stated she he incident from 8/13/17, at 11:40 and the same and delay in reporting the delay the facility needed to revisit lat guidelines. In p.m. the director of nursing alleged abuse incidents should SA within two hours. The DON stated there should an report completed which med what time the DON, medical doctor were notified of out. The DON stated she was nysical altercation between R24	F 22	26			
	The SSD said ther incident to her, and the vulnerable adu On 9/14/17, at 2:2' (DON) verified all abe reported to the verified the report was late. Further, thave been an ever would have confirm administrator and the 8/12/17, incide not aware of the pland her father with 8/13/17, until asket	e was a delay in reporting the dethe facility needed to revisit lit guidelines. In p.m. the director of nursing alleged abuse incidents should SA within two hours. The DON submitted to the SA on 8/13/17 he DON stated there should not report completed which need what time the DON, medical doctor were notified of nt. The DON stated she was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245579	B. WING			09 /	14/2017
	PROVIDER OR SUPPLIER	ОМЕ		11	TREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET FRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	the 8/13/17, incider visited with the SSI to visit. The DON visit. The DON visit. The DON visit the event from the complete at thorough stated the staff men vulnerable adult po On 9/14/17, 2:35 p. she heard about be 8/12/17, and 8/13/1 confirmed staff updes soon as they were at the administrator viceport observed annours to the SA, after administrator idential at thorough investigically failed to immediately investigated and the complete staff updes and the staf	id not see much follow up of ht. The DON reported staff of and directed R24's dad not verified the facility did not m 8/13/17, to the SA or the investigation. The DON inber should have followed the licy. In the administrator stated of the facility incidents, on the administrator stated of the facility incidents, on the administrator stated her on the situation as able and stated it was timely. The administrator stated her on the situation as able and stated it was timely. The reflect of alleged abuse within two ster protecting the resident. The field staff was then to complete ation as outlined in the licy. In the incident on 7/24/17. The necliately report to the SA and ate the elopement. The progress note dated an unwitnessed, off property. The progress note lacked to the administrator or SA mally, the progress notes failed on of a thorough investigation.	F 2	226			
	Alzheimer's disease depression. R48's I severely cognitively	diagnoses which included e, dementia, anxiety and MDS identified R48 was impaired and ambulated th supervision. R48's MDS					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245579	B. WING			09/ ⁻	14/2017
	PROVIDER OR SUPPLIER	OME		116	EET ADDRESS, CITY, STATE, ZIP CODE WEST SECOND STREET ACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	also indicated R48 at significant risk of dangerous place ar activities of others. R48's behavioral sy Assessment (CAA) wandered through to exit the facility. Twore a bracelet on she was leaving the R48's nursing progregistered nurse (R the north door alarm nursing assistant (N not seen, but noted immediately north twas located inside accompany NA-F b Safety Events-Essedated 7/24/17, indicative and entered the house. Staff went of to see her right awas to the house immediately. The report in about "getting out of attempted to go out outside. A wanderg properly. R48 was we to impaired short te	wandered daily, placing R48 getting to a potentially and intruding on the privacy or emptoms Care Area dated 6/27/17, indicated R48 but the facility and attempted the CAA also indicated R48 ther ankle to alert staff when a building. The sess note created by N)-A dated 7/24/17, indicated an sounded and when a NA)-F walked outside R48 was the back door to the house of the facility was closing. R48 the house and was reluctant to ack to the facility. The sential Elopement (11/2010), stated R48 exited the facility boor, walked across a parking back door of a neighboring ut to get R48 but was unable by. Staff noted the back door diately north of the facility was side the house and panied staff back to the indicated R48 often talked of here" and going home. R48 to doors and sometimes made it ward was in place and worked wery difficult to redirect related rm memory and inattention. Indicate if the SA was notified	F 2	26			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245579	B. WING			09 /	14/2017	
	PROVIDER OR SUPPLIER	OME		STREET ADDRESS, CITY, STATE, ZIP (116 WEST SECOND STREET GRACEVILLE, MN 56240	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPF	BE	(X5) COMPLETION DATE	
F 226	During interview on stated she was wor was the charge nur recalled the elopemactive that day and R48 walked out the and a nursing assis neighboring house went to the house a could not recall if shanyone. RN-A confivulnerable adult repelopement. During an interview DON confirmed that on 7/23/17, and wa house. The DON st elopement and depsafety, because R4 The DON confirmed was completed on I wanderguard was a was made aware of interdisciplinary me 7/25/17. The DON steport was not com DON indicated she report an elopement two hours of the eloidentify if the admin elopement. R20 and R48 had a immediately reported investigated.	ge 20 9/14/17, at 1:19 p.m. RN-A king the day of 7/23/17, and se for the facility. RN-A lent and stated R48 was really she just couldn't settle down. north door, the alarm went off tant saw the back door of the closing. The nursing assistant and returned with R48. RN-A line reported the elopement to rmed she did not make a loort with the SA regarding this on 9/14/17, at 2:33 p.m. the t R48 eloped from the building liked into the neighboring liked into the neighboring liked into the neighboring ated R48 was at risk for ended on facility staff for 8 lacked safety awareness. d an elopement assessment R48 upon admission and a lipplied. She confirmed she if the elopement on during an eting review of the event on stated a vulnerable adult pleted for this elopement. The would expect nursing staff to at off property to the SA within lippement. The DON could not instrator was updated on this an altercation which was not led to the SA or thoroughly be dated 8/19/17, indicated R20 by another resident (R48) that	F 2	226				

AND PLAN OF CORRECTION	` '			COMPLETED			
	245579	B. WING			09	/14/2017	
NAME OF PROVIDER OR SUPPLIEF ESSENTIA HEALTH GRACE		•	116	REET ADDRESS, CITY, STATE, ZIP CODE WEST SECOND STREET ACEVILLE, MN 56240	COMPL 09/14 ZIP CODE F CORRECTION CTION SHOULD BE THE APPROPRIATE		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
information. R20's admission MR20 had diagnose non-displaced fracther right foot, type diabetic polyneuro nerves that causes burning pain), and indicated R20 was identified she had her at risk for physinterfered with her Behavior and Moo Aggressive/Combo 8/19/17, indicated area. Prior to R48' behavior R48 was Day Room. Event function varied own usually on the moorestlessness, and The report also individually on the resident The event report in behavior symptom four to six days a sand other behavior towards others like put others at signiful The report stated R48 hit her. Progret the interdisciplinar behavior of R48. The report of R48. The report of R48.	age 21 e incident report for further MDS dated 7/3/17, indicated a sture of the fifth metatarsal of II Diabetes Mellitus with pathy (damage to peripheral s weakness, numbness and depression. R20's MDS acognitively intact. R20's MDS daily verbal behaviors that put sical injury and significantly social interactions. d Events Essentia active Behavior (11/2010) dated R48 hit R20 on the mid-back saggressive/combative wandering around in the North report indicated R48's mental er the course of the day, was be physically, had anxiety, behaviors throughout each day dicated R48 was easily annoyed as and very difficult to redirect. Indicated R48 had physical as directed toward others on week, verbal behaviors daily, ral symptoms not directed a pacing/rummaging daily that ficant risk for physical injury. R20 was "angry" and upset that ess notes indicated they would rage rummaging and activities		226				

				ATE SURVEY DMPLETED		
		245579	B. WING _		09	/14/2017
	PROVIDER OR SUPPLIER	ОМЕ		STREET ADDRESS, CITY, STATE, ZIP COD 116 WEST SECOND STREET GRACEVILLE, MN 56240	•	
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F 226	R48's physician abordacement in behave medication manage for R20 dated 8/29/discussed the event to the kitchen to the When I stood up shoackside. It didn't he [R48] was still by the moves fast." On 9/14/17, at 2:45 event of aggressive 8/19/17, appeared resident (R20) on the post of the facility to a rewould be to immed each resident was: (VA) report. The DON ont filed for this resupdated. The DON resident to resident the administrator at stated R48 was at a abuse from others. On 9/14/17, at 2:55 if an event occurred report, the administration of the facility's Comb Adult Abuse Prevent Procedures Policy abuse, neglect and	out medications and possible vioral health facility for ement. Another progress note (17, indicated that SSD-A at with R20. R20 stated "I went row away my ice cream cup. he was behind me and hit my turt it just startled me. I thought he other doors, she sure (1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1	F 22	26		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245579	B. WING _		09/	14/2017	
	SSENTIA HEALTH GRACE HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 241 Continued From page 23 F 241 F 241 SS=D INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that			STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 241 F 241	Continued From pa 483.10(a)(1) DIGN INDIVIDUALITY (a)(1) A facility must resident in a mann promotes maintenather quality of life reindividuality. The fapromote the rights This REQUIREME by: Based on observative, the facility of dining experience observed during the Finding include: R7's care plan (CP R7 had diagnoses (paralysis) and her left non-dominant of dementia. R7's CP process and requir complete all activities Further review of the	age 23 ITY AND RESPECT OF st treat and care for each er and in an environment that ance or enhancement of his or ecognizing each resident's acility must protect and of the resident. NT is not met as evidenced tion, interview and document failed to ensure a dignified for 1 of 1 residents (R7) e breakfast meal. P) revised on 8/1/17, identified which included hemiplegia miparesis (weakness) affecting side, dysphasia and vascular identified altered thought ed assistance from staff to lies of daily living (ADL's). The CP directed staff to provide the ce with meals and cues on	F 24	DEFICIENCY)	ts right for staff to ltimes if t one of nd-ups, or nd petency (this is eractions activities ain and d	10/24/17	
	During continual of meal on 9/12/17, b seated in a wheelc the main dining roo on her chest. R7 w with bedside table was higher than the food in front of her. (LPN)-A was obser	pservation of the breakfast eginning at 8:54 a.m. R7 was hair in the far north corner of om. R7 had a clothing protector as seated at a table by herself in front of her. The wheelchair e dining room table. R7 had Licensed practical nurse eved standing next to the R7 on the left side. LPN-A had		- Grooming as the resident wish groomed Promoting independence and dining experience such as to avof: I. Day-to day use of plastic cut! II. Staff standing over residents assisting them to eat; III. Staff interacting/ conversing each other rather that with resid assisting residents;	dignity in oidance ery; while only with		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 241	right hand and was At 8:55 a.m. LPN-A cup with a straw in offered R7 a drink suck up the straw" LPN-A repeated R7 childish tone attem the straw. At 8:56 a.m. LPN-A and asked R7 if sh LPN-A repeated R7 childish tone of voice and continued atternot cereal while tall At 8:58 a.m. R7 was LPN-A removed R7 juice. and wheeled adjacent sitting are drinks of the juice with the straw of the juice with the juice with the straw of the juice with the	left hand, a silver spoon in her giving R7 bites of hot cereal. A took a white covered plastic it half full of juice. LPN-A while stating "[R7] you have to in a childish tone of voice. 7's name several times in the pting to get her to drink from A took R7's bowl of hot cereal e was ready for another bite. 7's name several times using a ce. LPN-A remained standing mpting to give R7 bites of the king in a childish tone of voice. As done eating the hot cereal. 7's clothing protector, took the R7 from the dining room to the ca. LPN-A continued to give R7 while standing next to her. SO p.m. LPN-A verified she feeding R7, stating "I stand is so high." LPN-A indicated h or see R7 if she did not stand LPN-A indicated she could use t did not think the facility had a LPN-A stated "I have always d I like to see her face." LPN-A ved she fed R7 in a dignified a LPN-A the dietary manager e has seen staff standing while the higher wheelchairs. The should be seated at eye level ents further stating "we could r staff." The DM indicated staff posed to be seated while	F 241	b) Respecting residents by sprespectfully. addressing the rea name of their choice, etc. Training video on assisting reswill be used to assist in education along with competency evaluated following the training video. The completed by 10/20/17 All residents have the potential affected by the alleged deficienthe entire dinning service will monitored to assure no other were affected. No other concludent noted. Yearly staff education on residuith the Ombudsman is scheckled on 11/9/17. Compliance Monitoring will be at various meals X 1 week and weekly X3 weeks. Results will reviewed with the Quality Assisteries and the provement complete in the provement comple	esident with sident to eat sting staff ation raining wil al to be ent practice, be residents erns have dents rights duled to be e done daily d then ll be urance		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY PLETED
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(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
feeding residents. On 9/14/17, at 2:56 (DON) confirmed st residents "for dignity indicated staff shou dignity while feeding. Review of facility poreviewed on 1/17/17 right to a dignified eand communication and services inside 483.21(b)(3)(ii) SEF PERSONS/PER CARTONS/PER CARTONS/P	p.m. the director of nursing aff should sit while feeding y, respect." The DON ld treat the resident with g them. Dicy titled, Resident Rights 7, indicated the resident has a xistence, self- determination with and access to persons and outside the facility. RVICES BY QUALIFIED ARE PLAN The care Plans ed or arranged by the facility, omprehensive care plan, and comprehensive care plan of the resident's written plan of the resident's written plan of the resident's written plan of the resident's and document and to provide oral hygiene as a plan for 3 of 3 residents addition, the facility failed to all interventions related to the butter with meals as directed 1 of 3 residents (R41) in.		282	reviewed for accuracy and commur book updated in the dietary departn Individual peanut butter packets als placed in the condiments container R41 table. Reviewed and revised comprehens care plan and oral hygiene policies. reviewed nutritional care policy and appropriate and accurate.	was nication nent. so on sive . Also,	10/24/17
R11's care plan, rev	rised on 9/12/17, identified			Identified all residents needing assi	st with	
	PROVIDER OR SUPPLIER SUMMARY STAY (EACH DEFICIENCY REGULATORY OR LS) Continued From particle feeding residents. On 9/14/17, at 2:56 (DON) confirmed st residents "for dignity indicated staff shou dignity while feeding. Review of facility por reviewed on 1/17/17 right to a dignified eand communication and services inside 483.21(b)(3)(ii) SEF PERSONS/PER CAST (b)(3) Comprehensing The services provides outlined by the care outlined by the care. This REQUIREMENT by: Based on observative review the facility fadirected by the care (R11, R10, R47). In implement nutritions provision of peanut by the care plan for reviewed for nutrition. Findings include:	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 25 feeding residents. On 9/14/17, at 2:56 p.m. the director of nursing (DON) confirmed staff should sit while feeding residents "for dignity, respect." The DON indicated staff should treat the resident with dignity while feeding them. Review of facility policy titled, Resident Rights reviewed on 1/17/17, indicated the resident has a right to a dignified existence, self- determination and communication with and access to persons and services inside and outside the facility. 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide oral hygiene as directed by the care plan for 3 of 3 residents (R11, R10, R47). In addition, the facility failed to implement nutritional interventions related to the provision of peanut butter with meals as directed by the care plan for 1 of 3 residents (R41) reviewed for nutrition.	PROVIDER OR SUPPLIER A HEALTH GRACE HOME	PROVIDER OR SUPPLIER A HEALTH GRACE HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 25 feeding residents. On 9/14/17, at 2:56 p.m. the director of nursing (DON) confirmed staff should sit while feeding residents "for dignity, respect." The DON indicated staff should treat the resident with dignity while feeding them. Review of facility policy titled, Resident Rights reviewed on 1/17/17, indicated the resident has a right to a dignified existence, self- determination and communication with and access to persons and services inside and outside the facility. 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide oral hygiene as directed by the care plan for 3 of 3 residents (R11, R10, R47). In addition, the facility failed to implement nutritional interventions related to the provision of peanut butter with meals as directed by the care plan for 1 of 3 residents (R41) reviewed for nutrition. Findings include:	PROVIDER OR SUPPLIER A HEALTH GRACE HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIRED TO PREVIOUS DESTRICTION OF U.S. DENTIFYING INFORMATION) Continued From page 25 feeding residents. On 9/14/17, at 2:56 p.m. the director of nursing (DON) confirmed staff should sit while feeding residents "Tor dignily, respect." The DON indicated staff should treat the resident with dignity while feeding the management of the desired persons and services inside and outside the facility. 48.3.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must. (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide or all hygiene as directed by the care plan for 3 of 3 residents (R11, R10, R47). In addition, the facility failed to implement nutritional interventions related to the provision of peanut butter packets als placed in the condiments container reviewed for nutrition. Findings include: A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240 FREVIX TAG STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240 FREFIX GRACEVILLE,	PROVIDER OR SUPPLIER A HEALTH GRACE HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY STATE). PROVIDER SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MYST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 25 feeding residents. On 9/14/17, at 2:56 p.m. the director of nursing (DON) confirmed staff should reat the resident with dignity while feeding them. Review of facility policy titled, Resident Rights reviewed on 1/17/17, indicated the resident with dignity while feeding them. Review of facility policy titled, Resident Rights reviewed on 1/17/17, indicated the resident with dignity while feeding them. Review of facility policy titled, Resident Rights reviewed on 1/17/17, indicated the resident has a right to a dignified existence, self- determination and communication with and access to persons and services inside and outside the facility, 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and document review the facility failed to provide oral hygiene as directed by the care plan for 3 of 3 residents (R11, R11, R14, R17, In addition, the facility failed to the provision of peanut butter with meals as directed by the care plan for 1 of 3 residents (R41) reviewed for nutrition. Findings include:

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	PROVIDER OR SUPPLIER	IOME		STREET ADDRESS, CITY, STATE, ZIP CO 116 WEST SECOND STREET GRACEVILLE, MN 56240	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	R11 had potential for hospice patient, we manifested by need personal hygiene. If had his own teeth we directed staff to profor oral care. On 9/13/17, from 8 observed to receive assistance time. At 9:15 a.m. If down. NA-B assiste washing his face, a room at 9:29 a.m. If provided oral cares. On 9/13/17, at 12:1 was currently a host assistance with all hygiene. NA-B indicattempted oral care R11 got upset. NA-have good teeth." Noral cares to R11 fout he gets mad at On 9/14/17, at 3:09 no teeth on the top the bottom, which we discolored black/gr. On 9/14/17, at 9:35 was currently a host assistance with all hygiene. RN-A indicated assistance.	or self care deficit related to eakness, decrease cognition, ding more assistance with R11's care plan indicated R11 with cavities. The care plan ovide set up and supervision :19 a.m. to 8:46 a.m. R11 was a morning cares. R11 did not with oral cares during this R11 indicated he wanted to lay and lying down. NA-B left the R11 was not offered or by NA-B during this time. 3 p.m. NA-B confirmed R11 spice patient and needed of his ADL's including oral cated she had not offered or es with R11 recently because B further stated "he does not NA-B verified she did not offer urther stating she "forgot to, times, so I quite trying." 9 p.m. R11 was noted to have of his mouth and four teeth on were badly decayed and ay/yellow in color. 5 a.m. RN-A confirmed R11 spice patient and needed of his ADL's including oral cated staff should be following stated staff should be offering	F 28	oral cares in the facility and identified residents care plar reviewed for accuracy. Hartman publishing training providing oral cares will be uwith educating appropriate scompetency evaluation follow training video. DON or designee will compledaily X 1 week of either ame see that appropriate oral hygprovided as care planned to residents as well as others a alleged deficient practice and X3 weeks. Results will be rethe Quality Assurance Perform Improvement committee. DON or designee will complecompliance monitoring daily various meal times to see the appropriate nutritional intervery provided as care planned and X3 weeks. Results will be rethe Quality Assurance Perform Improvement committee.	video on used to assist staff with wing the ete monitoring or hs shifts to giene is being identified at risk for this d then weekly viewed with rmance ete X 1 week of nat entions are ad then weekly viewed with	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	NG		MPLETED
		245579	B. WING		09	9/14/2017
	PROVIDER OR SUPPLIER	IOME		STREET ADDRESS, CITY, STATE, ZIP COE 116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	On 9/14/17, at 10:1 (DON) confirmed F needed assistance oral hygiene. The E following the care p staff to offer and er for him." R10's care plan, re R10 had potential f mucosa related to reares and history opersonal hygiene. The encourage and assistimes a day, if she will be shown on the encourage and assistimes a day, if she will be shown of the encourage and assistimes and at 9:36 was observice. At 10:21 a room eating popcor independently. R10 oral cares during the encourage and assistance oral hygiene. NA-B R10's oral cares. Nabout her mouth call indicated R10 had a needed assistance. On 9/14/17, at 3:10 her own natural tee which had several fixer noted to be dispersion.	9 p.m. the director of nursing R11's care plan stating R11 with all of his ADL's including DON indicated staff should be plan and stated "I would expect incourage dental care and do it vised on 8/14/17, identified or alteration in mouth and oral needing assistance with oral f resistance to ADL's including The care plan identified staff to sist with oral cares at least two will allow. :45 a.m. to 8:10 a.m. R10 was a morning cares. Following D was assisted to breakfast served to wait for church am. R10 was in the activity rn and drinking coffee D was not offered or provided his time. 8 a.m. NA-B confirmed R10 with all of her ADL's including stated she forgot to complete IA-B further stated "I forgot are this morning." NA-B an electric toothbrush and	F 2	32		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	` '	E SURVEY PLETED
		245579	B. WING			09/ ⁻	14/2017
	PROVIDER OR SUPPLIER	ОМЕ		1	STREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	needed assistance oral hygiene. RN-A directions, and indicare plan. RN-A stato ask." On 9/14/17, at 10:2 R10's care plan and assistance with orastaff should follow twould expect staff tand to offer it and to R47 was not provide care plan. R47's caidentified the denta a potential for oral pher own teeth and didentified staff to preares daily. During observation from 9:12 a.m. to 9 (NA)-C assisted R4 offered the opportucares. R47's natural areas of white matton her right, lower I partial was not in planm. R47 was obsescrambled egg and not have her upper breakfast meal. On 9/13/17, at 9:44 finished with R47's reported R47 requirables, including oras	with all of her ADL's including a confirmed the care plan cated staff should follow the sted "she [R10] does not know 7 a.m. the DON confirmed diverified R10 needed I hygiene. The DON indicated he care plan and stated "I to assist her with oral cares	F 2	282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245579	B. WING			09/ ⁻	14/2017
	PROVIDER OR SUPPLIER	ОМЕ		1	TREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET GRACEVILLE, MN 56240	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	NA-C verified she cares or provide R4 and should have do 09/13/17, at 10:36 a confirmed R47 sho cares prior to break placed in R47's mo 09/14/17, at 11:26 a verified R47 should cares and given pa confirmed R47 required staff assist DON confirmed sta R47's partial was in prior to breakfast. all staff to follow R4 The facility's Care F dated 8/17, indicate comprehensive car measurable objective sident's medical, psychological need resident. R41 was not providincluded peanut bur plan revised on 8/7, for BMI continuing in history of weight loss.	did not provide, nor offer oral 17's partial prior to breakfast one so. a.m. registered nurse (RN)-B ould have been offered oral fast, including the partial uth. a.m., registered nurse (RN)-A have been provided oral rial prior to breakfast, and uired staff assistance of one o.m. the DON verified R47 tance of one for all ADL's. The ff are expected to ensure place and provided oral cares The DON stated she expected 7's care plan.	F 2	282	DEFICIENCY		
	of offering peanut b	outter at meals for bread/toast. s of breakfast on 9/13/17, from					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (V41) PROVIDED (SUBDILITATION AND HUMAN SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245579	B. WING _		09	/14/2017
	PROVIDER OR SUPPLIER	ОМЕ		STREET ADDRESS, CITY, STATE, ZIP COL 116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	9:38 a.m. to 10:20 her entire breakfas peanut butter for he On 9/13/17, from 1 was observed to ea R41 had bread and was not offered or during her dinner mon 9/13/17, at 8:55 confirmed R41 currand indicated she was upposed to receive meals. DA-A indicate butter and would on 0/13/17, at 9:41 stated R41's current ablespoons of pearidentified. DC-A state this." DC-A indicate would right it in the on the dietary cards aware of this, I gue On 9/13/17 at 12:44 (DM) confirmed R4 The DM could not opeanut butter with a thinking I did not cabutter." The DM could not opeanut butter got missed." lost more weight, Filbs, and indicated swith the peanut but	a.m. R41 was observed to eat to but had been provided no er toast. 1:53 a.m. to 12:27 p.m. R41 at her dinner meal. Although I crackers at her meal, R41 provided any peanut butter neal. a.m. dietary aid (DA)-A rent diet from her dietary card was not aware R41 was be peanut butter with her ted that R41 liked peanut provided any ask for it. a.m. dietary cook (DC)-A rent dietary card did not have two nut butter with meals ted "no I was not aware of ed the dietary manager (DM) communication book and list it is. "I might of missed this, not se we are in the dark." B p.m. clinical dietary manager 1's current care plan and diet. Werify if R41 was receiving meals. The DM stated "I am arry through with the peanut profirmed R41's BMI was reight and indicated "the peanut the DM confirmed R41 had lat's current weight was 86 of the should of followed through ter. The DM confirmed staff of the peanut butter with meals		32		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY PLETED
		245579	B. WING		09/·	14/2017
_	PROVIDER OR SUPPLIER	IOME		STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	confirmed R41 curi was slightly below a indicated she though peanut butter at me. The RD indicated hoffer the peanut butter at. The RD indicated hoffer the peanut butter ad. The RD indicated hoffer the peanut butter and the care plan as direcommendations. BMI for a person of 18.5 and stated "a she added the peastaff was already of Review of facility perevised on 4/15, indicated in the care plan as the care plan	a.m. register dietician (RD) rent diet and indicated R41 a healthy BMI. The RD ght staff were offering R41 eals to maintain R41 weight. her expectation of staff was to tter with meals that received licated staff should be following rected and per The RD indicated a normal f R41's height and weight was little under." The RD indicated nut butter because she thought	F 282			
F 312 SS=D	routines and will be who have responsi services to the resi 483.24(a)(2) ADL ODEPENDENT RESI (a)(2) A resident what is activities of daily liv services to maintai personal and oral rational rational rational rational rational rational rational review the facility facare and services to maintai personal and oral rational ratio	e available to staff personnel bility for providing care or dent. CARE PROVIDED FOR BIDENTS no is unable to carry out ring receives the necessary n good nutrition, grooming, and nygiene. NT is not met as evidenced tion, interview and document ailed to provide the necessary o maintain oral hygiene for 3, R10, R47), reviewed for	F 312	Reviewed and revised oral hygiene policy. Identified all residents needi assist with oral cares in the facility, identified residents care plans were reviewed for accuracy. Hartman publishing training video or	ng all the	10/24/17
	Findings included			providing oral cares will be used to		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY IPLETED
		245579	B. WING		09/	14/2017
	PROVIDER OR SUPPLIER	IOME		STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 312	R11's significant ch Set (MDS) dated 8, including anemia, h insufficiency. The M hospice care, had a and needed limited perform personal h R11's care plan, re R11 had potential f hospice patient, we manifested by need personal hygiene. I had his own teeth w On 9/13/17, at 8:19 in bed when nursin room to answer R1 needed to go to the assistance and put for help. R11 was w a white incontinent called for assistance and placed the tran Registered nurse (assisted NA-B with wheelchair. NA-B p voided. At 8:31 a.m standing mechanic cleaning, emptying a.m. NA-C assisted placed a blanket on NA-B moved R11 to could watch TV, pla of him with the call left the room. At 8:6 breakfast tray, place	nange in status Minimum Data /29/17, identified diagnoses neart failure, and renal MDS identified R11 was on severe cognitive impairment I assistance of one staff to hygiene including oral hygiene. vised on 9/12/17, identified or self care deficit related to eakness, decreased cognition, ding more assistance with R11's care plan indicated R11	F 312	with educating appropriate staff competency evaluation following training video. DON or designee will complete daily X 1 week of either am or h see that appropriate oral hygien provided as care planned to ide residents as well as others at ris alleged deficient practice and th X3 weeks. Results will be review the Quality Assurance Performal Improvement committee.	monitoring s shifts to e is being ntified sk for this en weekly wed with	

	FEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245579	B. WING		09/14/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240	1 00/11/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION
F 312	room at 8:46 a.m. morning cares, R1 oral cares from sta On 9/13/17, at 9:11 family was in visitir the room, and R11 down. NA-B obtain NA-B hooked R11 and assisted R11 t R11, provided peri incontinent brief. Nand assisted R11 t a.m. NA-B left R11 dirty linen and gark the breakfast tray. was not offered or On 9/13/17, at 12: was currently on he assistance with all hygiene. NA-B indi attempted oral care R11 would get ups does not have goo not offer oral cares	ndependently. NA-B left the During the observation of 1 was not offered or provided	F 312	,	
	on 9/14/17, at 3:09 no teeth on the top the bottom, which discolored black/gr	9 p.m. R11 was noted to have of his mouth and four teeth on were badly decayed and			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y1) PROVIDED (STATEMENT OF DEFICIENCIES (Y1) PROVIDED (STATEMENT)

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED
		245579	B. WING _		09/	14/2017
	PROVIDER OR SUPPLIER	OME		STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240	, 55	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 312	offering dental care On 9/14/17, at 10:1 (DON) confirmed F verified R11 was coneeded assistance oral hygiene. The E following the care p staff to offer and er for him." R10 was not provid Quarterly MDS date diagnoses which in and dementia. The severe cognitive im extensive assistance personal hygiene, i R10's care plan, re R10 had potential f mucosa related to re cares and history or personal hygiene. The interventions include assist with oral care she would allow it. On 9/13/17, at 7:45 in bed. NA-B asked up for breakfast, ar NA-B assisted R10 the bathroom. At 7: assisted her to get the day. At 8:05 a.r with a walker, provi R10's pants. At At 8:	the care plan and "should be even if he refuses it." 9 a.m. the director of nursing this care plan as current, arrently a hospice patient and with all of his ADL's including DON indicated staff should be plan and stated "I would expect accourage dental care and do it ded oral cares by staff. R10's ed 8/7/17, identified R10 had cluded anemia, depression MDS identified R10 had apairment and needed are of one staff to perform including oral hygiene. Vised on 8/14/17, identified or alteration in mouth and oral fresistance to ADL's including the care plan listed various ing staff to encourage and as at least two times a day, if a.m. R10 was observed lying IR10 if she was ready to get and R10 agreed. At 7:49 a.m. to sit up, stand, and walk to to 53 a.m. NA-B toileted R10 and washed up and dressed for in. NA-B assisted R10 to stand ded peri cares, and pulled up 3:08 a.m. NA-B assisted R10 groom area for breakfast. At	F 31	2		

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		245579	B. WING _		09	/14/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 116 WEST SECOND STREET GRACEVILLE, MN 56240		,, <u>-</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 312	8:11 a.m. R10 sat on NA-B removed gains a clothing protecto a.m. R10 ate her bea.m. R10 was done the chapel area was 10:21 a.m. R10 was popcorn and drinking During the observation of provided oral cares. On 9/13/17, at 8:13 needed assistance oral hygiene due to following command to do R10's oral cather mouth care this R10 has an electric assistance to use in behind." On 9/14/17, at 3:10 her own natural teas which had several were noted to be do On 9/14/17, at 9:43 needed assistance oral hygiene. RN-A indicated staff plan and further state to ask." RN-A indicated staff plan and further state of this on her own on 9/14/17, at 10:210 to scare plan, and assistance with all	down at the breakfast table, to belt form her waist and placed or on her chest area. At 8:52 treakfast independently. At 9:36 to with breakfast and sitting in alting for church to begin. At as in the activity room eating and coffee independently. At ation R10 was not offered or as by staff. B. a.m. NA-B confirmed R10 to with all of her ADL's including of increased confusion and not acts. NA-B indicated she forgot area and stated "I forgot about as morning." NA-A indicated that act toothbrush and does need to and stated "I forgot running." Op.m. R10 was noted to have beth on the top and bottom fillings and some of her teeth iscolored yellow/gray. B. a.m. RN-A stated R10 to with all of her ADL's including A confirmed the current care of should be following the care ated "she [R10] does not know that all of stated "she [R10] would not have the condition of the stated "she [R10] would not have the stated "she [R10] would not	F 31	2		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245579	B. WING _		05	0/14/2017
	PROVIDER OR SUPPLIER	OME		STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 312	been getting worse commands. The Do following the care pataff to assist her wand to encourage had been gettered to assist her wand to encourage had been gettered to assist her wand to encourage had 10/07, indicated nuresidents with mourand as needed. Mo two hours for those mouth). R47 was not provide Admission MDS dahad diagnosis which depression, heart for pulmonary disease disease. The MDS cognitive impairme one staff to perform oral hygiene.	and she does not follow DN indicated staff should be plan and stated "I would expect rith oral cares and to offer it her." Dlicy, Oral Hygiene reviewed in rising staff will provide all the care every morning, night buth care would be given every residents on NPO (nothing by led oral cares by staff. R47's ted 8/22/17, identified R47 h included anemia, ailure, chronic obstructive (COPD) and Alzheimer's identified R47 had severe and needed assistance of a personal hygiene, including	F3	12		
	had potential for increlated to Alzheime and weakness. R4 there was a potenti R47 having her own The care plan listed including staff to procares daily. On 9/13/17, from 9 assistant (NA)-C as personal cares which	vised on 9/1/17, identified R47 creasing self care deficit r's disease, dementia, COPD 7's dental care plan indicated al for oral problems due to n teeth and upper partials. It various interventions ovide assistance with oral sisted R47 with morning ch included washing her face,				
	observation, R47 w offered the opportu	dressing. During this as not assisted with nor nity for completion of oral al teeth were observed with				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245579	B. WING			09/·	14/2017
	PROVIDER OR SUPPLIER	ОМЕ		1	TREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	on her right, lower I partial was not in pl At 9:44 a.m. following cares, NA-C assisted table. NA-C stated a morning cares. NA assist of one staff for care. NA-C confirmutilized an upper panot provide, nor offer partial prior to break so. At 9:53 a.m. R47 w scrambled egg and not have her upper break fast meal. On 9/13/17, at 10:3 (RN)-B confirmed oral cares prior to be placed in R47's mo On 9/14/17, at 11:2 (RN)-A verified R47 oral cares and give confirmed R47 required staff assist DON confirmed staff R47's partial was in	er build up between them and ip. Further, R47's upper ace prior to breakfast. Ing the observation of morning ed R47 to the dining room she was finished with R47's and an action of all ADL's, including oral and R47 had natural teeth and artial. NA-C verified she did er oral cares or provide R47's action of all ADL's are or provide R47's action of a served eating a banana, toast independently. R47 did right partial in place during the R47 should have been offered areakfast, including the partial	F3	312			
F 325	all staff to follow R4 483.25(g)(1)(3) MA	-7's care plan. INTAIN NUTRITION STATUS	F3	325			10/24/17

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245579	B. WING		09/14/	2017
	PROVIDER OR SUPPLIER	ОМЕ	1	STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) DMPLETION DATE
F 325 SS=D	both percutaneous percutaneous endocenteral fluids). Base comprehensive assensure that a reside (1) Maintains acceptatus, such as usubody weight range the resident's clinic this is not possible indicate otherwise; (3) Is offered a ther nutritional problem orders a therapeuti This REQUIREMED by: Based on observareview, the facility finterventions related dense foods which meals in order to prof 3 residents (R41 Findings include: R41's quarterly Min 7/27/17, identified Findings including inc	on and hydration. tric and gastrostomy tubes, endoscopic gastrostomy and escopic jejunostomy, and ed on a resident's essment, the facility must ent- otable parameters of nutritional lal body weight or desirable and electrolyte balance, unless al condition demonstrates that or resident preferences	F 325	,	nication ment. so on R41 d it is d all ares in dents	
	impairment, needer staff for activities of independent with e	had severe cognitive d limited assistance of one f daily living (ADL's) and was ating after set up help from her indicated R41 was 58		Following RD monthly visits any recommendations that may have be made will be documented on the di referral flow sheet, the CDM will ma appropriate updates to tray cards.	etician ake	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245579	B. WING		09/	14/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240	, 33.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 325	inches (in), weight weight loss, no eat therapeutic diet. Review of R41's si Screening and Assindicated R41 was nutritional intervencereal and ate in the current height 58 in body mass index (status. Review of R41's quand Assessment dwas on a regular dutritional intervencereal and ate in the current height 58 in BMI 18.4 under weight 18.4 under weigh	age 39 ad 88 pounds (lbs), had no ing problems and had a gnificant change Nutritional dessment dated 5/2/17, on a regular diet with tions of super potatoes, super ne main dining room. R41's and weight 89.5 lbs. R41's BMI) 18.7 low end of health uarterly Nutritional Screening ated 7/27/17, indicated R41 iet, small portions, with tions of super potatoes, super ne main dining room. R41's and weight 87.5 lbs. R41's eight status and continue with esident Progress Notes on stered dietician (RD) revealed ht 86.5 lbs which is stable and which is underweight. Family ome 85 lbs. Diet is regular with alke at breakfast 76-100 percent lunch and dinner. R41 calories and protein through r potatoes and two anut butter at meals. vised on 8/7/17, identified R41 continuing in underweight ry of weight loss and prior to weight. The care plan identified lent with eating and needed set at times. The care plan listed	F 32	plans, etc. The cook will also init acknowledge that the recommen have been completed by CDM. Staff will be educated on the upd policies and procedures by at leathe following 1:1 meetings, stand scheduled meetings with compet evaluations following education. DON or designee will complete compliance monitoring daily X 1 various meal times to see that appropriate nutritional interventio provided as care planned and the X3 weeks. Results will be review the Quality Assurance Performar Improvement committee.	dations ated st on of ups, or ency week of ns are en weekly ed with	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION			E SURVEY PLETED
		245579	B. WING			09/ ⁻	14/2017
	PROVIDER OR SUPPLIER	OME		STREET ADDRESS, CITY, STATE, Z 116 WEST SECOND STREET GRACEVILLE, MN 56240	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 325	small portion diet as provide super cerea potatoes at dinner that and record and mo 8/7/17, offering pead bread/toast was ad Review of R41's die receiving a regular cereal for breakfast R41's dietary card of two tablespoons of On 9/13/17, at 9:38 dining room table who contained a bowel of eggs, toast, half of juice, half a glass of Registered nurse (Fopening her package it on her cereal. At 9 banana into her cereindependently. At 1 R41 if she was don was, so dietary staff the kitchen area and to finish. R41 at early for a small piece of a.m. dietary manage done with her drink DM took the glasse of her juice and mill observation R41 was peanut butter during On 9/13/17, at 11:5 dining room table was so dietary staff the piece and mill observation R41 was peanut butter during On 9/13/17, at 11:5 dining room table was so dietary manage of her juice and mill observation R41 was peanut butter during On 9/13/17, at 11:5 dining room table was so dietary manage of her juice and mill observation R41 was peanut butter during on 9/13/17, at 11:5 dining room table was so dietary at 11:5 dining room	ge 40 Is such as: provide regular, sordered per medical doctor, al at breakfast and super o aid with weight maintenance nitor intake. When revised on mut butter at meals for ded to the plan of care. Petary cards revealed she was diet with small portions, super and super potatoes for lunch. Did not identify the need for peanut butter with meals. a.m. R41 was seated at the with a plate in front of her which of super cereal, scrambled a banana, half glass of orange f milk and a cup of coffee. RN)-A was assisting R41 by ge of brown sugar and putting 9:43 a.m. R41 sliced up her real and began to eat 0:05 a.m. dietary staff asked e eating, R41 indicated she f took her tray and dishes to d left her milk and juice for her verything on her plate except crust from her toast. At 10:21 er (DM) asked R41 if she was so, R41 indicated she was and s from the table. R41 drank all k. During the breakfast meal as not offered or provided any g her breakfast meal. 3 a.m. R41 was seated at the with a clothing protector on her da plate of food in front of her da plate of food in front of her	F3	325			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
		245579	B. WING _		09	/14/2017
	PROVIDER OR SUPPLIER	IOME		STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240		,,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 325	super potatoes with bread, half glass of and coffee. At this R41 if she would lik indicated she wante crackers. R41 had potatoes and her bher stomach was of a.m. R41 continued a few more bites of R41 had a bowl of crackers. At 12:29 soup with crackers to not to eat her so didn't feel like eating not offered or proving her meal. Review of the Vitall 5/1/17 to 9/13/17, r - 5/18/17 weight 88 - 6/15/17 weight 88 - 8/16/17 weight 88 - 8/16/17 weight 88 - 9/13/17, at 9:41 cur and indicated she was supposed to received meals. DA-A indicated butter and would offurther stated "no I new one for us." On 9/13/17, at 9:41 verified R41 did not grant and would offurther stated "no I new one for us."	piece of breaded chicken, a gravy, half slice of white cranberry juice, glass of water time dietary manager asking to a bowl of soup instead, R41 and a bowl of soup and taken a few bites of her readed chicken. R41 indicated ut of whack today. At 11:57 at to take sips of her coffee and ther potatoes. At 12:07 p.m. chicken noodle soup with p.m. R41 was not eating her. At 12:47 p.m. R41 continued up or crackers stating she g. During the meal R41 was ded any peanut butter during Report weights for R41 from evealed: .5 lbs .5 lbs .5 lbs	F 32	25		

_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	COMPLETED	
		245579	B. WING			09/	14/2017
	PROVIDER OR SUPPLIER	OME		1	STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 325	and stated "no I wai indicated the DM w communication book cards so staff would stated "I might of m guess we are in the On 9/13/17, at 12:2 (NA)-B indicated Releating and needed packages and cutting she had to tell the k portions, otherwise by the amount of fowas not a big eater told staff when she On 9/13/17, at 12:4 manager (DM) contand diet. The DM verceiving super cerpotatoes for dinner. R41 was receiving stated "I am thinking the peanut butter." was borderline und was the one that we staff know of change the menu cards for stated "the peanut be confirmed R41 had current weight was should have followed butter. The DM indite to follow the care pleanung cards. The DM menu cards.	s not aware of this." DC-A ould write it in the ok and list it on the dietary d know of the changes. DC-A issed this, not aware of this, I dark." 2 p.m. nursing assistant 41 was independent with staff assistance with opening ng up her food. NA-B indicated ditchen to give R41 small R41 would get overwhelmed od given. NA-B indicated R41 but more of a snacker and wanted something to eat. 8 p.m. clinical dietary firmed R41's current care plan erified R41 was currently eal for breakfast and super. The DM could not verify if peanut butter with meals and g I did not carry through with The DM confirmed R41's BMI er weight and indicated she ould update the care plan, let les in resident's diets, updated staff to follow and further outer got missed." The DM lost more weight, R41's 86 lbs and indicated she ed through with the peanut cated she would expect staff an and follow the resident's M confirmed staff was eanut butter with meals and	F3	325			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245579	B. WING		09/	14/2017	
	PROVIDER OR SUPPLIER	ОМЕ		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 PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 325	(RD) confirmed R4 R41 was slightly be indicated she thoug peanut butter at me The RD indicated h offer the peanut but bread. The RD ind the care plan as dir normal BMI for a pe weight was 18.5 an RD indicated she a because she thoug to R41. Review of facility po dated 2/2012, indic needs of residents residents condition weights, intake, lab diet plan as needed nutritional risk resid assessment and re 483.45(d)(e)(1)-(2) FROM UNNECESS 483.45(d) Unneces Each resident's dru unnecessary drugs drug when used	a.m. the registered dietician 1's current diet and indicated flow a healthy BMI. The RD pht staff were offering R41 eals to maintain R41 weight. her expectation of staff was to tter with meals that included icated staff should be following ected. The RD indicated a ferson of R41's height and d stated "a little under." The dded the peanut butter ht staff was already offering it blicy titled, Nutritional Care ated the RD will cover dietary and recommend changes as changes. The DM will monitor s, and recommend changes to d. The DM will refer high lents to RD for nutritional commendations as needed. DRUG REGIMEN IS FREE BARY DRUGS sary Drugs-General. g regimen must be free from . An unnecessary drug is any uration; or		329		10/24/17	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (V1) PROVIDED (SUBBLIFB) OF THE SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE COMP	PLETED
		245579	B. WING _		09/1	4/2017
	PROVIDER OR SUPPLIER	OME		STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	(5) In the presence which indicate the or discontinued; or (6) Any combination paragraphs (d)(1) the same serior of the lipid lowering and thyroid not be lipid lowering serior of the lipid	te indications for its use; or of adverse consequences dose should be reduced or as of the reasons stated in arough (5) of this section. Opic Drugs. Chensive assessment of a must ensure that mave not used psychotropic these drugs unless the assary to treat a specific sed and documented in the use psychotropic drugs receive stions, and behavioral as clinically contraindicated, in	F 32	Labs obtained for (R10) result by her provider with no change medications or treatments made and revised transcriphysician orders policy and properties. Reviewed and revised standing orders. Reviewed all lab orders from 2 verified all have been drawn as Night charge nurse will review	es to (R10) de. ption of ocedure. g physician 017 and s ordered.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245579	B. WING		 	09/1	4/2017
_	PROVIDER OR SUPPLIER	IOME		1	TREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Simvastatin 40 mill evening for hyperlip once an evening for Levothyroxine 50 monce a morning for review of the signe R10 was to have a stimulating hormor twelve months. Review of R10's mevidence a recent completed to moni The most recent lip R10's medical recompleted to moni The most recent lip R10's medical recompleted to moni The most recent lip R10's medical recompleted to monion the blood) 241 (reference range found in the blood) 241 (reference range found for the look) 241 (reference range for	igrams (mg) by mouth once an oidemia, Zetia 10 mg by mouth or hyperlipidemia and nicrograms (mcg) by mouth or hypothyroidism. Further d physician orders indicated lipid profile and thyroid ne (TSH) labs completed every edical record did not include lipid profile or TSH had been tor the efficacy of medications. Oid profile and TSH were not in ord but obtained from the on request. The labs were striglyceride (a type of fat level was noted to be high at ge: 10-200) and her HDL scholesterol) level was noted to ence range: 40-60). R10's TSH is noted to be at 1.77	F3	329	report daily to see if any labs are deficient and the Routine lab day is Wednesday. The tech will give the charge nurse a "lareport whenever they are here to deficient and verify the labs are drawn. Licensed staff and lab department educated by at least one of the following on this new process. DON or designee will review weekl weeks that all ordered labs are drawordered. Results of this audit will be reviewed with QAPI committee.	e lab ab due" raw any will be lowing uled y X 4 wn as	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	COMPLETED	
		245579	B. WING		09/	14/2017
	PROVIDER OR SUPPLIER	OME		STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
F 329	On 9/14/17, at 2:22 the consulting phare 9:10 a.m. the CP restated if the medicato be done yearly, source the labs were lithey should be dor labs were reviewed reviews and indicate their goals, no recount their goals, and with this age group abnormal labs, followed and with health she would have given abnormal labs and	p.m. a message was left for macist (CP). On 9/18/17, at sturned the phone call and all doctor ordered follow up labs the expected staff to make being done. The CP stated are yearly." The CP indicated during the monthly pharmacy ed if the resident was within mmendations would be made. TSH should be done yearly and if a resident had are up labs should be done as a changes. The CP indicated en recommendation for said "I would have addressed edical doctor wanted any	F3	329		
F 428 SS=D	Transcription Of reviaboratory/x-ray ind appropriate lab or x notify lab or x-ray if immediately or at a place resident namedraw calendar at pr 483.45(c)(1)(3)-(5) REPORT IRREGULC) Drug Regimen R	•	F 4	.28		10/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245579	B. WING		09	/14/2017
	PROVIDER OR SUPPLIER	IOME		STREET ADDRESS, CITY, STATE, ZIP COD 116 WEST SECOND STREET GRACEVILLE, MN 56240		,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 428	brain activities assorand behavior. The limited to, drugs in (i) Anti-psychotic; (ii) Anti-depressant (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist to the attending physicial divided these reports of the attending physician divided these reports of the attending physician director and director and director and director and the irregularity (iii) The attending physician director has been tall be no change in the physician should do the resident's medical irregularity must and procedures for the limited to the facility must and procedures for the limited to	drug is any drug that affects ociated with mental processes se drugs include, but are not the following categories: """ """ """ """ """ """ """	F 42	8		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE : COMPI	
		245579	B. WING		09/14	4/2017
	PROVIDER OR SUPPLIER	ОМЕ	1	TREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	frames for the diffe steps the pharmaci identifies an irregul to protect the reside This REQUIREMED by: Based on interview facility failed to ensidentified and report for lipid lowering moderation and a thyroid for 1 of 5 residents unnecessary medic Findings include: R10's signed physicidentified diagnoses (high cholesterol), a orders also include Simvastatin 40 millicevening for hyperlip once an evening for Levothyroxine 50 monce a morning for review of the signed R10 was to have a	rent steps in the process and st must take when he or she arity that requires urgent action ent. NT is not met as evidenced and document review the ure the consulting pharmacist ted incomplete lab monitoring edications (Simvastatin and medication (Levothyroxine) (R10) reviewed for	F 428	Labs obtained for (R10) results wer reviewed by her provider and no chain her medications or treatments we made. Reviewed and revised pharmacist diregimen policy. Reviewed and revisit transcription of physician orders policy and procedure. 10/3/17 Monthly consultant pharmacist will revery residents records including lal Staff reviewed all lab orders from 20 and verified all have been drawn and results are in residents chart. Reviewed and revised physician state orders. Night charge nurse will review "lab or report daily to see if any labs are du Routine lab day is Wednesday. The tech will give the charge nurse a "lal report whenever they are here to dra labs and verify the labs are drawn. Licensed staff and lab department weducated by at least one of the follows.	anges ere lrug sed icy eview bs. 017 d anding due" e. e lab b due" aw any vill be wing;	
	evidence a recent I completed to monit The most recent lip R10's medical reco hospital by staff up dated 6/9/16; R10's found in the blood)	edical record did not include ipid profile or TSH had been or the efficacy of medications. id profile and TSH were not in rd but obtained from the on request. The labs were a triglyceride (a type of fat level was noted to be high at the 10-200) and her HDI		1:1 meetings, stand-ups, or schedul meetings on this new process. DON or designee will review weekly weeks that all ordered labs are draw ordered. Results of this audit will be reviewed with QAPI committee.	X 4 vn as	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y1) PROVIDED (STATEMENT OF DEFICIENCIES (Y1) PROVIDED (STATEMENT)

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		E SURVEY MPLETED
		245579	B. WING _		09/	/14/2017
	PROVIDER OR SUPPLIER	IOME		STREET ADDRESS, CITY, STATE, ZIP COI 116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 428	cholesterol (good of be low at 23 (refere level on 6/9/16, wa (reference range: Commendations related to the use of Levothyroxine. On 9/14/17, at 2:22 the consulting phare 9:10 a.m. the CP restated if the medicate of the use of Levothyroxine with the labs were "they should be done yearly, some the labs were "they should be done with this age group abnormal labs, followell and with health she would have give abnormal labs and this" to see if the mechanges or labs reconsulting the modern of the DON of the DON of the lipid profile and TSH checked orders. The DON of the labs were the labs and the la	cholesterol) level was noted to ence range: 40-60). R10's TSH is noted to be at 1.77 (0.40-3.99). Imacist Drug Regimen if through 8/31/17, identified no for laboratory monitoring of Simvastatin, Zetia or In p.m. a message was left for emacist (CP). On 9/18/17, at eturned the phone call and all doctor ordered follow up labs she expected staff to make being done. The CP stated he yearly." The CP indicated if during the monthly pharmacy ted if the resident was within immendations would be made. TSH should be done yearly and if a resident had ow up labs should be done as a changes. The CP indicated fren recommendation for said "I would have addressed redical doctor wanted any	F 42	28		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	` '	E SURVEY IPLETED
		245579	B. WING		09/	14/2017
	PROVIDER OR SUPPLIER	OME		STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 441 SS=F	orders to the lab de lab work to be done facility. The DON in order over rode the maybe why R10's late. Review of the facility Services revised or residents drug/med managed and monimaintain the reside mental, physical and defined by the reside collaboration with the facility staff. The conformal each residents drug compliance with ap guidelines. 483.80(a)(1)(2)(4)(6) PREVENT SPREAL (a) Infection preventation must be sand control program a minimum, the following services in a minimum, the following services in a management based conducted according services in a minimum to the services in	automatically sent the lab partment and generated the every Wednesday in the dicated she thought another original lab orders and that's abs did not get done. If y policy titled, Pharmacy 2/17/17, indicated each iation regimen shall be tored to: help promote or nt's highest practicable d psychosocial well-being, as lent and representative in the attending physician and insultant pharmacist reviews in regimen monthly to ensure plicable state and federal epicable state and federal epicable state and federal epicables are include, at the attending infection prevention in (IPCP) that must include, at the attending infections and asses for all residents, staff, and other individuals under a contractual upon the facility assessment g to §483.70(e) and following tandards (facility assessment	F 441			10/24/17

245579 B. WING	09/14/2017
ESSENTIA HEALTH GRACE HOME 116 WEST SECOND STREET GRACEVILLE, MN 56240	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 441 Continued From page 51 (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED	
		245579	B. WING			09/14/2017	
	PROVIDER OR SUPPLIER	OME	STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETION DATE	
F 441	(f) Annual review. annual review of its program, as necess This REQUIREMEN by: Based on interview facility failed to esta program which inclus surveillance of resid analyze possible pa facility. This deficie affect all 39 resider Findings include: Review of the facilit surveillance progra The facility utilized Reports, which inclus floor plan showing in room) from 9/16 the Monthly Infection R areas: resident nan admission date, one site, date of culture ordered, start date, ongoing, care plan up. The monthly log infections for which however, did not co results and no color	nel must handle, store, port linens so as to prevent the The facility will conduct an IPCP and update their sary. IT is not met as evidenced and document review, the ablish an infection control aded comprehensive dent infections to identify and atterns of infection in the not practice had the potential to atts who resided in the facility. It is not met as evidenced and document review, the ablish an infection control and the potential to atterns of infection in the not practice had the potential to atts who resided in the facility. It is not met as evidenced and comprehensive dent infection of infection in the not practice had the potential to attempt the potential to attempt the potential to the potential to attempt the potential to a potenti	F 4	1.The facility Infection reviewed and revised 2.Reviewed the Urinar checklist policy on 10-3.Track all symptoms/ Infection Log, including or are not being treate 4.Update Infection Cor "Added a section to trainfection was communa a nosocomial infection "Infection Preventionis ensure that culture residocumented on Infection the culture results secupdated. 5.Events are opened for symptoms of infection. 6.MatrixCare added In problem category so winfections through mat will start care planning MatrixCare starting 10 Corrective Action Plan 1.The infection prevented the physicians from the	on 10-3-17. ry Tract Infection -3-17. /infections on the g infections that a ed with antibiotics. ntrol Logs ack whether the nity acquired or if n on 10-4-17. et or designee will sults are ion Control Logs if ction, when the log for all new signs a . nfection to the we can care plan trix care. The faci g infections in 0-4-17. ntionist will meet w in a filiated hospit in a filiat	are it is in g is and lity	
	or nosocomial. Add	ons were community acquired itionally, the logs failed to notoms/infections that were		and inform them how to implement infection sure McGeer is criteria.		0	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245579	B. WING			09/-	14/2017
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH GRACE HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				11	TREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET GRACEVILLE, MN 56240		,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	through 8/17, inclu 3/17: There was ar with two symptoms incontinence and n There was no date Ciprofloxacin (antit Another entry was with no listed symp result and an antib did not specify if th ongoing and did no was updated. 4/17: An entry was tract infection (UTI changes prior to th analysis. Order red started antibiotic or indicated E. coli, be count. There was another no symptoms track the infection was re identify if the plan of A third entry was m one symptom of m urinary analysis. R on 4/3/17, the sam completed with the mixed contaminant contaminated sam repeated). 5/17: There was or	Infection Report from 3/17 ded: n entry for urinary symptoms identified of increased nood/personality change. of culture, or culture results.	F4	141	2.Facility s Infection Preventionist APIC Basic Infection Prevention Cotraining Scheduled for October 18-2017. The course is taught individually who have a Certification in Infection Control. This is an interactive cour will offer a comprehensive foundation professionals specializing in infection prevention. The course learning outcomes inclinating the participants: "Examine the elements of effective infection prevention programs and resources that support them. "Gain understanding of how evidenced-based recommendation used to implement best practices to prevent infections. "Sharpen networking skills with colleagues to share experience and gain access to additional resources." Increase awareness of Centers for Medicare and Medicaid is condition participation to qualify for 3rd party reimbursement. "Expand knowledge of compliance state and national regulatory standath impact the facility is licensure accreditation." Improve understanding of the imprinfection prevention strategies to set the mission and goals of your healt system. 4. The infection preventionist or design will audit orders of prescribed antibus 30 days starting 10-4-17, seeing it orders follow McGeer is criteria. 5. Inservices are scheduled for Octon Nursing staff will be educated on the standard of the second of	ourse 20, ials ise that on for on udes the s are of to is. r ins of with ards or act of upport hcare signee iotics f the ober.	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONST	RUCTION		TE SURVEY MPLETED
245579	B. WING		 	09	/14/2017
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH GRACE HOME		116 WEST	DDRESS, CITY, STATE, ZIP COL SECOND STREET VILLE, MN 56240		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR EACH CORRECTIVE ACTION SI OSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441 Continued From page 54 sugars and lethargy. A urinalysis was ordered. Culture results identified Escherichia coli (E. cobut no colony count and no further information was available. 6/17: An entry for a potential UTI with an unknown date of culture and no culture results. Resident was admitted to the facility on antibiot for UTI, but no further information available. There was no indication of whether the infectio was resolved or ongoing. 7/17: An entry was made for a potential UTI, wit two symptoms identified of fatigue and weakne prior to order for urinary analysis. Culture results show E. coli, but no information on colony cour if it was resolved or ongoing or if the care plan was updated. 8/17: An entry was made for a potential UTI with no symptoms but an ordered follow up to an urinary analysis. No information provided as to what urinary analysis this is a follow up for or when it occurred. Culture results identified "no growth", but sulfamethaoxaxazole [sic] and augmentin (antibiotics) ordered. The only other information available was the UTI was ongoing without a start date or plan for "ongoing" status Another entry was made for a potential UTI with culture orders on 8/22/17 but culture results identified "No report yet". Cefuroxime axetil and sulfamethoxazole-trimethoprim ordered after a clinic visit, but no documented culture results. On 9/14/17, at 1:34 p.m., registered nurse (RN)-B, indicated she was currently responsible for the facility's infection control program. RN-E confirmed the Grace Home Monthly Infection	li), ics th ss s ts, th	McGe follow sched evalua meeti 6.The will re	clist policy and procedure eer s criteria by at least ring: 1:1 meetings, stand duled meetings. Compet ations will be given follow ings e Facility s Infection Pre eport to the Quality Assur rmance Improvement co w and further recommen	one of the d-ups, or ency wing the eventionist rance ommittee for	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		245579	B. WING		05)/14/2017
	PROVIDER OR SUPPLIER	OME		STREET ADDRESS, CITY, STATE, ZIP CO 116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 441	facility had been take Control Assessment program (a program capacity across Mir representative in the facility add non-antitheir Monthly Infections as influenza, shingle	ntibiotics. RN-B indicated the king part in the Infection at and Response (ICAR) to improve infection control nesota). The ICAR e past had suggested the biotic treated infections to ion Report logs. This would notential viral infections (such es) as well. RN-B indicated yet implemented tracking of	F	141		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 29, 2017

Ms. Julie Rosenberg, Administrator Essentia Health Grace Home 116 West Second Street Graceville, MN 56240

Re: State Nursing Home Licensing Orders - Project Number S5579027

Dear Ms. Rosenberg:

The above facility was surveyed on September 11, 2017 through September 14, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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.

Essentia Health Grace Home September 29, 2017 Page 2

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson at (218) 332-5140 or email: gail.anderson@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 letter.

Sincerely,

Mark Meeth

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

Email: <u>mark.meath@state.mn.us</u>

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

cc: Licensing and Certification File

(X6) DATE

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00762	B. WING		09/1	4/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENTIA HEALTH GRACE HOME			SECOND S LLE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

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

10/08/17 **Electronically Signed**

TITLE

Minnesota Department of Health

00762 B. WING 09/-	4/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
ESSENTIA HEALTH GRACE HOME 116 WEST SECOND STREET GRACEVILLE, MN 56240	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Fulles, 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 September 11th, 12th, 13th and 14th 2017, 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 statutes/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	

Minnesota Department of Health

STATE FORM 5899 ZWHB11 If continuation sheet 2 of 47

Minnesota Department of Health

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-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. 1.			ATE SURVEY OMPLETED	
	2. 302311011		A. BUILDING:		501111		
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NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
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		GRACEVI	LLE, MN 56	240			
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	THIS WILL APPEA						
	THIS WILL APPEAL	R ON EACH PAGE.					
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.					
2 565	MN Rule 4658.0405 Plan of Care; Use	Subp. 3 Comprehensive	2 565			10/31/17	
		omprehensive plan of care personnel involved in the .					
	by: Based on observation review the facility factorized by the care (R11, R10, R47). In implement nutritions provision of peanut by the care plan for reviewed for nutrition Findings include: R11's care plan, reviewed for nutrition for the care plan for reviewed for nutrition for the care plan, reviewed for nutrition for the care plan for t	rised on 9/12/17, identified or self care deficit related to akness, decrease cognition,		R41 care plan and meal tray card vereviewed for accuracy and community book updated in the dietary departred Individual peanut butter packets also placed in the condiments container R41 table. Reviewed and revised comprehens care plan and oral hygiene policies reviewed nutritional care policy and appropriate and accurate. Identified all residents needing assoral cares in the facility and all the identified residents care plans were	nication ment. so on sive . Also, I it is		
	personal hygiene. F had his own teeth w directed staff to pro- for oral care.	ling more assistance with R11's care plan indicated R11 with cavities. The care plan vide set up and supervision 19 a.m. to 8:46 a.m. R11 was		reviewed for accuracy. Hartman publishing training video of providing oral cares will be used to with educating appropriate staff wit competency evaluation following the training video.	assist h		

Minnesota Department of Health

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Minnesota Department of Health

-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	2) MULTIPLE CONSTRUCTION (X3) DATE SUI BUILDING: COMPLET		
		00762	B. WING		09/1	4/2017
AND PLAN	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa observed to receive receive assistance time. At 9:15 a.m. F down. NA-B assiste washing his face, a room at 9:29 a.m. F provided oral cares On 9/13/17, at 12:1 was currently a hos assistance with all of hygiene. NA-B indic attempted oral care R11 got upset. NA- have good teeth." N oral cares to R11 fu but he gets mad at On 9/14/17, at 3:09	OME STREET ADI 116 WEST GRACEVI GRAC	A. BUILDING	STATE, ZIP CODE	ON LD BE PRIATE onitoring shifts to is being ified for this in weekly ed with ce week of ins are in weekly ed with ins are in weakly ed with ins a	LETED
	the bottom, which we discolored black/gray On 9/14/17, at 9:35 was currently a host assistance with all of hygiene. RN-A indicate care plan and second dental care even if On 9/14/17, at 10:1 (DON) confirmed R needed assistance oral hygiene. The Discolor following the care postaff to offer and enfor him."	a.m. RN-A confirmed R11 spice patient and needed of his ADL's including oral cated staff should be following tated staff "should be offering				

Minnesota Department of Health

STATE FORM 5899 ZWHB11 If continuation sheet 4 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00769	B. WING		00/1	4/2017
		00762			09/1	4/2017
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S SECOND S	STATE, ZIP CODE TREET		
ESSENT	IA HEALTH GRACE H	OME	LLE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 4	2 565			
	mucosa related to recares and history of personal hygiene. The encourage and asset times a day, if she will on 9/13/17, from 7	needing assistance with oral fresistance to ADL's including The care plan identified staff to ist with oral cares at least two will allow.				
	morning cares, R10 and at 9:36 was ob- service. At 10:21 a. room eating popcor	e morning cares. Following I was assisted to breakfast served to wait for church m. R10 was in the activity rn and drinking coffee was not offered or provided is time.				
	On 9/13/17, at 8:13 a.m. NA-B confirmed R10 needed assistance with all of her ADL's including oral hygiene. NA-B stated she forgot to complete R10's oral cares. NA-B further stated "I forgot about her mouth care this morning." NA-B indicated R10 had an electric toothbrush and needed assistance to use it.					
	her own natural tee which had several f	p.m. R10 was noted to have th on the top and bottom illings and some of her teeth scolored yellow/gray.				
	needed assistance oral hygiene. RN-A directions, and indic	a.m. RN-A confirmed R10 with all of her ADL's including confirmed the care plan cated staff should follow the ited "she [R10] does not know				
	R10's care plan and assistance with ora staff should follow t	7 a.m. the DON confirmed d verified R10 needed I hygiene. The DON indicated he care plan and stated "I to assist her with oral cares				

Minnesota Department of Health

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00762	B. WING		09/1	4/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/1	.,
ESSENT	IA HEALTH GRACE H	OME	SECOND S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	and to offer it and to R47 was not provid care plan. R47's ca identified the dental a potential for oral pher own teeth and didentified staff to procares daily. During observation from 9:12 a.m. to 9 (NA)-C assisted R4 offered the opportucares. R47's natural areas of white matton her right, lower I partial was not in planm. R47 was obsescrambled egg and not have her upper breakfast meal. On 9/13/17, at 9:44 finished with R47's reported R47 requiral ADL's, including oral had natural teeth an NA-C verified sheed cares or provide R4 and should have do 09/13/17, at 10:36 a confirmed R47 shocares prior to break placed in R47's mo 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, at 11:26 a verified R47 should should have do 09/14/17, a	ed oral care as directed by the re plan, revised on 9/1/17, I care plan indicated there was problems due to R47 having upper partials. The care plan ovide assistance with oral of morning cares on 9/13/17, :44 a.m. nursing assistant in the completion of oral al teeth were observed with er build up between them and in in Further, R47's upper ace prior to breakfast. At 9:53 inved eating a banana, toast independently. R47 did right partial in place during the a.m. NA-C verified she was morning cares. NA-C red assist of one staff for all al care. NA-C confirmed R47 and utilized an upper partial. In did not provide, nor offer oral in the interpretation of the confirmed R47 and utilized an upper partial. In the confirmed R47 and utilized an upper partial. In the confirmed R47 and utilized an upper partial. In the confirmed R47 and utilized an upper partial. In the confirmed R47 and utilized an upper partial. In the confirmed R47 and utilized an upper partial. In the confirmed R47 and utilized an upper partial. In the confirmed R47 and utilized an upper partial. In the confirmed R47 and utilized an upper partial. In the confirmed R47 and utilized an upper partial. In the confirmed R47 and utilized an upper partial. In the confirmed R47 and utilized an upper partial. In the confirmed R47 and utilized an upper partial. In the confirmed R47 and utilized an upper partial. In the confirmed R47 and utilized an upper partial. In the confirmed R47 and utilized an upper partial. In the confirmed R47 and utilized an upper partial. In the confirmed R47 and utilized an upper partial. In the confirmed R47 and utilized an upper partial. In the confirmed R47 and utilized an upper partial u	2 565			

Minnesota Department of Health

STATE FORM 5899 ZWHB11 If continuation sheet 6 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		00762	B. WING		09/1	4/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME	SECOND S LLE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 6	2 565			
	confirmed R47 required for oral cares.	uired staff assistance of one				
	required staff assis DON confirmed sta R47's partial was in	o.m. the DON verified R47 tance of one for all ADL's. The ff are expected to ensure place and provided oral cares The DON stated she expected 17's care plan.				
	dated 8/17, indicate comprehensive car measurable objectiresident's medical,	Plans-Comprehensive policy ed an individualized e plan that includes ves and timetables to meet the nursing, mental and s is developed for each				
	included peanut bur plan revised on 8/7, for BMI continuing i history of weight los body weight. The ca	led calorie dense foods, which tter with meals. R41's care /17, identified R41 was at risk in underweight status due to ess and prior to admit under are plan listed the intervention butter at meals for bread/toast.				
	9:38 a.m. to 10:20	s of breakfast on 9/13/17, from a.m. R41 was observed to eat tout had been provided no er toast.				
	was observed to ea	1:53 a.m. to 12:27 p.m. R41 at her dinner meal. Although I crackers at her meal, R41 provided any peanut butter neal.				
	confirmed R41 curr	a.m. dietary aid (DA)-A rent diet from her dietary card vas not aware R41 was				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 7 of 47 ZWHB11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00762	B. WING		09/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME	SECOND S LLE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	supposed to receiv meals. DA-A indical butter and would of On 9/13/17, at 9:41 stated R41's currer tablespoons of peal identified. DC-A stathis." DC-A indicate would right it in the on the dietary cards aware of this, I gue On 9/13/17 at 12:48 (DM) confirmed R4 The DM could not opeanut butter with refinking I did not cabutter." The DM could not opeanut butter with refinking I did not cabutter got missed." lost more weight, R lbs, and indicated swith the peanut but was unaware of R4 and indicated it was On 9/14/17 at 9:04 confirmed R41 curr was slightly below a indicated she thougheanut butter at me The RD indicated hoffer the peanut butter at me The RD indicated hoffer the peanut butter at me The RD indicated hoffer the peanut butter at me The RD indicated hoffer the peanut butter at me The RD indicated she thougheanut butter at me The RD indicated she thougheanut butter at me The RD indicated hoffer the peanut butter at me The RD indicated she thougheanut butter at me The RD indicated she though the Care plan as directors.	e peanut butter with her ted that R41 liked peanut casionally ask for it. a.m. dietary cook (DC)-A at dietary card did not have two nut butter with meals ted "no I was not aware of ed the dietary manager (DM) communication book and list it s. "I might of missed this, not ss we are in the dark." B p.m. clinical dietary manager 1's current care plan and diet. Verify if R41 was receiving meals. The DM stated "I am arry through with the peanut of the DM confirmed R41's BMI was eight and indicated "the peanut The DM confirmed R41 had 41's current weight was 86 he should of followed through ter. The DM confirmed staff 1's peanut butter with meals is human error. a.m. register dietician (RD) ent diet and indicated R41 healthy BMI. The RD pht staff were offering R41 wals to maintain R41 weight. er expectation of staff was to tter with meals that received icated staff should be following				

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Minnesota Department of Health			1		•	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00762	B. WING		09/1	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE, ZIP CODE			
		116 WEST	SECOND S			
ESSENT	IA HEALTH GRACE H	IOME	LLE, MN 56			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	THAIL	DAIL
0.505	0 1 1 5		0.505			
2 565	Continued From pa	ige 8	2 565			
	staff was already of	ffering it to R41.				
	D 1 (1)					
		olicy titled, Care Plan Use Of dicated the care plan shall be				
		the resident's daily care				
		available to staff personnel				
	who have responsil	bility for providing care or				
	services to the resi	dent.				
	SUGGESTED METHOD OF CORRECTION:					
		sing (DON) or designee could				
		policies and procedures related				
	to ensuring the care	e plan for each individual				
		. The director of nursing or				
		velop a system to educate staff				
		itoring system to ensure e. The auditing results could				
		e quality improvement group.				
		a damin mbaarama araba				
		R CORRECTION: Twenty-one				
	(21) days.					
0.000	MNI D. I. 4050 050	S Cultur C D Dahah ADI a	0.000			10/01/17
2 920	MIN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920			10/31/17
	Subp. 6. Activities	of daily living. Based on the				
		ident assessment, a nursing				
	home must ensure					
		is unable to carry out				
		ing receives the necessary n good nutrition, grooming,				
	and personal and o					
	p	79				
	-	ent is not met as evidenced				
	by: Based on observati	ion, interview and document		Reviewed and revised oral hygien	a nolicy	
		ailed to provide the necessary		Identified all residents needing ass		
		o maintain oral hygiene for 3		oral cares in the facility, all the ide		
		, R10, R47), reviewed for		residents care plans were reviewe		

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B 14/11/0			
		00762	B. WING		09/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME	SECOND S LLE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 9	2 920			
	activities of daily liv	ing (ADLs).		accuracy.	on	
	Findings included			Hartman publishing training video providing oral cares will be used to with educating appropriate staff w	assist	
	Set (MDS) dated 8/including anemia, hinsufficiency. The Nospice care, had sand needed limited perform personal hinsufficiency are plan, revenue to the perform personal formula formul	ange in status Minimum Data 29/17, identified diagnoses leart failure, and renal MDS identified R11 was on severe cognitive impairment assistance of one staff to ygiene including oral hygiene. Vised on 9/12/17, identified or self care deficit related to akness, decreased cognition, ding more assistance with R11's care plan indicated R11 with cavities.		competency evaluation following t training video. DON or designee will complete medaily X 1 week of either am or his see that appropriate oral hygiene provided as care planned to identification residents as well as others at risk alleged deficient practice and ther X3 weeks. Results will be reviewed the Quality Assurance Performance Improvement committee.	he conitoring shifts to s being fied for this weekly d with	
	in bed when nursing room to answer R1 needed to go to the assistance and put for help. R11 was wa white incontinent called for assistance and placed the transplaced the transplaced nurse (I assisted NA-B with wheelchair. NA-B poided. At 8:31 a.m. standing mechanical cleaning, emptying a.m. NA-C assisted placed a blanket or NA-B moved R11 to could watch TV, placed in the call of him with the call	a.m. R11 was observed lying g assistant (NA)-B entered the 1's call light. R11 indicated he bathroom. NA-B called for R11's shoes on while waiting rearing a long sleeve shirt and brief. At 8:23 a.m. NA-B again e on her walkie talkie again sfer belt around R11's waist. RN)-A entered the room and transferring R11 to his laced the urinal while R11 a. NA-C entered the room with al lift and assisted NA-B with R11's colostomy bag. At 8:35 I R11 to wash and dry his face, in his lap and left at 8:39 a.m. of the middle of the room so he aced the bedside table in front light, combed R11's hair and 42 a.m. NA-B returned with a				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00762	B. WING		09/1	4/2017
-	PROVIDER OR SUPPLIER	OMF 116 WEST	DRESS, CITY, S' F SECOND ST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 920	breakfast tray, place R11's chest area, s R11 began to eat in room at 8:46 a.m. I morning cares, R11 oral cares from state On 9/13/17, at 9:11 family was in visitin the room, and R11 down. NA-B obtaine NA-B hooked R11 to R11, provided periodincontinent brief. Not and assisted R11 to a.m. NA-B left R11' dirty linen and garb the breakfast tray. I was not offered or possistance with all thygiene. NA-B indicated she provide oral cares to, but he gets mad NA-B indicated she provide oral cares to the bottom, which we discolored black/gr. On 9/14/17, at 9:35 on 9/14/	ed a clothing protector on et him up to eat breakfast and adependently. NA-B left the During the observation of was not offered or provided if. a.m. R11's call light was on, g. At 9:15 a.m. NA-B entered indicated he wanted to lay ed the standing mechanical lift to the standing mechanical lift or clean his face. NA-B stood cares and placed a clean A-B transferred R11 to his bed to lay down in bed. At 9:29 is room after collecting the age, and returned to remove During the observation R11 provided oral cares by staff. 3 p.m. NA-B confirmed R11 provided oral cares by staff. 3 p.m. NA-B confirmed R11 provided oral cares by staff. 3 p.m. NA-B confirmed R11 provided oral cares by staff. 4 to R11 and not offered or the swith R11 recently because et. NA-B further stated "he did to R11 and stated she "forgot lat times, so I quite trying." would have to start trying to o R11. p.m. R11 was noted to have of his mouth and four teeth on were badly decayed and	2 920			

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) A. BUILDING: B. WING O9/14/2017 PREFIX (EACH CORRECTION (X5) (EACH CORRECTION SHOULD BE DEFICIENCY) A. BUILDING: D9/14/2017	STATEMENT OF DEFIC
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE OST 14/2017	
ESSENTIA HEALTH GRACE HOME 116 WEST SECOND STREET GRACEVILLE, MN 56240 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 116 WEST SECOND STREET GRACEVILLE, MN 56240 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE	
CRACEVILLE, MN 56240 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE)	NAME OF PROVIDER (
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	ESSENTIA HEALT
	PREFIX (EAC
all ADL's including oral hygiene. RN-A stated staff should be following the care pian and "should be offering dental care even if he refuses it." On 9/14/17, at 10:19 a.m. the director of nursing (DON) confirmed R11's care plan as current, verified R11 was currently a hospice patient and needed assistance with all of his ADL's including oral hygiene. The DON indicated staff should be following the care plan and stated "I would expect staff to offer and encourage dental care and do it for him." R10 was not provided oral cares by staff. R10's Quarterly MDS dated 8/7/17, identified R10 had diagnoses which included anemia, depression and dementia. The MDS identified R10 had severe cognitive impairment and needed extensive assistance of one staff to perform personal hygiene, including oral hygiene. R10's care plan, revised on 8/14/17, identified R10 had potential for alteration in mouth and oral mucosa related to needing assistance with oral cares and history of resistance to ADL's including personal hygiene. The care plan listed various interventions including staff to encourage and assist with oral cares at least two times a day, if she would allow it. On 9/13/17, at 7:45 a.m. R10 was observed lying in bed. NA-B assisted R10 to sit up, stand, and walk to to the bathroom. At 7:53 a.m. NA-B assisted R10 to stand with a walker, provided peri cares, and pulled up R10's pants. At 48:08 a.m. NA-B assisted R10 to stand with a walker, provided peri cares, and pulled up	all ADL's should be offering. On 9/14 (DON) of verified needed oral hyg following staff to offer him.' R10 was Quarterly diagnost and dem severe of extensive personal intervention assist where would be a severe of the severe

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00762	B. WING		09/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME	SECOND S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	8:11 a.m. R10 sat on NA-B removed gait a clothing protector a.m. R10 ate her but a.m. R10 was done the chapel area wather chapel area wather chapel area wather chapel area wather popcorn and drinking During the observation provided oral cares. On 9/13/17, at 8:13 needed assistance oral hygiene due to following command to do R10's oral cather mouth care this R10 has an electric assistance to use it behind." On 9/14/17, at 3:10 her own natural tee which had several fivere noted to be differed assistance oral hygiene. RN-A plan, indicated staff plan and further state to ask." RN-A indicated staff plan and further state of this on her own. On 9/14/17, at 10:210's care plan, and assistance with all of the poon.	down at the breakfast table, belt form her waist and placed on her chest area. At 8:52 reakfast independently. At 9:36 with breakfast and sitting in iting for church to begin. At is in the activity room eating ng coffee independently. Ition R10 was not offered or by staff. a.m. NA-B confirmed R10 with all of her ADL's including increased confusion and not its. NA-B indicated she forgot res and stated "I forgot about its morning." NA-A indicated that it toothbrush and does need and stated "I forgot running increased confusion and not its morning." NA-A indicated that its toothbrush and does need and stated "I forgot running increased confusion and not its morning." NA-A indicated that its toothbrush and does need and stated "I forgot running increased confirmed to have the on the top and bottom its scolored yellow/gray. a.m. RN-A stated R10 with all of her ADL's including a confirmed the current care if should be following the care atted "she [R10] does not know atted she would expect staff to a stated "she [R10] would not	2 920			

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STATEMENT OF DEFICIENCIES (X1)

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			231251170.			
		00762	B. WING		09/1	4/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME	SECOND S LLE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 13	2 920			
	following the care p	ON indicated staff should be plan and stated "I would expect with oral cares and to offer it per."				
	10/07, indicated nu residents with mout and as needed. Mo	olicy, Oral Hygiene reviewed in rsing staff will provide all th care every morning, night outh care would be given every residents on NPO (nothing by				
	R47 was not provided oral cares by staff. R47's Admission MDS dated 8/22/17, identified R47 had diagnosis which included anemia, depression, heart failure, chronic obstructive pulmonary disease (COPD) and Alzheimer's disease. The MDS identified R47 had severe cognitive impairment and needed assistance of one staff to perform personal hygiene, including oral hygiene.					
	had potential for inc related to Alzheime and weakness. R47 there was a potenti R47 having her own The care plan listed	vised on 9/1/17, identified R47 creasing self care deficit r's disease, dementia, COPD 7's dental care plan indicated al for oral problems due to n teeth and upper partials. d various interventions ovide assistance with oral				
	assistant (NA)-C as personal cares whice perineal cares and observation, R47 we offered the opportu- cares. R47's natura	:12 a.m. to 9:44 a.m. nursing sisted R47 with morning ch included washing her face, dressing. During this as not assisted with nor nity for completion of oral al teeth were observed with er build up between them and				

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		E SURVEY PLETED
		00762	B. WING		09/	14/2017
	PROVIDER OR SUPPLIER	OME 116 WES	DRESS, CITY, S F SECOND S' ILLE, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 920	on her right, lower I partial was not in pl At 9:44 a.m. followi cares, NA-C assiste table. NA-C stated morning cares. NA assist of one staff ficare. NA-C confirmutilized an upper panot provide, nor offe partial prior to break so. At 9:53 a.m. R47 w scrambled egg and not have her upper breakfast meal. On 9/13/17, at 10:3 (RN)-B confirmed oral cares prior to be placed in R47's mo On 9/14/17, at 11:2 (RN)-A verified R47 oral cares and give confirmed R47 required staff assis DON confirmed staff to follow R4	ip. Further, R47's upper ace prior to breakfast. Ing the observation of morning and R47 to the dining room she was finished with R47's L-C reported R47 required or all ADL's, including oral ned R47 had natural teeth and artial. NA-C verified she did are oral cares or provide R47's kfast and should have done as observed eating a banana, toast independently. R47 did right partial in place during the R47 should have been offered oreakfast, including the partial uth. 6 a.m., registered nurse as and, registered nurse as and, registered nurse are hould have been provided or partial prior to breakfast, and uired staff assistance of one as as a subserved to ensure a place and provided oral cares and place and provided oral cares and place and provided oral cares and poon stated she expected				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		(X3) DATE COMPI	
		00762	B. WING		09/1	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	A HEALTH GRACE H	OME	SECOND S			
		GRACEVI	LLE, MN 56		1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 15	2 920			
	services to maintain and personal and of nursing or designed audits of the delived appropriate care and The results of the and quality improvement	y are receiving the necessary in good nutrition, grooming, ral hygiene. The director of e, could conduct random ery of care; to ensure ind services are implemented, audits could be brought to the at for review. R CORRECTION: Twenty-one				
2 965	MN Rule 4658.0600 -Nutritional Status	Subp. 2 Dietary Service	2 965			10/31/17
	must ensure that a which supplies the determined by the cassessment. Subs	nal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food				
	by: Based on observation review, the facility for interventions related dense foods which meals in order to prof 3 residents (R41). Findings include: R41's quarterly Minimus in the second residents.	ent is not met as evidenced on, interview and document ailed to implement nutritional d to the provision of calorie included peanut butter with revent further weight loss for 1) reviewed for nutrition. imum Data Set (MDS) dated 341 had diagnosis which		R41care plan and meal tray card we reviewed for accuracy and commus book updated in the dietary departs Individual peanut butter packets also placed in the condiment container table. Reviewed nutritional care policy and appropriate and accurate. Identified residents needing assist with oral of the facility and all the identified residents.	nication ment. so on R41 ad it is d all cares in	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMPI	
		00762	B. WING		09/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	ОМЕ	r SECOND S LLE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	MDS identified R41 impairment, needed staff for activities of independent with eastaff. The MDS furth inches (in), weighed weight loss, no eatitherapeutic diet. Review of R41's sign Screening and Assessindicated R41 was indicated R41 was indicat	depression and anxiety. The had severe cognitive dilimited assistance of one daily living (ADL's) and was ating after set up help from her indicated R41 was 58 d 88 pounds (lbs), had no ng problems and had a grificant change Nutritional essment dated 5/2/17, on a regular diet with ons of super potatoes, super e main dining room. R41's and weight 89.5 lbs. R41's 8MI) 18.7 low end of health arterly Nutritional Screening ated 7/27/17, indicated R41 et, small portions, with ons of super potatoes, super e main dining room. R41's and weight 87.5 lbs. R41's ght status and continue with esident Progress Notes on stered dietician (RD) revealed at 86.5 lbs which is stable and nich is underweight. Family ome 85 lbs. Diet is regular with we at breakfast 76-100 percent unch and dinner. R41 calories and protein through potatoes and two	2 965	care plans were reviewed for accurollowing RD monthly visits any recommendations that may have made will be documented on the creferral flow sheet, the CDM will mappropriate updates to tray cards, plans, etc. The cook will also initial acknowledge that the recommend have been completed by CDM. DON or designee will complete compliance monitoring daily X 1 warious meal times to see that appropriate nutritional intervention provided as care planned and the X3 weeks. Results will be reviewed the Quality Assurance Performant Improvement committee.	been dietician nake care al to lations veek of as are n weekly d with	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00762	B. WING		09/14/2017	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	TATE, ZIP CODE	-	
ESSENTIA HEALTH GRACE HOME 116 WES		SECOND S	TREET		
ESSENTIA TIERETT GHASE TIS	GRACEVI	LLE, MN 56	240		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	E
status due to history admit under body we R41 was independen up help from staff at several intervention is small portion diet as provide super cereal potatoes at dinner to and record and moni 8/7/17, offering pean bread/toast was added Review of R41's dietareceiving a regular dicereal for breakfast a R41's dietary card did two tablespoons of pomonial of the pean o	ontinuing in underweight of weight loss and prior to eight. The care plan identified it with eating and needed set times. The care plan listed such as: provide regular, ordered per medical doctor, at breakfast and super aid with weight maintenance itor intake. When revised on but butter at meals for ed to the plan of care. The care plan listed such as it with small portions, super and super potatoes for lunch. If and the the plan of care it with small portions, super and super potatoes for lunch. If and super potatoes for lunch it with meals. The care plan is to a super and super potatoes for lunch. If and super potatoes for lunch it with meals. The care plan is to a super and super potatoes for lunch it with super cereal, scrambled banana, half glass of orange milk and a cup of coffee. The care plan identified is a super and super cereal, scrambled banana, half glass of orange milk and a cup of coffee. The care plan identified is a plate in front of her which is super cereal, scrambled banana, half glass of orange milk and a cup of coffee. The care plan identified is a plate in front of her which is super cereal, scrambled banana, half glass of orange milk and a cup of coffee. The care plan identified is a plate in front of her which is super cereal, scrambled banana, half glass of orange milk and a cup of coffee. The care plan identified is a plate in front of her which is a plate in fr	2 965			

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING:

00762

B. WING ___

09/14/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

116 WEST SECOND STREET

ESSENTIA HEALTH GRACE HOME		SECOND ST LLE, MN 562		
(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
	REGULATORY OR LSC IDENTIFYING INFORMATION)		CROSS-REFERENCED TO THE APPROPRIATE	
	new one for us."			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		00762	B. WING		09/1	4/2017
NAME OF PROVIDER OF	SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENTIA HEALTH	GRACE H	IOME	T SECOND S ILLE, MN 56			
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
verified R peanut bu and state indicated communic cards so s stated "I r guess we On 9/13/1 (NA)-B ine eating and packages she had to portions, by the am was not a told staff of On 9/13/1 manager and diet. receiving potatoes R41 was stated "I a the peanu was borde was the o staff know the menu stated "th confirmed current we should ha butter. Th to follow to	7, at 9:41 41 did no otter with a dino I was the DM we cation bookstaff would night of mare in the T, at 12:2 dicated R dineeded and cuttion tell the botherwise ount of for big eater when she T, at 12:4 (DM) con The DM visuper cerfor dinner receiving am thinking the butter." The cards for the epanut I R41 had beight was the pollower of the DM included the pollower of the pollower	a.m. dietary cook (DC)-A t have two tablespoons of meals listed on her dietary card as not aware of this." DC-A yould write it in the ok and list it on the dietary d know of the changes. DC-A nissed this, not aware of this, I				

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09/14/2017

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING:

00762

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING ___

ESSENT	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) COMPLETE DATE		
2 965	Continued From page 20	2 965				
	indicated it was "human error."					
	On 9/14/17, at 9:04 a.m. the registered dietician (RD) confirmed R41's current diet and indicated R41 was slightly below a healthy BMI. The RD indicated she thought staff were offering R41 peanut butter at meals to maintain R41 weight. The RD indicated her expectation of staff was to offer the peanut butter with meals that included bread. The RD indicated staff should be following the care plan as directed. The RD indicated a normal BMI for a person of R41's height and weight was 18.5 and stated "a little under." The RD indicated she added the peanut butter because she thought staff was already offering it to R41.					
	Review of facility policy titled, Nutritional Care dated 2/2012, indicated the RD will cover dietary needs of residents and recommend changes as residents condition changes. The DM will monitor weights, intake, labs, and recommend changes to diet plan as needed. The DM will refer high nutritional risk residents to RD for nutritional assessment and recommendations as needed.					
	SUGGESTED METHOD OF CORRECTION: The dietician or designee, could review all residents nutritional needs to assure they are offered a diet meeting their nutrient needs determined by the comprehensive resident assessment. The dietician or designee, could conduct random audits of the nutritional care; to ensure appropriate care and services are implemented. The audits could be reviewed with the quality improvement group.					
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.					

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00762	B. WING		09/1	4/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ESSENT	IA HEALTH GRACE H	I/ 18/11=	SECOND S				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
21375	Continued From pa	ge 21	21375				
21375	MN Rule 4658.0800 Program	0 Subp. 1 Infection Control;	21375			10/31/17	
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.					
	by: Based on interview facility failed to esta program which inclus surveillance of resid analyze possible pa facility. This deficie affect all 39 resider Findings include: Review of the facilit surveillance progra The facility utilized Reports, which included room) from 9/16 the	and document review, the ablish an infection control uded comprehensive dent infections to identify and atterns of infection in the nt practice had the potential to nts who resided in the facility. ty's infection control m was conducted on 9/14/17. Grace Home Monthly Infection uded Infection Maps (facility resident rooms and dining rough 9/17. The Grace Home deport included the following		1.The facility Infection Control Polireviewed and revised on 10-3-17. 2.Reviewed the Urinary Tract Infections of Infection Log, including infections or are not being treated with antibity 4.Update Infection Control Logs "Added a section to track whether infection was community acquired a nosocomial infection on 10-4-17 "Infection Preventionist or designed ensure that culture results are documented on Infection Control I the culture results section, when the updated. 5.Events are opened for all new signal infection and infection in the section in the secti	the or if it is ee will cogs in the log is		
	areas: resident nan admission date, ons site, date of culture ordered, start date, ongoing, care plan up. The monthly log infections for which however, did not coresults and no color lacked if the infection	ne, room number, physician, set date, symptoms, infection, culture results, antibiotic discontinue date, resolved or updated, and comments/follow gs included residents with antibiotics were prescribed, onsistently include culture ny counts recorded. Logs also ons were community acquired litionally, the logs failed to		symptoms of infection. 6.MatrixCare added Infection to the problem category so we can care infections through matrix care. The will start care planning infections in MatrixCare starting 10-4-17. Corrective Action Plan: 1.The infection preventionist will me the physicians from the affiliated he and inform them how the facility plimplement infection surveillance under the symptoms.	ne e facility n neet with nospital lans to		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
		00762	B. WING		09/1	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
ESSENTIA HEALTH GRACE HOME 116 WES		OME 116 WEST	SECOND S	STREET		
LOGENT	IA TILALITI GITAGE II	GRACEVI	LLE, MN 56	240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 22	21375			
213/3	identify resident syrnot treated with ant Review of Monthly through 8/17, included 3/17: There was an with two symptoms incontinence and mand there was no date Ciprofloxacin (antibe Another entry was result and an antibile did not specify if the ongoing and did not was updated. 4/17: An entry was tract infection (UTI) changes prior to the analysis. Order recestanted antibiotic on indicated E. coli, but count. There was another no symptoms track the infection was reidentify if the plan of A third entry was mone symptom of mourinary analysis. Recompleted with the mixed contaminants	inptoms/infections that were libiotics. Infection Report from 3/17 Ided: entry for urinary symptoms identified of increased good/personality change. of culture, or culture results. iotic) was started. made for an urinary infection toms. There was a culture obtic was ordered. The entry infection was resolved or indicate if the plan of care made for a potential urinary with one symptom of mood exphysician order for urinary elived for urinary analysis and a 4/11/17. Culture results it did not indicate a colony entry for a potential UTI with ed. The entry did not specifiy if solved or ongoing and did not for care was updated. and for a potential UTI with ed changes prior to order for esident started on Bactrim DS en day the urinalysis was culture results showing only	213/3	McGeer s criteria. 2.Facility s Infection Prevention of training Scheduled for October 18-2017. The course is taught individe have a Certification in Infection Course that wa comprehensive foundation for professionals specializing in infect prevention. The course learning outcomes inchaving the participants: "Examine the elements of effective infection prevention programs and resources that support them. "Gain understanding of how evidenced-based recommendation used to implement best practices in prevent infections. "Sharpen networking skills with course to share experience and to gain an additional resources. "Increase awareness of Centers for Medicare and Medicaid s conditional participation to qualify for 3rd party reimbursement. "Expand knowledge of compliance state and national regulatory standate and	ourse -20, uals who ontrol. vill offer ion ludes the as are to lleagues ccess to or ons of v e with dards or oact of support thcare signee	
		e entry for a potential UTI with included elevated blood		x30 days starting 10-4-17, seeing orders follow McGeer s criteria. 5.Inservices are scheduled for Oct Nursing staff will be educated on t	tober.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE S	
		00700	B. WING		00/4	4/0047
		00762			09/1	4/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME	SECOND S LLE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 23	21375			
	sugars and lethargy Culture results iden but no colony count was available. 6/17: An entry for a unknown date of culture Resident was admit for UTI, but no furth There was no indic was resolved or on 7/17: An entry was two symptoms iden prior to order for unshow E. coli, but no	y. A urinalysis was ordered. Itified Escherichia coli (E. coli), It and no further information potential UTI with an Ilture and no culture results. Itted to the facility on antibiotics Itter information available. ation of whether the infection		checklist policy and procedure and McGeer s criteria by at least one following: 1:1 meetings, stand-ups scheduled meetings. Competency evaluations will be given following meetings 6.The Facility s Infection Prevent will report to the Quality Assurance Performance Improvement comm review and further recommendation	of the s, or the ionist e ittee for	
	no symptoms but a urinary analysis. No what urinary analysis when it occurred. O growth", but sulfam augmentin (antibiot information availab without a start date Another entry was a culture orders on 8 identified "No repor sulfamethoxazole-t clinic visit, but no do On 9/14/17, at 1:34 (RN)-B, indicated s for the facility's infeconfirmed the Grace Report logs tracked	made for a potential UTI with a ordered follow up to an ordered follow up to an ordered follow up for or culture results identified "no ethaoxaxazole [sic] and ics) ordered. The only other le was the UTI was ongoing, or plan for "ongoing" status. made for a potential UTI with 1/22/17 but culture results tryet". Cefuroxime axetil and rimethoprim ordered after a ocumented culture results. To p.m., registered nurse he was currently responsible ction control program. RN-B is ethome Monthly Infection donly those infections which intibiotics. RN-B indicated the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME	SECONDS LLE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Control Assessment program (a program capacity across Mir representative in the facility add non-antitheir Monthly Infections ensure tracking of passinfluenza, shingle the facility had not your viral infections within SUGGESTED MET. The administrator, of designee could reviprocedures related developed and implementation of practice based of practice based of qualified organization. The administrator, of designee could developed and a monitoring sycompliance. The fact quality assurance procedures recommendations.	king part in the Infection It and Response (ICAR) In to improve infection control Innesota). The ICAR It is past had suggested the It is biotic treated infections to It is non Report logs. This would It is possible to the infections (such It is possible to the infection (such It is possible to	21375			
21530	A. The drug regim reviewed at least m currently licensed b This review must be Appendix N of the S	on A.B.C Drug Regimen Review en of each resident must be onthly by a pharmacist y the Board of Pharmacy. The done in accordance with State Operations Manual, the stor Pharmaceutical Service	21530			10/31/17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		00762	B. WING		09/14/2017
	PROVIDER OR SUPPLIER	OMF 116 WES	DRESS, CITY, STEEPING STATES		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
21530	Requirements in Lot the Department of I Health Care Finance This standard is in available through the system. It is not sure B. The pharma irregularities to the and the attending pure must be acted upon physician visit, or sure pharmacist. For pure upon "means the arreport and the sign of nursing services C. If the attend with the pharmacist not provide adequate pharmacist believed being adversely after the matter to the attending physician. If the medical direct physician does not must be referred for assessment and as by part 4658.0070. The medical direct must refer the matter the matt	ge 25 Ing-Term Care, published by Health and Human Services, sing Administration, April 1992. Corporated by reference. It is the Minitex interlibrary loan bject to frequent change. Cist must report any director of nursing services hysician, and these reports in by the time of the next coner, if indicated by the proses of this part, "acted coceptance or rejection of the ing or initialing by the director and the attending physician. In inging physician does not concurr's recommendation, or does the justification, and the instead of the ingential director for review for its not the attending edical director determines that coin does not have adequate order and if the attending change the order, the matter is review to the quality esurance committee required. If the attending physician is or, the consulting pharmacist er directly to the quality esurance committee.	21530	Labs obtained for (R10) results were reviewed by her provider and no cha	
	identified and repor	ted incomplete lab monitoring edications (Simvastatin and		in her medications or treatments were made.	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00762 B. WING			09/1	4/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME	SECOND S LLE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 26	21530			
21550	Zetia) and a thyroid for 1 of 5 residents unnecessary medic. Findings include: R10's signed physic identified diagnoses (high cholesterol), a orders also include Simvastatin 40 milli evening for hyperlip once an evening for Levothyroxine 50 monce a morning for review of the signed R10 was to have a stimulating hormon twelve months. Review of R10's me evidence a recent lip completed to monit The most recent lip R10's medical reconspital by staff updated 6/9/16; R10's found in the blood) 241 (reference range cholesterol (good cobe low at 23 (reference range: 0) Review of the Phar Reviews dated 1/17 recommendations for the signed staff updated for the phar Reviews dated 1/17 recommendations fo	medication (Levothyroxine) (R10) reviewed for rations. cian orders dated 8/14/17, sincluding: hyperlipidemia and hypothyroidism. The da current order for grams (mg) by mouth once an idemia, Zetia 10 mg by mouth rhyperlipidemia and hicrograms (mcg) by mouth hypothyroidism. Further dephysician orders indicated lipid profile and thyroid e (TSH) labs completed every edical record did not include pid profile or TSH had been or the efficacy of medications, id profile and TSH were not in red but obtained from the control request. The labs were striglyceride (a type of fat level was noted to be high at ge: 10-200) and her HDL cholesterol) level was noted to once range: 40-60). R10's TSH is noted to be at 1.77	21330	Reviewed and revised pharmacist regimen policy. Reviewed and reviranscription of physician orders procedure. 10/3/17 Monthly consultant pharmacist will every residents records including Staff reviewed all lab orders from and verified all have been drawn a results are in residents chart. Reviewed and revised physician sorders. Night charge nurse will review "lab report daily to see if any labs are of Routine lab day is Wednesday. The tech will give the charge nurse a "report whenever they are here to alabs and verify the labs are drawn Licensed staff and lab department educated by at least one of the fold 1:1 meetings, stand-ups, or schedings on this new process. DON or designee will review week weeks that all ordered labs are drawn ordered. Results of this audit will reviewed with QAPI committee.	rised olicy and labs. 2017 and tanding o due" due. he lab lab due" draw any . will be lowing; luled sty X 4 awn as	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING.			
	00762	B. WING		09/1	4/2017
NAME OF PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	TATE, ZIP CODE		
ESSENTIA HEALTH GRACE HOME		SECOND S			
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST E TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
On 9/14/17, at 2:22 p.m. athe consulting pharmacist 9:10 a.m. the CP returned stated if the medical doctor to be done yearly, she exposure the labs were being of "they should be done year labs were reviewed during reviews and indicated if the their goals, no recommend The CP indicated a TSH swith this age group and if abnormal labs, follow up lawell and with health changes he would have given receabnormal labs and said "It this" to see if the medical changes or labs repeated. On 9/14/17, at 2:13 p.m. to (DON) confirmed R10 was and TSH checked yearly porders. The DON verified her lipid profile and TSH of the DON indicated her exto make sure the labs are signed orders. The DON in get entered into Matrix (elementary to the lab departmentary to the lab departmenta	the phone call and or ordered follow up labs bected staff to make done. The CP stated by "The CP indicated of the monthly pharmacy is resident was within dations would be made. Should be done yearly a resident had abs should be done as ges. The CP indicated ommendation for would have addressed doctor wanted any. The director of nursing is to have her lipid profile per signed doctors the last time R10 had shecked was on 6/9/16. Expectations of staff was done per the doctors indicated the lab orders ectronic medical matically sent the lab ent and generated the wednesday in the dishe thought another all lab orders and that's it not get done. Ty titled, Pharmacy 17, indicated each regimen shall be to: help promote or	21530			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00762	B. WING		09/1	4/2017
	PROVIDER OR SUPPLIER	IOME 116 WEST	DRESS, CITY, S SECOND S LLE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	mental, physical and defined by the resident collaboration with the facility staff. The collaboration with appropriate nursing these systems. The develop an auditing compliance. The authe quality assurance recommendations.	d psychosocial well-being, as dent and representative in ne attending physician and insultant pharmacist reviews gregimen monthly to ensure plicable state and federal THOD OF CORRECTION: The (DON) or designee could policies and procedures for of medication usage. It is staff could be educated on the DON or designee, could gregisted to ensure ongoing undits could be reviewed with the committee for further	21530			
21540	Subp. 2. Monitoring monitor each reside unnecessary drug u home's policies and pharmacist must reresident's attending physician does not home's recommend adequate justification believes the resider adversely affected, matter to the medical director is	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the eport any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist ent's quality of life is being the pharmacist must refer the eal director for review if the not the attending physician. If r determines that the attending	21540			10/31/17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE : COMPI		
		00762	B. WING		09/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
FOOFNE		116 WES	SECOND S	STREET		
ESSENI	IA HEALTH GRACE H	GRACEVI GRACEVI	LLE, MN 56	6240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCY PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		.D BE	(X5) COMPLETE DATE		
21540	Continued From pa	ge 29	21540	BEI IGIEITO I		
	physician does not the order and if the change the order, the review to the Qualit (QAA) committee re the attending physician	have adequate justification for attending physician does not ne matter must be referred for y Assurance and Assessment equired by part 4658.0070. If cian is the medical director, macist shall refer the matter				
	by: Based on interview facility failed to mor to the lipid lowering Zetia) and thyroid m 1 of 5 residents (R1 medications. Finding include: R10's signed physic identified diagnoses (high cholesterol), a orders also included Simvastatin 40 milli evening for hyperlip once an evening for Levothyroxine 50 m once a morning for review of the signed R10 was to have a stimulating hormont twelve months. Review of R10's me evidence a recent lie	and document review the nitor laboratory levels related medications (Simvastatin and nedication (Levothyroxine) for 0) reviewed for unnecessary cian orders dated 8/14/17, sincluding: hyperlipidemia and hypothyroidism. The dia current order for grams (mg) by mouth once an idemia, Zetia 10 mg by mouth rhyperlipidemia and icrograms (mcg) by mouth hypothyroidism. Further diphysician orders indicated lipid profile and thyroid e (TSH) labs completed every edical record did not include pid profile or TSH had been or the efficacy of medications.		Labs obtained for (R10) results we reviewed by her provider and no cin her medications or treatments vinded. Reviewed and revised pharmacist regimen policy. Reviewed and revised pharmacist regimen policy. Reviewed and reviranscription of physician orders procedure. 10/3/17 Monthly consultant pharmacist will every residents records including Staff reviewed all lab orders from and verified all have been drawn a results are in residents chart. Reviewed and revised physician sorders. Night charge nurse will review "lab report daily to see if any labs are concerned to the charge nurse a "report whenever they are here to clabs and verify the labs are drawn Licensed staff and lab department educated by at least one of the fold 1:1 meetings, stand-ups, or sched meetings on this new process. DON or designee will review weeks.	hanges vere drug vised olicy and I review labs. 2017 and tanding o due" due. he lab lab due" draw any twill be lowing; luled	
	orders also included Simvastatin 40 milli evening for hyperlip once an evening for Levothyroxine 50 m once a morning for review of the signed R10 was to have a stimulating hormontwelve months. Review of R10's me evidence a recent licompleted to monit. The most recent lip	d a current order for grams (mg) by mouth once an idemia, Zetia 10 mg by mouth rhyperlipidemia and icrograms (mcg) by mouth hypothyroidism. Further d physician orders indicated lipid profile and thyroid e (TSH) labs completed every		results are in residents chart. Reviewed and revised physician s orders. Night charge nurse will review "lab report daily to see if any labs are of Routine lab day is Wednesday. T tech will give the charge nurse a "report whenever they are here to olabs and verify the labs are drawn Licensed staff and lab department educated by at least one of the fol 1:1 meetings, stand-ups, or sched	tanding o due" due. he lab lab due" draw any twill be lowing; luled dly X 4 awn as	

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00762	B. WING		09/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
FOOTNE	IA LICALTIL CDACE II	116 WEST	SECOND S	STREET		
ESSENTIA HEALTH GRACE HOME GRACEV		GRACEVI	LLE, MN 56	240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 30	21540			
	hospital by staff upodated 6/9/16; R10's found in the blood) 241 (reference rang cholesterol (good clot be low at 23 (refere level on 6/9/16, was (reference range: 0 On 9/14/17, at 2:13 (DON) confirmed R and TSH checked y orders. The DON veher lipid profile and The DON indicated to make sure the lasigned orders. The get entered into Marecord), the system orders to the lab de lab work to be done facility. The DON in order over rode the	on request. The labs were triglyceride (a type of fat level was noted to be high at ge: 10-200) and her HDL holesterol) level was noted to nce range: 40-60). R10's TSH is noted to be at 1.77		reviewed with QAPI committee.		
	the consulting phare 9:10 a.m. the CP restated if the medicato be done yearly, some sure the labs were longer they should be done labs were reviewed reviews and indicate their goals, no reconstruction of the CP indicated a with this age group abnormal labs, followell and with health	p.m. a message was left for macist (CP). On 9/18/17, at sturned the phone call and all doctor ordered follow up labs the expected staff to make being done. The CP stated during the monthly pharmacy ed if the resident was within mmendations would be made. TSH should be done yearly and if a resident had by up labs should be done as a changes. The CP indicated en recommendation for				

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-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
		00762	B. WING		09/1	4/2017
	PROVIDER OR SUPPLIER	OME 116 WEST	DRESS, CITY, S F SECOND S ILLE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21540	abnormal labs and this" to see if the m changes or labs reportant appropriate lab or x notify lab or x-ray if immediately or at a place resident named and calendar at processary medication systems compliance. The authe quality assurance recommendations.	said "I would have addressed edical doctor wanted any beated. Dicy titled, Physician Orders, vised on 10/11 indicated under icated staff was to fill out erray requisition in Matrix, something needs to be done specific time and date and e and lab to be drawn on lab ospective nurses station. THOD OF CORRECTION: The (DON) or designee could solicies and procedures for eations. Appropriate nursing ated on the systems. The could audit unnecessary is to ensure ongoing udit results could be brought to	21540			
21805	Residents of HC Fa Subd. 5. Courteon residents have the courtesy and respe	ac.Bill of Rights us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a	21805			10/31/17
	This MN Requirement	ent is not met as evidenced				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00762	B. WING		09/1	09/14/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
		116 WEST	SECOND S	STREET			
ESSENTIA HEALTH GRACE HOME GRACEVI		OME GRACEVII	LLE, MN 56	240			
(X4) ID PREFIX TAG	FEIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRE AG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE		
21805	Continued From pa	ge 32	21805				
21003	Based on observation, interview and document review, the facility failed to ensure a dignified dining experience for 1 of 1 residents (R7) observed during the breakfast meal. Finding include: R7's care plan (CP) revised on 8/1/17, identified R7 had diagnoses which included hemiplegia (paralysis) and hemiparesis (weakness) affecting left non-dominant side, dysphasia and vascular dementia. R7's CP identified altered thought process and required assistance from staff to complete all activities of daily living (ADL's). Further review of the CP directed staff to provide extensive assistance with meals and cues on staying awake at meals. During continual observation of the breakfast meal on 9/12/17, beginning at 8:54 a.m. R7 was seated in a wheelchair in the far north corner of the main dining room. R7 had a clothing protector on her chest. R7 was seated at a table by herself with bedside table in front of her. The wheelchair was higher than the dining room table. R7 had		21003	Reviewed and revised Residents repolicy. Taller chair was made aware avails staff to use to sit and assist during mealtimes if resident is in higher wheelchair. Staff will be educated by at least of the following; 1:1 meetings, standscheduled meetings on F241 and interpretive guidelines with comperevaluations following education. (In not al all-inclusive list): a) "Dignity" means that their interase with residents, staff carries out act that assist the resident to maintain enhance his/her self-esteem and self-worth. Some examples including the including as the resident wishes	able for ne of ups, or tency his is ctions ivities and		
				groomed Promoting independence and dig dining experience such as to avoid I. Day-to day use of plastic cutler. II. Staff standing over residents wassisting them to eat;	dance of: y; hile		
	(LPN)-A was observed bedside table with F a white bowl in her right hand and was At 8:55 a.m. LPN-A	Licensed practical nurse wed standing next to the R7 on the left side. LPN-A had left hand, a silver spoon in her giving R7 bites of hot cereal. took a white covered plastic it half full of juice. LPN-A		III. Staff interacting/ conversing on each other rather that with residen assisting residents;b) Respecting residents by speakirespectfully. addressing the residename of their choice, etc.	its while		
	cup with a straw in it half full of juice. LPN-A offered R7 a drink while stating "[R7] you have to suck up the straw" in a childish tone of voice. LPN-A repeated R7's name several times in the childish tone attempting to get her to drink from the straw. At 8:56 a.m. LPN-A took R7's bowl of hot cereal and asked R7 if she was ready for another bite. LPN-A repeated R7's name several times using a			Training video on assisting resider will be used to assist in educating along with competency evaluation following the training video. Traini be completed by 10/20/17 All residents have the potential to affected by the alleged deficient procession.	staff ng wil be		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240 PREETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CONTINUED FROM TAG CHOOL OF THE PROVIDER SPLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG 21805 Continued From you have been been been been been continued attempting to give R7 bites of the hot cereal while stalking in a childsh tone of voice. At 8:58 a.m. R7 was done eating the hot cereal. LPN-A removed R7's clothing protector, took the juice. and wheeled R7 from the dirining room to the adjacent sitting area. LPN-A continued to give R7 dirinks of the juice while standing next to her. On 9/14/17, at 12:50 p.m. LPN-A verified she always stood while feeding next to her. On 9/14/17, at 12:50 p.m. LPN-A remained standing while feeding her. LPN-A indicated she could not reach or see R7 if she did not stand while feeding her. LPN-A indicated she could not reach or see R7 if she did not stand while feeding her. LPN-A indicated she believed she fed R7 in a dignified manner. On 9/14/17, at 2:52 p.m. the dietary manager (DM) confirmed she has seen staff standing while feeding resident in the higher wheelchairs. The DM indicated staff should be seated at eye level while feeding resident in the higher wheelchairs. The DM indicated staff should be seated while feeding residents staff should sit while feeding residents staff should staff should staff should the staff should the staff should staff should the staff shoul	-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH GRACE HOME (164) ID SUMMARY STATEMENT OF DEFICIENCIES (RACEVILLE, MM 56240) [X44) ID PRIEFIX TAG (REGULATORY OR LOS IDENTIFYING INFORMATION) (REGULATORY OR LOS IDENTIFYING INFORMATION) 21805 Continued From page 33 childish tone of voice. LPN-A remained standing and continued attempting to give R7 bites of the hot cereal while talking in a childish tone of voice. At 8:59 a.m. R7 was done eating the hot cereal. LPN-A removed R7's clothing protector, took the juice, and wheeled R7 from the dining room to the adjacent sitting area. LPN-A continued to give R7 drinks of the juice while standing next to her. On 9/14/17, at 12:50 p.m. LPN-A verified she always stood while feeding R7, stating "I stand because her chair is so high." LPN-A indicated she could not reach or see R7 if she did not stand while feeding her. LPN-A indicated she could use a different chair but did not think the facility had a chair high enough. LPN-A stated "I have always done it this way and I like to see her face." LPN-A indicated she believed she fed R7 in a dignified manner. On 9/14/17, at 2:52 p.m. the dietary manager (DM) confirmed she has seen staff standing while feeding residents further stating 'we could try higher chairs for staff." The DM indicated staff know they are supposed to be seated while feeding residents. The DM indicated staff should treat the resident with							
SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES MN 56240			00762	B. WING		09/14/2017	
CKA ID SUMMARY STATEMENT OF DEFICIENCIES (FRACH DEFICIENCY MUST BE PRECEDED BY PULL) REGULATORY OR LSC IDENTIFYING INFORMATION) PRECIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE ACTION SHOULD BE COMPANIED TO THE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE ACTION SHOULD BE CONSTRUCTED. CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPERIATE DATE OF THE ACTION SHOULD BE CONCERN TO SHOULD BE CONCERN TO SHOULD BE CROSS-REFERENCED TO NETWER DEFICIENCY. 28805 28805 28805 28805 28805 28805 28805 28805 28805 28805 28805 28805 28805 28805 28805 28805 28805 28805 28805 28805 28805 28805 28805 28805 28805 28805 28805 28805 28805	NAME OF I	PROVIDER OR SUPPLIER					
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 21805 Continued From page 33 childish tone of voice. LPN-A remained standing and continued attempting to give R7 bites of the hot cereal while talking in a childish tone of voice. At 8:58 a.m. R7 was done eating the hot cereal. LPN-A removed R7's clothing protector, took the juice. and wheeled R7 from the dining room to the adjacent sitting area. LPN-A continued to give R7 drinks of the juice while standing next to her. On 9/14/17, at 12:50 p.m. LPN-A verified she always stood while feeding R7, stating "I stand because her chair is so high." LPN-A indicated she could use a different chair but did not think the facility had a chair high enough. LPN-A stated "I have always done it this way and I like to see her face." LPN-A indicated she believed she ted R7 in a dignified manner. On 9/14/17, at 2:52 p.m. the dietary manager (DM) confirmed she has seen staff standing while feeding resident in the higher wheelchairs. The DM indicated staff should be seated at eye level while feeding residents. On 9/14/17, at 2:55 p.m. the director of nursing (DON) confirmed staff should staff while feeding residents "for dignity, respect." The DON indicated staff should trat the resident with	ESSENT	IA HEALTH GRACE H	OME				
childish tone of voice. LPN-A remained standing and continued attempting to give R7 bites of the hot cereal while talking in a childish tone of voice. At 8:58 a.m. R7 was done eating the hot cereal. LPN-A removed R7's clothing protector, took the juice. and wheeled R7 from the dining room to the adjacent sitting area. LPN-A continued to give R7 drinks of the juice while standing next to her. On 9/14/17, at 12:50 p.m. LPN-A verified she always stood while feeding R7, stating "I stand because her chair is so high." LPN-A indicated she could not reach or see R7 if she did not stand while feeding her. LPN-A indicated she could use a different chair but did not think the facility had a chair high enough. LPN-A stated "I have always done it this way and I like to see her face." LPN-A indicated she believed she fed R7 in a dignified manner. On 9/14/17, at 2:52 p.m. the dietary manager (DM) confirmed she has seen staff standing while feeding resident in the higher wheelchairs. The DM indicated staff should be seated at eye level while feeding residents further stating "we could try higher chairs for staff." The DM indicated staff should stower and the provided the provided staff should stir while feeding residents. On 9/14/17, at 2:56 p.m. the director of nursing (DON) confirmed staff should stir while feeding residents "for dignity, respect." The DON indicated staff should treat the resident with	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE COMPLETE	
Review of facility policy titled, Resident Rights reviewed on 1/17/17, indicated the resident has a right to a dignified existence, self- determination	21805	childish tone of voice and continued atter hot cereal while talk At 8:58 a.m. R7 wa LPN-A removed R7 juice. and wheeled adjacent sitting are drinks of the juice which is the could not reach while feeding her. La different chair but chair high enough. done it this way and indicated she believed manner. On 9/14/17, at 2:52 (DM) confirmed she feeding resident in DM indicated staff swhile feeding resident in DM indicated staff swhile feeding residents. On 9/14/17, at 2:56 (DON) confirmed staff should the staff should indicated on 1/17/11 reviewed on 1/17/11	ce. LPN-A remained standing inpting to give R7 bites of the king in a childish tone of voice. It is done eating the hot cereal. It is clothing protector, took the R7 from the dining room to the a. LPN-A continued to give R7 while standing next to her. O p.m. LPN-A verified she feeding R7, stating "I stand is so high." LPN-A indicated in or see R7 if she did not stand in think the facility had a LPN-A stated "I have always if I like to see her face." LPN-A wed she fed R7 in a dignified in the higher wheelchairs. The should be seated at eye level ents further stating "we could it staff." The DM indicated staff is should sit while feeding y, respect." The DON all treat the resident with gothern.	21805	monitored to assure no other residence affected. No other concerns been noted. Yearly staff education on residents with the Ombudsman is scheduled held on 11/9/17. Compliance Monitoring will be don at various meals X 1 week and the weekly X3 weeks. Results will be reviewed with the Quality Assuran	have s rights d to be ne daily en	

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
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21805	Continued From pa	ge 34	21805			
	The administrator of implement systems maintained. The fact these systems. Rare be done to ensure administrator or decresults to the quality and further recommends.	THOD OF CORRECTION: or designee could develop and a to ensure resident dignity is cility could educate all staff on adom audits for dignity could ongoing compliance. The signee could take that audit y assurance group for review nendations. R CORRECTION: Twenty-one				
21855	MN St. Statute 144 Residents of HC Fa	.651 Subd. 15 Patients & ac.Bill of Rights	21855			10/31/17
	residents shall have and privacy as it re- personal care progressions. exami- confidential and shall be residential, and other a	nent privacy. Patients and the the right to respectfulness lates to their medical and ram. Case discussion, ination, and treatment are all be conducted discreetly. Spected during toileting, activities of personal hygiene, or patient or resident safety or				
	by: Based on observati review the facility fa information was no of 1 residents (R1) Findings include:	ent is not met as evidenced on, interview and document ailed to ensure private care tracessible to the public for 1 reviewed for privacy.		Reviewed the Notice of Privacy Pr policy and is accurate and up to da 9/14/17 Poster that was posted in room with verbal consent was rem R1 individual care plan was review updated. Future type information documented on individual "All abo sheets and updated in the care pla	ate. R1 noved. ved and will be ut me"	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00762	B. WING		09/14/2017	
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ESSENT	IA HEALIH GRACE H	GRACEVII	LLE, MN 56	240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLI	ETE.
21855	Continued From pa		21855	This was assistant Os		
	bright, colored pink private care informadirectly next to the laposter included R1' black letters), staff jyour time with me wR1 shared a room was facility. The poster when R1's bathroor open. On 9/12/17, observed from the lapast R1's door. On again at 12:15 p.m. the hallway. R1's care plan date needed an EZ standwith staff assist relawith staff assist on the shift during reports assist of one staff at times would swing laterals would	nroom was observed to have a 8 1/2 x 11 inch poster with ation affixed to the wall, bathroom door jam. The s first name, and stated (in just a friendly reminder to take when using the lift, thank you. with another resident in the was visible from the hallway mand bedroom door were at 3:44 p.m., the poster was nallway, and visitors walked 9/13/17, at 7:53 a.m and the poster was visible from d 3/16/17, indicated R1 d (mechanical lift) for transfers ated to weakness. 9/14/17, at 9:52 a.m. nursing nfirmed R1 received visitors, with another resident. NA-A member was made aware of eds by the resident care ans, and identified staff afformation at the beginning of cort. NA-A reported R1 required and the mechanical lift, and at the rarms out during the the sign was placed to remind lift slower during the transfer. Information on the poster of the hallway, and it contained mation that should be kept in a		This was reviewed at Resident Co 10/2/17. A facility walk thru to assess all are the building for any other private hinformation was posted in view of Staff will be re-educated on residerights and privacy in October by at one of the following; 1:1 meetings stand-ups, or scheduled meetings competency evaluations following education. Yearly staff education on residents with the Ombudsman is scheduled held on 11/9/17. DON or designee will complete Ramonthly facility audits X 3 months ensure compliance. Audit information will be presented Quality Assurance and Performant Improvement Committee.	eas of ealth others. nts least with rights I to be	
	nursing assistant (N	9/14/17, at 10:00 a.m. NA)-B confirmed the poster formation was affixed to R1's				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00762	B. WING		09/	14/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME	T SECOND S' ILLE, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21855	visible to visitors in were in the room. No placed on the wall the with R1's cares. During interview on registered nurse (Roon the poster regard in the hallway. During interview on director of nursing (placed on R1's wall R1 that staff had be explained after the collected, R1 denied clarified she felt stallift too fast when tradition to fast when using the menthe posted information and visitor's in R1's stated the information the resident cared. The facility's Notice 9/2013, indicated signifer mation means electronic or paper, by facility and is repayment for the prosumer suggestion.	B identified the sign was the hallway and those that IA-B stated the poster was o remind staff to slow down 9/14/17, at 10:36 a.m. N)-A identified the information ding R1 was visible to visitors 9/14/17, at 12:49 p.m. the DON) stated the sign was following an allegation from the pen rough with her. The DON initial information was diabuse or mistreatment, and and the stated the poster was then or remind staff to slow down chanical lift. The DON stated ion was direct care able to people in the hallway room. The DON further on should have been placed as sheet or care plan. of Privacy Practices dated the staff would protect resident any information, whether oral, which is created or received lated to health care or ovision of medical services. THOD OF CORRECTION: The	21855			
	and/or revise policie	signee could develop, review, es and procedures to ensure rivacy are maintained. The				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(3) DATE SURVEY COMPLETED	
		00762	B. WING	B. WING		4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME	SECOND S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21855	administrator or des on thesesystems. T could develop moni ongoing compliance reviewed with the q review and further r	signee could educate all staff the administrator or designee toring systems to ensure a. The audit results could be uality assurance group for	21855			
21995	Subd. 4a. Interna (a) Each facility sha ongoing written pro applicable licensing of suspected maltre facility has an interr mandated reporter requirements of this internally. However responsible for com reporting requirement This MN Requirement by: Based on record re failed to immediated (SA), and thoroughly physical abuse for elopement for 1 of resident to resident residents (R48, R20 failed to report to an	reporting of maltreatment. all establish and enforce an ocedure in compliance with rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting section by reporting the facility remains applying with the immediate ents of this section. The facility remains applying with the immediate ents of this section. The facility remains applying with the immediate ents of this section. The facility remains applying with the immediate ents of the section. The facility is reported to the state agency y investigate observed and interview, the facility y report to the state agency y investigate observed all of 1 resident (R24), and a latercation involving 2 of 2 of 2 of 1 and addition, the facility is allegation of physical abuse of manner for 1 of 1 residents	21995	SA was notified of all omitted even allegations of abuse and elopemer R48, R24, R20 and thoroughly investigated in accordance with sta Reviewed and revised the VA polic Staff will be educated on reporting requirements for alleged violations involving abuse, neglect, or mistre Licensed staff will be educated reg the requirement to initiate an even when an incident of potential abuse/mistreatment occurs and to	nt for ate laws. by. atment. garding t report	10/31/17

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00762	B. WING		09/14/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME 116 WEST	SECOND S	STREET		
LOOLIVI	GRACE\			3240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
21995	Continued From pa	ge 38	21995			
21995	R24's admission M 7/24/17, indicated F assistance with act and identified mode no behaviors. The M depression, anxiety tendon. R24's care plan data a self-care deficit reachilles tendon, and of one staff for ADL the potential for phyothers and infliction adults. R24's care pinterventions includ such behavior at timprogress note dated father. R24's progress note 7/23/17, at 3:48 p.m was tearful after a treported to the nursabusive" to her. R2	inimum Data Set (MDS) dated R24 required limited ivities of daily living (ADL's), erately impaired cognition and MDS included diagnoses of and strain of left Achilles red 8/4/17, indicated R24 had elated to surgery on the left d required limited assistance red is. R24's care plan indicated visical and verbal abuse by of abuse on other vulnerable	21995	alleged violations of abuse/mistrer immediately to the Administrator. Licensed staff will also be re-educinitiate an OHFC report immediate notification of a potential abuse/neglect/mistreatment report investigate any allegations, and retresults of the investigation and conactions taken to the appropriate of accordance with state law. Staff education/training will be by one of the following; 1:1, standups scheduled meetings held in Octob 2017. All new hires will be educated on a during orientation and through SA-facility electronic education and athere after and PRN. Reviewed at resident council mee 10/2/17 VA policy, if any residents unsafe at anytime to report to staff Ombudsmen is scheduled to hold education for staff, residents and in November, 2017. All residents have the potential to affected if alleged violations are not reported immediately and thorough	ated to ely upon t, port rective ficials in at least s or er, /A policy BA nnually ting on feel f. The families be of	
		ommunicated to staff. R24 was		investigated in accordance with st		
	directed to put her	call light on if her dad came to		through established procedures.		
		uld could remove her or her the plan. The purse informed		IDP team will review daily events f	or	
	dad. R24 agreed to the plan. The nurse informed R24 she would speak with the social service			appropriate reporting and on-call I	RN will	
	designee (SSD) on			review on weekends. Reconciliation 2017 events to VA log was complete.	on of all	
	7/24/17, at 4:29 p.m.: The SSD and director of nursing (DON) visited with R24 at her request. R24 stated she didn't want her dad to visit anymore. R24 stated "he talked mean" to her and told her to "shut up". R24 denied being fearful for			omissions have since been submithe SA. Social Service or designee will conweekly audit X3 weeks and monthresults to be reviewed with QAPI	nplete	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00762	B. WING		09/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME	SECOND S LLE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21995	Continued From pa	ge 39	21995			
	visitors and R24 wa	staff was to observe for as to use call light if she due to an unwanted visitor.		committee.		
	that her dad was pu wheelchair. When s her, he hit her on to was not hurt. The n	n.: R24 reported to the nurse ushing her outside in the she asked him to stop pushing up of the head. R24 stated she note identified "nurse will or her dad, at this time her dad				
	room waiting for dir approached her. R the incident on 8/12 medication cart. Whithe medication cart want him to come a stated he didn't car dad was observed arm and then on he	m.: R24 was in the dining oner when her father 124 was uncomfortable from 12/17. R24 agreed to sit by the hen her father came over to R24 told her dad she didn't around so much. R24's father e, he was still her father. Her to swat R24 on the side of the 12/14 to swat R24 on the side of the 13/14/17.				
	facility staff on 8/12 submitted to the SA 1:35 p.m An inves	nysical abuse reported to 1/17, at 3:35 p.m. was by the facility on 8/13/17, at 1/1/13/17 tigative report was completed e SA on 8/17/17, at 2:27 p.m.				
	on 8/13/17, at 11:40 father was not repo	ation observed by facility staff 0 a.m. between R24 and her orted to the SA. Additionally, noroughly investigate the				
	designee (SSD) ve	p.m. the social service rified she was in charge of the rogram in the facility. The SSD				

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Millinesc	nta Department of He	aim				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00762	B. WING		09/1	4/2017
		00.02			03/1	4/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FSSENT	IA HEALTH GRACE H	OME	SECOND S			
LOOLIVI	IA HEAEIH GHAOE H	GRACEVI	LLE, MN 56	240		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	THAIL	DAIL
				· · · · · · · · · · · · · · · · · · ·		
21995	Continued From pa	ge 40	21995			
	stated all allegation	s of abuse are expected to be				
		within two hours, and				
		ported allegation on 8/12/17				
		e SA late. The SSD indicated				
		in off again relationship with				
		ated whether or not she				
	wanted him to visit	her throughout her stay. The				
		was alert and oriented, a				
	reliable historian, ar	nd capable of making her				
	needs and desires	known. The SSD stated she				
	was not aware of th	e incident from 8/13/17, at				
	11:40 a.m. until she	got to work on 8/14/17. The				
	SSD verified the inc	cident on 8/13/17, at 11:40				
		ed to the SA or investigated.				
		was a delay in reporting the				
		the facility needed to revisit				
	the vulnerable adult					
		p.m. the director of nursing				
		lleged abuse incidents should				
		SA within two hours. The DON				
		ubmitted to the SA on 8/13/17				
		ne DON stated there should				
		t report completed which				
		ed what time the DON,				
		nedical doctor were notified of it. The DON stated she was				
		ysical altercation between R24				
		essed by facility staff on				
		by the surveyor on 9/14/17,				
		ON then reviewed progress				
		d not see much follow up of				
		it. The DON reported staff				
		and directed R24's dad not				
		rerified the facility did not				
		m 8/13/17, to the SA or				
		h investigation. The DON				
		mber should have followed the				
	vulnerable adult po					
		m. the administrator stated				
		th of R24's incidents, on				

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00762	B. WING		09/1	4/2017
NAME OF F	PROVIDER OR SUPPLIER		<u>.</u>	STATE, ZIP CODE	1 00/1	.,
FSSENT	IA HEALTH GRACE H	OME	SECOND S			
		GRACEVI	LLE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
21995	Continued From pa	ge 41	21995			
	confirmed staff upd soon as they were a The administrator we report observed and hours to the SA, aft administrator identia a thorough investig vulnerable adult po The facility's Vulner 1/19/17, indicated to resident safety by a respond and report adults, and to estable responsibilities for providing the porting/Investigation suspected abuse/not. Any employee we maltreatment or is in a facility employee to the administrator 2. The administrator facility Incident/Evereportable.	rable Adult Policy dated the facility would assure assisting staff to recognize, maltreatment of vulnerable blish procedures and protecting all residents the facility for their health care and them a safe environment. Ation Procedures for actual or the eglect: The witnesses, suspects informed of an event involving immediately reports the event				
		nediately report to the SA and				
	through 8/30/17, re 7/24/17, describing elopement by R48. information related notification. Addition	ogress notes from 7/1/17, vealed a progress note dated an unwitnessed, off property The progress note lacked to the adminstrator or SA nally, the progress notes failed on of a thorough investigation.				

R48's significant change MDS dated 6/22/17,
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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00762	B. WING		09/1	4/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/1	.,
		116 WEST	SECOND S	· · · · · · · · · · · · · · · · · · ·		
ESSENTIA HEALTH GRACE HOME			LLE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21995	Continued From pa	ge 42	21995			
	Alzheimer's disease depression. R48's I severely cognitively without a device wit also indicated R48 at significant risk of	diagnoses which included e, dementia, anxiety and MDS identified R48 was impaired and ambulated th supervision. R48's MDS wandered daily, placing R48 getting to a potentially and intruding on the privacy or				
	Assessment (CAA) wandered through to exit the facility. T	rmptoms Care Area dated 6/27/17, indicated R48 but the facility and attempted he CAA also indicated R48 her ankle to alert staff when building.				
	registered nurse (R the north door alarr nursing assistant (N not seen, but noted immediately north of	ress note created by N)-A dated 7/24/17, indicated in sounded and when a NA)-F walked outside R48 was the back door to the house of the facility was closing. R48 the house and was reluctant to ack to the facility.				
	dated 7/24/17, indice through the north do lot and entered the house. Staff went of to see her right away to the house immediate to the house immediate to the house immediate and the house immediately. The report is about "getting out of attempted to go out outside. A wanderg	entia Elopement (11/2010), cated R48 exited the facility oor, walked across a parking back door of a neighboring ut to get R48 but was unable ay. Staff noted the back door diately north of the facility was side the house and panied staff back to the ndicated R48 often talked of here" and going home. R48 to doors and sometimes made it uard was in place and worked very difficult to redirect related				

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Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00762	B. WING		09/1	4/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ESSENT	IA HEALTH GRACE H	OME	SECOND S			
(V4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	LLE, MN 56	PROVIDER'S PLAN OF CORRECTION)NI	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21995	Continued From pa	ge 43	21995			
	The report did not in of the vulnerable ac	erm memory and inattention. ndicate if the SA was notified dult incident. 9/14/17, at 1:19 p.m. RN-A				
	stated she was wor was the charge nur recalled the elopem active that day and R48 walked out the and a nursing assis neighboring house went to the house a could not recall if sh anyone. RN-A confi	cking the day of 7/23/17, and se for the facility. RN-A nent and stated R48 was really she just couldn't settle down. north door, the alarm went off stant saw the back door of the closing. The nursing assistant and returned with R48. RN-A ne reported the elopement to irmed she did not make a port with the SA regarding this				
	DON confirmed that on 7/23/17, and was house. The DON steelopement and dep safety, because R4 The DON confirmed was completed on a wanderguard was a was made aware or interdisciplinary me 7/25/17. The DON report was not com DON indicated she report an elopement two hours of the eloidentify if the admin elopement.	on 9/14/17, at 2:33 p.m. the at R48 eloped from the building liked into the neighboring rated R48 was at risk for rended on facility staff for 8 lacked safety awareness. It is a lacked safety awaren				
		n altercation which was not ed to the SA or thoroughly				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00762	B. WING	·····	09/1	4/2017
	PROVIDER OR SUPPLIER	116 WFST	DRESS, CITY, S	TREET		
ESSENT	IA HEALTH GRACE H	OME	LLE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21995	Continued From pa	ge 44	21995			
	was hit in the back	e dated 8/19/17, indicated R20 by another resident (R48) that incident report for further				
	R20 had diagnoses non-displaced fract the right foot, type I diabetic polyneurop nerves that causes burning pain), and cindicated R20 was identified she had continued in the control of t	ure of the fifth metatarsal of I Diabetes Mellitus with bathy (damage to peripheral weakness, numbness and depression. R20's MDS cognitively intact. R20's MDS laily verbal behaviors that put cal injury and significantly				
	8/19/17, indicated Farea. Prior to R48's behavior R48 was a Day Room. Event refunction varied over usually on the mover restlessness, and but The report also individed with other residents. The event report in behavior symptoms four to six days a wand other behavior towards others like put others at signification The report stated R48 hit her. Progret the interdisciplinary behavior of R48. The	I Events Essentia tive Behavior (11/2010) dated R48 hit R20 on the mid-back aggressive/combative wandering around in the North eport indicated R48's mental r the course of the day, was e physically, had anxiety, behaviors throughout each day. I cated R48 was easily annoyed and very difficult to redirect. I dicated R48 had physical I directed toward others on eek, verbal behaviors daily, al symptoms not directed pacing/rummaging daily that cant risk for physical injury. I 20 was "angry" and upset that ss notes indicated on 8/21/17, I team (IDT) reviewed the ne IDT's indicated they would age rummaging and activities				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00762	B. WING		09/1	4/2017
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENT	IA HEALTH GRACE H	OME	SECOND S LLE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21995	in safe areas to atte attention. It also inc R48's physician abordacement in behaving medication manage for R20 dated 8/29/discussed the even to the kitchen to thr When I stood up shbackside. It didn't h [R48] was still by the moves fast." On 9/14/17, at 2:45 event of aggressive 8/19/17, appeared fresident (R20) on the by the facility to a rewould be to immedie each resident was so (VA) report. The DO not filed for this resupdated. The DON resident to resident the administrator are stated R48 was at rabuse from others of the facility's Combadult Abuse Prever Procedures Policy of abuse, neglect and	empt to occupy R48's time and licated that a discussion with out medications and possible vioral health facility for ement. Another progress note 17, indicated that SSD-A t with R20. R20 stated "I went ow away my ice cream cup. he was behind me and hit my urt it just startled me. I thought e other doors, she sure p.m., the DON stated the electrombative behavior on to be R48 hitting another he back. The normal response esident to resident altercation liately intervene to make sure safe and file a vulnerable adult DN confirmed a VA report was ident to resident altercation. In the administrator was not identified she would expect a latercation to be reported to a latercation of later later would expect to be laterator later	21995			

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STATEMENT OF DEFICIENCIES (X1)

			(X3) DATE			
AND PLAN OF C	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		LETED	
		00762	B. WING		09/1	4/2017
NAME OF PROV	VIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EQCENTIA L	IEALTH GRACE H	116 WEST	SECOND S			
ESSENTIATI	IEALIH GRACE H	GRACEVI	LLE, MN 56	240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21995 Co	ontinued From pag	ge 46	21995			
SL Th rev or on ad sys pro ad res im fur	JGGESTED MET ne administrator of vise abuse/negled designee could enthe system for All ministrator or desistem to audit to experly reported ar liministrator or designation of the could be sults to the quality provement (QAP) of their recommendation of the system of th	HOD OF CORRECTION: r designee could review and et systems. The administrator ensure all staff are educated buse/Neglect reporting. The signee could establish a nsure all allegations are nd investigated. The signee could report audit r assurance performance l) committee for review and	21995			

Minnesota Department of Health

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

PRINTED: 10/17/2017 **FORM APPROVED** OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	NG 01 - Main Building 01		MPLETED
		245579	B. WING		09/	/12/2017
	PROVIDER OR SUPPLIER	OME		STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION OF THE APPROVINCE AC	ULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	-S	K 00	00		
	ALLEGATION OF ODEPARTMENT'S A SIGNATURE AT THE CMS-2567 FORM NOT VERIFICATION OF UPON RECEIPT OF ON-SITE REVISITY VALIDATE THAT SIGNITH THE REGUL ATTAINED IN ACCOVERIFICATION. A Life Safety Code Minnesota Department of Marshal Division Essentia Health - Grompliance with the in Medicare/Medica 483.70(a), Life Safe edition of National For (NFPA) Standard 10 Chapter 19 Existing PLEASE RETURN	F AN ACCEPTABLE POC, AN MAY BE CONDUCTED TO UBSTANTIAL COMPLIANCE ATIONS HAS BEEN ORDANCE WITH YOUR Survey was conducted by the sent of Public Safety, State on. At the time of this survey, race Home was found not in requirements for participation id at 42 CFR, Subpart sty from Fire, and the 2012 Fire Protection Association D1, Life Safety Code (LSC), Health Care. THE PLAN OF R THE FIRE SAFETY				

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

(X6) DATE

TITLE

Electronically Signed

10/09/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 00762

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

PRINTED: 10/17/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		MPLETED
		245579	B. WING		09	/12/2017
	PROVIDER OR SUPPLIER	OME	•	STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET GRACEVILLE, MN 56240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of volto correct the deficition. 2. The actual, or proposed in the proposed in the correct the deficition. 3. The name and/or responsible for correct a reoccurred in the correct and reoccurred in the proposed in the prop	tate.mn.us and n@state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date.	KO	00		
	notification. The fac	cility has a licensed capacity of census of 35 at the time of the				

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

PRINTED: 10/17/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	LE CONSTRUCTION		SURVEY PLETED
		245579	B. WING		09/1	12/2017
	E OF PROVIDER OR SUPPLIER SENTIA HEALTH GRACE HOME		STREET ADDRESS, CITY, STATE, ZIP COD 116 WEST SECOND STREET GRACEVILLE, MN 56240			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 2	K 000			
K 920 SS=C	NOT MET as evide	t 42 CFR Subpart 483.70(a) is enced by: al Equipment - Power Cords	K 920			10/31/17
	Extension Cords Power strips in a paragraph of the patient-care-related (PCREE) assemble by qualified person 10.2.3.6. Power strong not be used for electronics), exceptrooms that do not up CREE meet UL 1 strips for non-PCR (outside of vicinity) care rooms, power standards. All powers processed powers and powers and ards. All powers processed powers with the powers of the powers	atient care vicinity are only nots of movable delectrical equipment es that have been assembled nel and meet the conditions of rips in the patient care vicinity or non-PCREE (e.g., personal tin long-term care resident use PCREE. Power strips for 363A or UL 60601-1. Power EE in the patient care rooms meet UL 1363. In non-patient strips meet other UL fer strips are used with general asion cords are not used as a wiring of a structure. Seed temporarily are removed completion of the purpose for ed and meets the conditions of (1, 10.2.4 (NFPA 99), 400-8 (NFPA 70), TIA 12-5 (See not met as evidenced by: strips are used with the 2012 (Section 10.2.3.6 item 2 for sed deficient practice could cause as excessary equipment or cause as excessary exce		Medical equipment in room 37 ha removed from power strip and pludirectly into a wall outlet. Complet 9/15/17 Refrigerator in room 13 has been removed from power strip and pluding the strip and plud	gged ed	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245579	B. WING			09/1	12/2017
	PROVIDER OR SUPPLIER	OME		11	TREET ADDRESS, CITY, STATE, ZIP CODE 16 WEST SECOND STREET RACEVILLE, MN 56240		
(X4) ID PREFIX T A G	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 920	an undetermined at Findings include: On the facility tour I on 09/12/2017 observealed: 1) Resident room 1 power strip. 2)Resident room 37 plugged into a power	ct 15 of the 35 residents and mount of staff and visitors. Detween 8:00 am to 12:00 pm ervations and staff interview 3 a refrigerator plugged into a redical equipment was er strip.	KS	920	directly into a wall outlet. completed 10/4/17 All resident rooms have been insperso that there are no problems with and power strips. completed 9/19/17 Flyers were distributed to highlight importance of electrical safety, use power strips and emergency outlet completed 10/3/17 Resident rooms will be put on a movement of the information will be recorded a log. Tom Montonye, maintenance superor designee will be responsible to sthe work is completed. The repair information will be submittee safety committee and Quality Assurance Performance Improvem committee for review.	ected outlets 17 the of s. onthly power orded in rvisor see that	