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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZWHB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00762

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

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

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

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/07/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 11/17/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 12/01/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/08/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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

DEPARTMENT OF HEALTH

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: ZWHB

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

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(L4) **116 WEST SECOND STREET**
(L5) **GRACEVILLE, MN** (L6) **56240**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/14/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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A. In Compliance With Program Requirements Compliance Based On:
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE-NE II 10/20/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certificatin Specialist 11/08/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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07/08/1991
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(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
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00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

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;

- 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245579	A. BUILDING _____ B. WING _____	09/14/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records,	F 164		10/24/17

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

Electronically Signed | 10/08/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245579	A. BUILDING _____ B. WING _____	09/14/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 1 regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure private care information was not accessible to the public for 1 of 1 residents (R1) reviewed for privacy. Findings include: During afternoon care observations on 9/11/17, at 4:03 p.m., R1's bathroom was observed to have a bright, colored pink 8 1/2 x 11 inch poster with private care information affixed to the wall, directly next to the bathroom door jam. The poster included R1's first name, and stated (in black letters), staff just a friendly reminder to take your time with me when using the lift, thank you. R1 shared a room with another resident in the facility. The poster was visible from the hallway	F 164	Reviewed the Notice of Privacy Practices policy and is accurate and up to date. 9/14/17 Poster that was posted in R1 room with verbal consent was removed. R1 individual care plan was reviewed and updated. Future type information will be documented on individual "All about me" sheets and updated in the care plan. This was reviewed at Resident Council on 10/2/17. A facility walk thru to assess all areas of the building for any other private health information was posted in view of others. Staff will be re-educated on residents rights and privacy in October by at least one of the following; 1:1 meetings,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245579	A. BUILDING _____ B. WING _____	09/14/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 2 when R1's bathroom and bedroom door were open. On 9/12/17, at 3:44 p.m., the poster was observed from the hallway, and visitors walked past R1's door. On 9/13/17, at 7:53 a.m and again at 12:15 p.m. the poster was visible from the hallway. R1's care plan dated 3/16/17, indicated R1 needed an EZ stand (mechanical lift) for transfers with staff assist related to weakness. During interview on 9/14/17, at 9:52 a.m. nursing assistant (NA)-A confirmed R1 received visitors, and shared a room with another resident. NA-A indicated each staff member was made aware of each resident's needs by the resident care sheets, the care plans, and identified staff received updated information at the beginning of the shift during report. NA-A reported R1 required assist of one staff and the mechanical lift, and at times would swing her arms out during the transfers. NA-A felt the sign was placed to remind staff to operate the lift slower during the transfer. NA-A confirmed the information on the poster was easily visible to the hallway, and it contained personal care information that should be kept in a private place. During interview on 9/14/17, at 10:00 a.m. nursing assistant (NA)-B confirmed the poster with private care information was affixed to R1's bathroom wall. NA-B identified the sign was visible to visitors in the hallway and those that were in the room. NA-B stated the poster was placed on the wall to remind staff to slow down with R1's cares. During interview on 9/14/17, at 10:36 a.m. registered nurse (RN)-A identified the information	F 164	stand-ups, or scheduled meetings with competency evaluations following education. Yearly staff education on residents rights with the Ombudsman is scheduled to be held on 11/9/17. DON or designee will complete Random monthly facility audits X 3 months to ensure compliance. Audit information will be presented to Quality Assurance and Performance Improvement Committee.	

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F 164	Continued From page 3 on the poster regarding R1 was visible to visitors in the hallway. During interview on 9/14/17, at 12:49 p.m. the director of nursing (DON) stated the sign was placed on R1's wall following an allegation from R1 that staff had been rough with her. The DON explained after the initial information was collected, R1 denied abuse or mistreatment, and clarified she felt staff had used the mechanical lift too fast when transferring her in and out of the bathroom. The DON stated the poster was then placed on the wall to remind staff to slow down when using the mechanical lift. The DON stated the posted information was direct care information and visible to people in the hallway and visitor's in R1's room. The DON further stated the information should have been placed on the resident care sheet or care plan. The facility's Notice of Privacy Practices dated 9/2013, indicated staff would protect resident privacy while handling health information. Health information means any information, whether oral, electronic or paper, which is created or received by facility and is related to health care or payment for the provision of medical services.	F 164		
F 225 SS=E	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;	F 225		10/24/17

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F 225	Continued From page 4 (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 225		

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F 225	Continued From page 5 (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to immediately report to the state agency (SA), and thoroughly investigate observed physical abuse for 1 of 1 resident (R24), an elopement for 1 of 1 resident (R48) and a resident to resident altercation involving 2 of 2 residents (R48, R20). In addition, the facility failed to report to an allegation of physical abuse to the SA in a timely manner for 1 of 1 residents (R24) reviewed for abuse prohibition. Findings include: R24's admission Minimum Data Set (MDS) dated 7/24/17, indicated R24 required limited assistance with activities of daily living (ADL's), and identified moderately impaired cognition and no behaviors. The MDS included diagnoses of depression, anxiety and strain of left Achilles tendon. R24's care plan dated 8/4/17, indicated R24 had a self-care deficit related to surgery on the left	F 225	SA was notified of all omitted events of allegations of abuse and elopement for R48, R24, R20 and thoroughly investigated in accordance with state laws. Reviewed and revised the VA policy. Staff will be educated on reporting requirements for alleged violations involving abuse, neglect, or mistreatment. Licensed staff will be educated regarding the requirement to initiate an event report when an incident of potential abuse/mistreatment occurs and to report alleged violations of abuse/mistreatment immediately to the Administrator. Licensed staff will also be re-educated to initiate an OHFC report immediately upon notification of a potential abuse/neglect/mistreatment report, investigate any allegations, and report results of the investigation and corrective actions taken to the appropriate officials in accordance with state law.	

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F 225	Continued From page 6 Achilles tendon, and required limited assistance of one staff for ADL's. R24's care plan indicated the potential for physical and verbal abuse by others and infliction of abuse on other vulnerable adults. R24's care plan listed various interventions including to encourage R24 to tell of such behavior at time of occurrence, refer to progress note dated 7/24/17 in regards to R24's father. R24's progress notes indicated the following: 7/23/17, at 3:48 p.m.: The note identified R24 was tearful after a telephone conversation and reported to the nurse that her dad was "verbally abusive" to her. R24 stated she did not want him visiting her at the facility. The nurse told R24 her wishes would be communicated to staff. R24 was directed to put her call light on if her dad came to the facility. Staff would could remove her or her dad. R24 agreed to the plan. The nurse informed R24 she would speak with the social service designee (SSD) on 7/24/17. 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 her safety. Nursing staff was to observe for visitors and R24 was to use call light if she needed assistance due to an unwanted visitor. 8/12/17, at 3:35 p.m.: R24 reported to the nurse that her dad was pushing her outside in the wheelchair. When she asked him to stop pushing her, he hit her on top of the head. R24 stated she was not hurt. The note identified "nurse will continue to watch for her dad, at this time her dad	F 225	Staff education/ training will be by at least one of the following; 1:1, standups or scheduled meetings held in October, 2017. All new hires will be educated on VA policy during orientation and through SABA -facility electronic education and annually there after and PRN. Reviewed at resident council meeting on 10/2/17 VA policy, if any residents feel unsafe at anytime to report to staff. All residents have the potential to be affected if alleged violations are not reported immediately and thoroughly investigated in accordance with state law, through established procedures. IDP team will review daily events for appropriate reporting and on-call RN will review on weekends. Reconciliation of all 2017 events to VA log was completed all omissions have since been submitted to the SA. Social Service or designee will complete weekly audit X3 weeks and monthly X 3 results to be reviewed with QAPI committee.	

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is not here."

8/13/17, at 11:40 a.m.: R24 was in the dining room waiting for dinner when her father approached her. R24 was uncomfortable from the incident on 8/12/17. R24 agreed to sit by the medication cart. When her father came over to the medication cart R24 told her dad she didn't want him to come around so much. R24's father stated he didn't care, he was still her father. Her dad was observed to swat R24 on the side of the arm and then on her thigh. Her dad then laughed and walked away. The nurse told R24 staff would talk to the SSD on 8/14/17.

The allegation of physical abuse reported to facility staff on 8/12/17, at 3:35 p.m. was submitted to the SA by the facility on 8/13/17, at 1:35 p.m.. An investigative report was completed and submitted to the SA on 8/17/17, at 2:27 p.m.

The physical altercation observed by facility staff on 8/13/17, at 11:40 a.m. between R24 and her father was not reported to the SA. Additionally, the facility did not thoroughly investigate the incident.

On 9/14/17, at 1:57 p.m. the social service designee (SSD) verified she was in charge of the abuse prohibition program in the facility. The SSD stated all allegations of abuse are expected to be reported to the SA within two hours, and confirmed R24's reported allegation on 8/12/17 was submitted to the SA late. The SSD indicated R24 had an on again off again relationship with her father. R24 dictated whether or not she wanted him to visit her throughout her stay. The SSD identified R24 was alert and oriented, a reliable historian, and capable of making her

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needs and desires known. The SSD stated she was not aware of the incident from 8/13/17, at 11:40 a.m. until she got to work on 8/14/17. The SSD verified the incident on 8/13/17, at 11:40 a.m. was not reported to the SA or investigated. The SSD said there was a delay in reporting the incident to her, and the facility needed to revisit the vulnerable adult guidelines.

On 9/14/17, at 2:21 p.m. the director of nursing (DON) verified all alleged abuse incidents should be reported to the SA within two hours. The DON verified the report submitted to the SA on 8/13/17 was late. Further, the DON stated there should have been an event report completed which would have confirmed what time the DON, administrator and medical doctor were notified of the 8/12/17, incident. The DON stated she was not aware of the physical altercation between R24 and her father witnessed by facility staff on 8/13/17, until asked by the surveyor on 9/14/17, at 2:30 p.m. The DON then reviewed progress notes stating she did not see much follow up of the 8/13/17, incident. The DON reported staff visited with the SSD and directed R24's dad not to visit. The DON verified the facility did not report the event from 8/13/17, to the SA or complete a thorough investigation. The DON stated the staff member should have followed the vulnerable adult policy.

On 9/14/17, 2:35 p.m. the administrator stated she heard about both of R24's incidents, on 8/12/17, and 8/13/17. The administrator confirmed staff updated her on the situation as soon as they were able and stated it was timely. The administrator verified she expected staff to report observed and alleged abuse within two hours to the SA, after protecting the resident. The administrator identified staff was then to complete a thorough investigation as outlined in the

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F 225	Continued From page 9 vulnerable adult policy. 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 adminstrator 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 without a device with supervision. R48's MDS also indicated R48 wandered daily, placing R48 at significant risk of getting to a potentially dangerous place and intruding on the privacy or	F 225		

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activities of others.

R48's behavioral symptoms Care Area Assessment (CAA) dated 6/27/17, indicated R48 wandered through out the facility and attempted to exit the facility. The CAA also indicated R48 wore a bracelet on her ankle to alert staff when she was leaving the building.

R48's nursing progress note created by registered nurse (RN)-A dated 7/24/17, indicated the north door alarm sounded and when a nursing assistant (NA)-F walked outside R48 was not seen, but noted the back door to the house immediately north of the facility was closing. R48 was located inside the house and was reluctant to accompany NA-F back to the facility.

Safety Events-Essentia Elopement (11/2010), dated 7/24/17, indicated R48 exited the facility through the north door, walked across a parking lot and entered the back door of a neighboring house. Staff went out to get R48 but was unable to see her right away. Staff noted the back door to the house immediately north of the facility was closing. R48 was inside the house and "reluctantly" accompanied staff back to the facility. The report indicated R48 often talked about "getting out of here" and going home. R48 attempted to go out doors and sometimes made it outside. A wanderguard was in place and worked properly. R48 was very difficult to redirect related to impaired short term memory and inattention. The report did not indicate if the SA was notified of the vulnerable adult incident.

During interview on 9/14/17, at 1:19 p.m. RN-A stated she was working the day of 7/23/17, and was the charge nurse for the facility. RN-A

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recalled the elopement and stated R48 was really active that day and she just couldn't settle down. R48 walked out the north door, the alarm went off and a nursing assistant saw the back door of the neighboring house closing. The nursing assistant went to the house and returned with R48. RN-A could not recall if she reported the elopement to anyone. RN-A confirmed she did not make a vulnerable adult report with the SA regarding this elopement.

During an interview on 9/14/17, at 2:33 p.m. the DON confirmed that R48 eloped from the building on 7/23/17, and walked into the neighboring house. The DON stated R48 was at risk for elopement and depended on facility staff for safety, because R48 lacked safety awareness. The DON confirmed an elopement assessment was completed on R48 upon admission and a wanderguard was applied. She confirmed she was made aware of the elopement on during an interdisciplinary meeting review of the event on 7/25/17. The DON stated a vulnerable adult report was not completed for this elopement. The DON indicated she would expect nursing staff to report an elopement off property to the SA within two hours of the elopement. The DON could not identify if the administrator was updated on this elopement.

R20 and R48 had an altercation which was not immediately reported to the SA or thoroughly investigated.

R20's progress note dated 8/19/17, indicated R20 was hit in the back by another resident (R48) that evening and to see incident report for further information.

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R20's admission MDS dated 7/3/17, indicated R20 had diagnoses which included a non-displaced fracture of the fifth metatarsal of the right foot, type II Diabetes Mellitus with diabetic polyneuropathy (damage to peripheral nerves that causes weakness, numbness and burning pain), and depression. R20's MDS indicated R20 was cognitively intact. R20's MDS identified she had daily verbal behaviors that put her at risk for physical injury and significantly interfered with her social interactions.

Behavior and Mood Events Essentia Aggressive/Combative Behavior (11/2010) dated 8/19/17, indicated R48 hit R20 on the mid-back area. Prior to R48's aggressive/combative behavior R48 was wandering around in the North Day Room. Event report indicated R48's mental function varied over the course of the day, was usually on the move physically, had anxiety, restlessness, and behaviors throughout each day. The report also indicated R48 was easily annoyed with other residents and very difficult to redirect. The event report indicated R48 had physical behavior symptoms directed toward others on four to six days a week, verbal behaviors daily, and other behavioral symptoms not directed towards others like pacing/rummaging daily that put others at significant risk for physical injury. The report stated R20 was "angry" and upset that R48 hit her. Progress notes indicated on 8/21/17, the interdisciplinary team (IDT) reviewed the behavior of R48. The IDT's indicated they would continue to encourage rummaging and activities in safe areas to attempt to occupy R48's time and attention. It also indicated that a discussion with R48's physician about medications and possible placement in behavioral health facility for medication management. Another progress note

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F 225	Continued From page 13 for R20 dated 8/29/17, indicated that SSD-A discussed the event with R20. R20 stated "I went to the kitchen to throw away my ice cream cup. When I stood up she was behind me and hit my backside. It didn't hurt it just startled me. I thought [R48] was still by the other doors, she sure moves fast." On 9/14/17, at 2:45 p.m., the DON stated the event of aggressive/combative behavior on 8/19/17, appeared to be R48 hitting another resident (R20) on the back. The normal response by the facility to a resident to resident altercation would be to immediately intervene to make sure each resident was safe and file a vulnerable adult (VA) report. The DON confirmed a VA report was not filed for this resident to resident altercation. The DON confirmed the adminstrator was not updated. The DON identified she would expect a resident to resident altercation to be reported to the administrator and SA immediately. The DON stated R48 was at risk for physical and verbal abuse from others due to her wandering. On 9/14/17, at 2:55 p.m., the administrator stated if an event occurred requiring a vulnerable adult report, the administrator would expect to be notified immediately. The facility's Combined Vulnerable Adult Policy Adult Abuse Prevention Plan Reporting Procedures Policy dated 1/19/17, indicated all abuse, neglect and misappropriation of resident property would be reported to the administrator and state agencies immediately.	F 225		
F 226 SS=E	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		10/24/17

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F 226	Continued From page 14 483.12 (b) The facility must develop and implement written policies and 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, 483.95 (c) 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- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their abuse prevention policy for 3 of 3 residents (R20,R24,R48) reviewed for abuse prohibition. Findings include:	F 226	SA was notified of all omitted events of allegations of abuse and elopement for R48, R24, R20 and thoroughly investigated in accordance with state laws.	

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F 226	Continued From page 15 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. R24's admission Minimum Data Set (MDS) dated 7/24/17, indicated R24 required limited assistance with activities of daily living (ADL's), and identified moderately impaired cognition and no behaviors. The MDS included diagnoses of depression, anxiety and strain of left Achilles tendon. R24's care plan dated 8/4/17, indicated R24 had a self-care deficit related to surgery on the left Achilles tendon, and required limited assistance of one staff for ADL's. R24's care plan indicated the potential for physical and verbal abuse by others and infliction of abuse on other vulnerable adults. R24's care plan listed various interventions including to encourage R24 to tell of such behavior at time of occurrence, refer to progress note dated 7/24/17 in regards to R24's father. R24's progress notes indicated the following: 7/23/17, at 3:48 p.m.: The note identified R24 was tearful after a telephone conversation and reported to the nurse that her dad was "verbally	F 226	Reviewed and revised the VA policy. Staff will be educated on reporting requirements for alleged violations involving abuse, neglect, or mistreatment. Licensed staff will be educated regarding the requirement to initiate an event report when an incident of potential abuse/mistreatment occurs and to report alleged violations of abuse/mistreatment immediately to the Administrator. Licensed staff will also be re-educated to initiate an OHFC report immediately upon notification of a potential abuse/neglect/mistreatment report, investigate any allegations, and report results of the investigation and corrective actions taken to the appropriate officials in accordance with state law. Staff education/ training will be by at least one of the following; 1:1, standups or scheduled meetings held in October, 2017. All new hires will be educated on VA policy during orientation and through SABA -facility electronic education and annually there after and PRN. Reviewed at resident council meeting on 10/2/17 VA policy, if any residents feel unsafe at anytime to report to staff. The Ombudsmen is scheduled to hold education for staff, residents and families in November, 2017. All residents have the potential to be affected if alleged violations are not reported immediately and thoroughly investigated in accordance with state law, through established procedures.	

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F 226	Continued From page 16 abusive" to her. R24 stated she did not want him visiting her at the facility. The nurse told R24 her wishes would be communicated to staff. R24 was directed to put her call light on if her dad came to the facility. Staff would could remove her or her dad. R24 agreed to the plan. The nurse informed R24 she would speak with the social service designee (SSD) on 7/24/17. 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 her safety. Nursing staff was to observe for visitors and R24 was to use call light if she needed assistance due to an unwanted visitor. 8/12/17, at 3:35 p.m.: R24 reported to the nurse that her dad was pushing her outside in the wheelchair. When she asked him to stop pushing her, he hit her on top of the head. R24 stated she was not hurt. The note identified "nurse will continue to watch for her dad, at this time her dad is not here." 8/13/17, at 11:40 a.m.: R24 was in the dining room waiting for dinner when her father approached her. R24 was uncomfortable from the incident on 8/12/17. R24 agreed to sit by the medication cart. When her father came over to the medication cart R24 told her dad she didn't want him to come around so much. R24's father stated he didn't care, he was still her father. Her dad was observed to swat R24 on the side of the arm and then on her thigh. Her dad then laughed and walked away. The nurse told R24 staff would talk to the SSD on 8/14/17. The allegation of physical abuse reported to facility staff on 8/12/17, at 3:35 p.m. was submitted to the SA by the facility on 8/13/17, at 1:35 p.m.. An investigative report was completed	F 226	IDP team will review daily events for appropriate reporting and on-call RN will review on weekends. Reconciliation of all 2017 events to VA log was completed all omissions have since been submitted to the SA. Social Service or designee will complete weekly audit X3 weeks and monthly X 3 results to be reviewed with QAPI committee.	

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and submitted to the SA on 8/17/17, at 2:27 p.m. The physical altercation observed by facility staff on 8/13/17, at 11:40 a.m. between R24 and her father was not reported to the SA. Additionally, the facility did not thoroughly investigate the incident.

On 9/14/17, at 1:57 p.m. the social service designee (SSD) verified she was in charge of the abuse prohibition program in the facility. The SSD stated all allegations of abuse are expected to be reported to the SA within two hours, and confirmed R24's reported allegation on 8/12/17 was submitted to the SA late. The SSD indicated R24 had an on again off again relationship with her father. R24 dictated whether or not she wanted him to visit her throughout her stay. The SSD identified R24 was alert and oriented, a reliable historian, and capable of making her needs and desires known. The SSD stated she was not aware of the incident from 8/13/17, at 11:40 a.m. until she got to work on 8/14/17. The SSD verified the incident on 8/13/17, at 11:40 a.m. was not reported to the SA or investigated. The SSD said there was a delay in reporting the incident to her, and the facility needed to revisit the vulnerable adult guidelines.

On 9/14/17, at 2:21 p.m. the director of nursing (DON) verified all alleged abuse incidents should be reported to the SA within two hours. The DON verified the report submitted to the SA on 8/13/17 was late. Further, the DON stated there should have been an event report completed which would have confirmed what time the DON, administrator and medical doctor were notified of the 8/12/17, incident. The DON stated she was not aware of the physical altercation between R24 and her father witnessed by facility staff on 8/13/17, until asked by the surveyor on 9/14/17, at 2:30 p.m. The DON then reviewed progress

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notes stating she did not see much follow up of the 8/13/17, incident. The DON reported staff visited with the SSD and directed R24's dad not to visit. The DON verified the facility did not report the event from 8/13/17, to the SA or complete a thorough investigation. The DON stated the staff member should have followed the vulnerable adult policy.
On 9/14/17, 2:35 p.m. the administrator stated she heard about both of R24's incidents, on 8/12/17, and 8/13/17. The administrator confirmed staff updated her on the situation as soon as they were able and stated it was timely. The administrator verified she expected staff to report observed and alleged abuse within two hours to the SA, after protecting the resident. The administrator identified staff was then to complete a thorough investigation as outlined in the vulnerable adult policy.

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 adminstrator 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 without a device with supervision. R48's MDS

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also indicated R48 wandered daily, placing R48 at significant risk of getting to a potentially dangerous place and intruding on the privacy or activities of others.

R48's behavioral symptoms Care Area Assessment (CAA) dated 6/27/17, indicated R48 wandered through out the facility and attempted to exit the facility. The CAA also indicated R48 wore a bracelet on her ankle to alert staff when she was leaving the building.

R48's nursing progress note created by registered nurse (RN)-A dated 7/24/17, indicated the north door alarm sounded and when a nursing assistant (NA)-F walked outside R48 was not seen, but noted the back door to the house immediately north of the facility was closing. R48 was located inside the house and was reluctant to accompany NA-F back to the facility.

Safety Events-Essentia Elopement (11/2010), dated 7/24/17, indicated R48 exited the facility through the north door, walked across a parking lot and entered the back door of a neighboring house. Staff went out to get R48 but was unable to see her right away. Staff noted the back door to the house immediately north of the facility was closing. R48 was inside the house and "reluctantly" accompanied staff back to the facility. The report indicated R48 often talked about "getting out of here" and going home. R48 attempted to go out doors and sometimes made it outside. A wanderguard was in place and worked properly. R48 was very difficult to redirect related to impaired short term memory and inattention. The report did not indicate if the SA was notified of the vulnerable adult incident.

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During interview on 9/14/17, at 1:19 p.m. RN-A stated she was working the day of 7/23/17, and was the charge nurse for the facility. RN-A recalled the elopement and stated R48 was really active that day and she just couldn't settle down. R48 walked out the north door, the alarm went off and a nursing assistant saw the back door of the neighboring house closing. The nursing assistant went to the house and returned with R48. RN-A could not recall if she reported the elopement to anyone. RN-A confirmed she did not make a vulnerable adult report with the SA regarding this elopement.

During an interview on 9/14/17, at 2:33 p.m. the DON confirmed that R48 eloped from the building on 7/23/17, and walked into the neighboring house. The DON stated R48 was at risk for elopement and depended on facility staff for safety, because R48 lacked safety awareness. The DON confirmed an elopement assessment was completed on R48 upon admission and a wanderguard was applied. She confirmed she was made aware of the elopement on during an interdisciplinary meeting review of the event on 7/25/17. The DON stated a vulnerable adult report was not completed for this elopement. The DON indicated she would expect nursing staff to report an elopement off property to the SA within two hours of the elopement. The DON could not identify if the administrator was updated on this elopement.

R20 and R48 had an altercation which was not immediately reported to the SA or thoroughly investigated.

R20's progress note dated 8/19/17, indicated R20 was hit in the back by another resident (R48) that

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evening and to see incident report for further information.

R20's admission MDS dated 7/3/17, indicated R20 had diagnoses which included a non-displaced fracture of the fifth metatarsal of the right foot, type II Diabetes Mellitus with diabetic polyneuropathy (damage to peripheral nerves that causes weakness, numbness and burning pain), and depression. R20's MDS indicated R20 was cognitively intact. R20's MDS identified she had daily verbal behaviors that put her at risk for physical injury and significantly interfered with her social interactions.

Behavior and Mood Events Essentia Aggressive/Combative Behavior (11/2010) dated 8/19/17, indicated R48 hit R20 on the mid-back area. Prior to R48's aggressive/combative behavior R48 was wandering around in the North Day Room. Event report indicated R48's mental function varied over the course of the day, was usually on the move physically, had anxiety, restlessness, and behaviors throughout each day. The report also indicated R48 was easily annoyed with other residents and very difficult to redirect. The event report indicated R48 had physical behavior symptoms directed toward others on four to six days a week, verbal behaviors daily, and other behavioral symptoms not directed towards others like pacing/rummaging daily that put others at significant risk for physical injury. The report stated R20 was "angry" and upset that R48 hit her. Progress notes indicated on 8/21/17, the interdisciplinary team (IDT) reviewed the behavior of R48. The IDT's indicated they would continue to encourage rummaging and activities in safe areas to attempt to occupy R48's time and attention. It also indicated that a discussion with

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R48's physician about medications and possible placement in behavioral health facility for medication management. Another progress note for R20 dated 8/29/17, indicated that SSD-A discussed the event with R20. R20 stated "I went to the kitchen to throw away my ice cream cup. When I stood up she was behind me and hit my backside. It didn't hurt it just startled me. I thought [R48] was still by the other doors, she sure moves fast."

On 9/14/17, at 2:45 p.m., the DON stated the event of aggressive/combative behavior on 8/19/17, appeared to be R48 hitting another resident (R20) on the back. The normal response by the facility to a resident to resident altercation would be to immediately intervene to make sure each resident was safe and file a vulnerable adult (VA) report. The DON confirmed a VA report was not filed for this resident to resident altercation. The DON confirmed the adminstrator was not updated. The DON identified she would expect a resident to resident altercation to be reported to the administrator and SA immediately. The DON stated R48 was at risk for physical and verbal abuse from others due to her wandering.

On 9/14/17, at 2:55 p.m., the administrator stated if an event occurred requiring a vulnerable adult report, the administrator would expect to be notified immediately.

The facility's Combined Vulnerable Adult Policy Adult Abuse Prevention Plan Reporting Procedures Policy dated 1/19/17, indicated all abuse, neglect and misappropriation of resident property would be reported to the administrator and state agencies immediately.

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F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: 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 food in front of her. Licensed practical nurse (LPN)-A was observed standing next to the bedside table with R7 on the left side. LPN-A had	F 241	Reviewed and revised Residents right policy. Taller chair was made available for staff to use to sit and assist during mealtimes if resident is in higher wheelchair. Staff will be educated by at least one of the following; 1:1 meetings, stand-ups, or scheduled meetings on F241 and interpretive guidelines with competency evaluations following education. (this is not al all-inclusive list): a) "Dignity" means that their interactions with residents, staff carries out activities that assist the resident to maintain and enhance his/her self-esteem and self-worth. Some examples include (but not limited to): - Grooming as the resident wishes to be groomed. - Promoting independence and dignity in dining experience such as to avoidance of: I. Day-to day use of plastic cutlery; II. Staff standing over residents while assisting them to eat; III. Staff interacting/ conversing only with each other rather that with residents while assisting residents;	10/24/17

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F 241	Continued From page 24 a white bowl in her left hand, a silver spoon in her right hand and was giving R7 bites of hot cereal. At 8:55 a.m. LPN-A took a white covered plastic 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 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 know they are supposed to be seated while	F 241	b) Respecting residents by speaking respectfully. addressing the resident with a name of their choice, etc. Training video on assisting resident to eat will be used to assist in educating staff along with competency evaluation following the training video. Training wil be completed by 10/20/17 All residents have the potential to be affected by the alleged deficient practice. The entire dinning service will be monitored to assure no other residents were affected. No other concerns have been noted. Yearly staff education on residents rights with the Ombudsman is scheduled to be held on 11/9/17. Compliance Monitoring will be done daily at various meals X 1 week and then weekly X3 weeks. Results will be reviewed with the Quality Assurance Performance Improvement committee.	

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F 241	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.	F 241		
F 282 SS=E	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: R11's care plan, revised on 9/12/17, identified	F 282	R41 care plan and meal tray card was reviewed for accuracy and communication book updated in the dietary department. Individual peanut butter packets also placed in the condiments container on R41 table. Reviewed and revised comprehensive care plan and oral hygiene policies. Also, reviewed nutritional care policy and it is appropriate and accurate. Identified all residents needing assist with	10/24/17

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

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F 282	Continued From page 26 R11 had potential for self care deficit related to hospice patient, weakness, decrease cognition, manifested by needing more assistance with personal hygiene. R11's care plan indicated R11 had his own teeth with cavities. The care plan directed staff to provide set up and supervision for oral care. On 9/13/17, from 8:19 a.m. to 8:46 a.m. R11 was observed to receive morning cares. R11 did not receive assistance with oral cares during this time. At 9:15 a.m. R11 indicated he wanted to lay down. NA-B assisted R11 with toileting services, washing his face, and lying down. NA-B left the room at 9:29 a.m. R11 was not offered or provided oral cares by NA-B during this time. On 9/13/17, at 12:13 p.m. NA-B confirmed R11 was currently a hospice patient and needed assistance with all of his ADL's including oral hygiene. NA-B indicated she had not offered or attempted oral cares with R11 recently because R11 got upset. NA-B further stated "he does not have good teeth." NA-B verified she did not offer oral cares to R11 further stating she "forgot to, but he gets mad at times, so I quite trying." On 9/14/17, at 3:09 p.m. R11 was noted to have no teeth on the top of his mouth and four teeth on the bottom, which were badly decayed and discolored black/gray/yellow in color. On 9/14/17, at 9:35 a.m. RN-A confirmed R11 was currently a hospice patient and needed assistance with all of his ADL's including oral hygiene. RN-A indicated staff should be following the care plan and stated staff "should be offering dental care even if he refuses it."	F 282	oral cares in the facility and all the identified residents care plans were reviewed for accuracy. Hartman publishing training video on providing oral cares will be used to assist with educating appropriate staff with competency evaluation following the training video. DON or designee will complete monitoring daily X 1 week of either am or hs shifts to see that appropriate oral hygiene is being provided as care planned to identified residents as well as others at risk for this alleged deficient practice and then weekly X3 weeks. Results will be reviewed with the Quality Assurance Performance Improvement committee. DON or designee will complete compliance monitoring daily X 1 week of various meal times to see that appropriate nutritional interventions are provided as care planned and then weekly X3 weeks. Results will be reviewed with the Quality Assurance Performance Improvement committee.	

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On 9/14/17, at 10:19 p.m. the director of nursing (DON) confirmed R11's care plan stating R11 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'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 identified staff to encourage and assist with oral cares at least two times a day, if she will allow.

On 9/13/17, from 7:45 a.m. to 8:10 a.m. R10 was observed to receive morning cares. Following morning cares, R10 was assisted to breakfast and at 9:36 was observed to wait for church service. At 10:21 a.m. R10 was in the activity room eating popcorn and drinking coffee independently. R10 was not offered or provided oral cares during this 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.

On 9/14/17, at 3:10 p.m. R10 was noted to have her own natural teeth on the top and bottom which had several fillings and some of her teeth were noted to be discolored yellow/gray.

On 9/14/17, at 9:43 a.m. RN-A confirmed R10

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needed assistance with all of her ADL's including oral hygiene. RN-A confirmed the care plan directions, and indicated staff should follow the care plan. RN-A stated "she [R10] does not know to ask."

On 9/14/17, at 10:27 a.m. the DON confirmed R10's care plan and verified R10 needed assistance with oral hygiene. The DON indicated staff should follow the care plan and stated "I would expect staff to assist her with oral cares and to offer it and to encourage her."

R47 was not provided oral care as directed by the care plan. R47's care plan, revised on 9/1/17, identified the dental care plan indicated there was a potential for oral problems due to R47 having her own teeth and upper partials. The care plan identified staff to provide assistance with oral cares daily.

During observation of morning cares on 9/13/17, from 9:12 a.m. to 9:44 a.m. nursing assistant (NA)-C assisted R47 was not assisted with nor offered the opportunity for completion of oral cares. R47's natural teeth were observed with areas of white matter build up between them and on her right, lower lip. Further, R47's upper partial was not in place prior to breakfast. At 9:53 a.m. R47 was observed eating a banana, scrambled egg and toast independently. R47 did not have her upper right partial in place during the breakfast meal.

On 9/13/17, at 9:44 a.m. NA-C verified she was finished with R47's morning cares. NA-C reported R47 required assist of one staff for all ADL's, including oral care. NA-C confirmed R47 had natural teeth and utilized an upper partial.

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NA-C verified she did not provide, nor offer oral cares or provide R47's partial prior to breakfast and should have done so.

09/13/17, at 10:36 a.m. registered nurse (RN)-B confirmed R47 should have been offered oral cares prior to breakfast, including the partial placed in R47's mouth.

09/14/17, at 11:26 a.m., registered nurse (RN)-A verified R47 should have been provided oral cares and given partial prior to breakfast, and confirmed R47 required staff assistance of one for oral cares.

09/14/17, at 12:42 p.m. the DON verified R47 required staff assistance of one for all ADL's. The DON confirmed staff are expected to ensure R47's partial was in place and provided oral cares prior to breakfast. The DON stated she expected all staff to follow R47's care plan.

The facility's Care Plans-Comprehensive policy dated 8/17, indicated an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident.

R41 was not provided calorie dense foods, which included peanut butter with meals. R41's care plan revised on 8/7/17, identified R41 was at risk for BMI continuing in underweight status due to history of weight loss and prior to admit under body weight. The care plan listed the intervention of offering peanut butter at meals for bread/toast.

During observations of breakfast on 9/13/17, from

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9:38 a.m. to 10:20 a.m. R41 was observed to eat her entire breakfast but had been provided no peanut butter for her toast.

On 9/13/17, from 11:53 a.m. to 12:27 p.m. R41 was observed to eat her dinner meal. Although R41 had bread and crackers at her meal, R41 was not offered or provided any peanut butter during her dinner meal.

On 9/13/17, at 8:55 a.m. dietary aid (DA)-A confirmed R41 current diet from her dietary card and indicated she was not aware R41 was supposed to receive peanut butter with her meals. DA-A indicated that R41 liked peanut butter and would occasionally ask for it.

On 9/13/17, at 9:41 a.m. dietary cook (DC)-A stated R41's current dietary card did not have two tablespoons of peanut butter with meals identified. DC-A stated "no I was not aware of this." DC-A indicated the dietary manager (DM) would right it in the communication book and list it on the dietary cards. "I might of missed this, not aware of this, I guess we are in the dark."

On 9/13/17 at 12:48 p.m. clinical dietary manager (DM) confirmed R41's current care plan and diet. The DM could not verify if R41 was receiving peanut butter with meals. The DM stated "I am thinking I did not carry through with the peanut butter." The DM confirmed R41's BMI was borderline under weight and indicated "the peanut butter got missed." The DM confirmed R41 had lost more weight, R41's current weight was 86 lbs, and indicated she should of followed through with the peanut butter. The DM confirmed staff was unaware of R41's peanut butter with meals and indicated it was human error.

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F 282	Continued From page 31 On 9/14/17 at 9:04 a.m. register dietician (RD) confirmed R41 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 received bread. The RD indicated staff should be following the care plan as directed and per recommendations. 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, Care Plan Use Of revised on 4/15, indicated the care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary care and services to maintain oral hygiene for 3 of 3 residents (R11, R10, R47), reviewed for activities of daily living (ADLs). Findings included	F 312	Reviewed and revised oral hygiene policy. Identified all residents needing assist with oral cares in the facility, all the identified residents care plans were reviewed for accuracy. Hartman publishing training video on providing oral cares will be used to assist	10/24/17

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F 312	Continued From page 32 R11's significant change in status Minimum Data Set (MDS) dated 8/29/17, identified diagnoses including anemia, heart failure, and renal insufficiency. The MDS identified R11 was on hospice care, had severe cognitive impairment and needed limited assistance of one staff to perform personal hygiene including oral hygiene. R11's care plan, revised on 9/12/17, identified R11 had potential for self care deficit related to hospice patient, weakness, decreased cognition, manifested by needing more assistance with personal hygiene. R11's care plan indicated R11 had his own teeth with cavities. On 9/13/17, at 8:19 a.m. R11 was observed lying in bed when nursing assistant (NA)-B entered the room to answer R11's call light. R11 indicated he needed to go to the bathroom. NA-B called for assistance and put R11's shoes on while waiting for help. R11 was wearing a long sleeve shirt and a white incontinent brief. At 8:23 a.m. NA-B again called for assistance on her walkie talkie again and placed the transfer belt around R11's waist. Registered nurse (RN)-A entered the room and assisted NA-B with transferring R11 to his wheelchair. NA-B placed the urinal while R11 voided. At 8:31 a.m. NA-C entered the room with standing mechanical lift and assisted NA-B with cleaning, emptying R11's colostomy bag. At 8:35 a.m. NA-C assisted R11 to wash and dry his face, placed a blanket on his lap and left at 8:39 a.m. NA-B moved R11 to the middle of the room so he could watch TV, placed the bedside table in front of him with the call light, combed R11's hair and left the room. At 8:42 a.m. NA-B returned with a breakfast tray, placed a clothing protector on R11's chest area, set him up to eat breakfast and	F 312	with educating appropriate staff with competency evaluation following the training video. DON or designee will complete monitoring daily X 1 week of either am or hs shifts to see that appropriate oral hygiene is being provided as care planned to identified residents as well as others at risk for this alleged deficient practice and then weekly X3 weeks. Results will be reviewed with the Quality Assurance Performance Improvement committee.	

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R11 began to eat independently. NA-B left the room at 8:46 a.m. During the observation of morning cares, R11 was not offered or provided oral cares from staff.

On 9/13/17, at 9:11 a.m. R11's call light was on, family was in visiting. At 9:15 a.m. NA-B entered the room, and R11 indicated he wanted to lay down. NA-B obtained the standing mechanical lift. NA-B hooked R11 to the standing mechanical lift and assisted R11 to clean his face. NA-B stood R11, provided peri cares and placed a clean incontinent brief. NA-B transferred R11 to his bed and assisted R11 to lay down in bed. At 9:29 a.m. NA-B left R11's room after collecting the dirty linen and garbage, and returned to remove the breakfast tray. During the observation R11 was not offered or provided oral cares by staff.

On 9/13/17, at 12:13 p.m. NA-B confirmed R11 was currently on hospice patient and needed assistance with all of his ADL's including oral hygiene. NA-B indicated she had not offered or attempted oral cares with R11 recently because R11 would get upset. NA-B further stated "he does not have good teeth." NA-B verified she did not offer oral cares to R11 and stated she "forgot to, but he gets mad at times, so I quite trying." NA-B indicated she would have to start trying to provide oral cares to R11.

On 9/14/17, at 3:09 p.m. R11 was noted to have no teeth on the top of his mouth and four teeth on the bottom, which were badly decayed and discolored black/gray/yellow in color.

On 9/14/17, at 9:35 a.m. RN-A identified R11 was currently on hospice and needed assistance with all ADL's including oral hygiene. RN-A stated staff

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should be following the care plan 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 asked R10 if she was ready to get up for breakfast, and R10 agreed. At 7:49 a.m. NA-B assisted R10 to sit up, stand, and walk to to the bathroom. At 7:53 a.m. NA-B toileted R10 and assisted her to get washed up and dressed for the day. At 8:05 a.m. NA-B assisted R10 to stand with a walker, provided peri cares, and pulled up R10's pants. At At 8:08 a.m. NA-B assisted R10 to walk to the dining room area for breakfast. At

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8:11 a.m. R10 sat down at the breakfast table, NA-B removed gait belt form her waist and placed a clothing protector on her chest area. At 8:52 a.m. R10 ate her breakfast independently. At 9:36 a.m. R10 was done with breakfast and sitting in the chapel area waiting for church to begin. At 10:21 a.m. R10 was in the activity room eating popcorn and drinking coffee independently. During the observation R10 was not offered or provided oral cares by staff.

On 9/13/17, at 8:13 a.m. NA-B confirmed R10 needed assistance with all of her ADL's including oral hygiene due to increased confusion and not following commands. NA-B indicated she forgot to do R10's oral cares and stated "I forgot about her mouth care this morning." NA-A indicated that R10 has an electric toothbrush and does need assistance to use it and stated "I forgot running behind."

On 9/14/17, at 3:10 p.m. R10 was noted to have her own natural teeth on the top and bottom which had several fillings and some of her teeth were noted to be discolored yellow/gray.

On 9/14/17, at 9:43 a.m. RN-A stated R10 needed assistance with all of her ADL's including oral hygiene. RN-A confirmed the current care plan, indicated staff should be following the care plan and further stated "she [R10] does not know to ask." RN-A indicated she would expect staff to offer dental care and stated "she [R10] would not do this on her own."

On 9/14/17, at 10:27 a.m. the DON confirmed 10's care plan, and verified she needed assistance with all of her ADL's including oral hygiene. The DON indicated R10's cognition has

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been getting worse and she does not follow commands. The DON indicated staff should be following the care plan and stated "I would expect staff to assist her with oral cares and to offer it and to encourage her."

Review of facility policy, Oral Hygiene reviewed in 10/07, indicated nursing staff will provide all residents with mouth care every morning, night and as needed. Mouth care would be given every two hours for those residents on NPO (nothing by mouth).
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.

R47's care plan, revised on 9/1/17, identified R47 had potential for increasing self care deficit related to Alzheimer's disease, dementia, COPD and weakness. R47's dental care plan indicated there was a potential for oral problems due to R47 having her own teeth and upper partials. The care plan listed various interventions including staff to provide assistance with oral cares daily.

On 9/13/17, from 9:12 a.m. to 9:44 a.m. nursing assistant (NA)-C assisted R47 with morning personal cares which included washing her face, perineal cares and dressing. During this observation, R47 was not assisted with nor offered the opportunity for completion of oral cares. R47's natural teeth were observed with

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 37 areas of white matter build up between them and on her right, lower lip. Further, R47's upper partial was not in place prior to breakfast. At 9:44 a.m. following the observation of morning cares, NA-C assisted R47 to the dining room table. NA-C stated she was finished with R47's morning cares. NA-C reported R47 required assist of one staff for all ADL's, including oral care. NA-C confirmed R47 had natural teeth and utilized an upper partial. NA-C verified she did not provide, nor offer oral cares or provide R47's partial prior to breakfast and should have done so. At 9:53 a.m. R47 was observed eating a banana, scrambled egg and toast independently. R47 did not have her upper right partial in place during the breakfast meal. On 9/13/17, at 10:36 a.m. registered nurse (RN)-B confirmed R47 should have been offered oral cares prior to breakfast, including the partial placed in R47's mouth. On 9/14/17, at 11:26 a.m., registered nurse (RN)-A verified R47 should have been provided oral cares and given partial prior to breakfast, and confirmed R47 required staff assistance of one for oral cares. On 9/14/17, at 12:42 p.m. the DON verified R47 required staff assistance of one for all ADL's. The DON confirmed staff was expected to ensure R47's partial was in place and provided oral cares prior to breakfast. The DON stated she expected all staff to follow R47's care plan.	F 312		
F 325	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS	F 325		10/24/17

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	245579	A. BUILDING _____ B. WING _____	09/14/2017

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F 325 SS=D	Continued From page 38 UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement nutritional interventions related to the provision of calorie dense foods which included peanut butter with meals in order to prevent further weight loss for 1 of 3 residents (R41) reviewed for nutrition. Findings include: R41's quarterly Minimum Data Set (MDS) dated 7/27/17, identified R41 had diagnosis which included dementia, depression and anxiety. The MDS identified R41 had severe cognitive impairment, needed limited assistance of one staff for activities of daily living (ADL's) and was independent with eating after set up help from staff. The MDS further indicated R41 was 58	F 325	R41care plan and meal tray card were reviewed for accuracy and communication book updated in the dietary department. Individual peanut butter packets also placed in the condiment container on R41 table. Reviewed nutritional care policy and it is appropriate and accurate. Identified all residents needing assist with oral cares in the facility and all the identified residents care plans were reviewed for accuracy. Following RD monthly visits any recommendations that may have been made will be documented on the dietician referral flow sheet, the CDM will make appropriate updates to tray cards, care	

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F 325	Continued From page 39 inches (in), weighed 88 pounds (lbs), had no weight loss, no eating problems and had a therapeutic diet. Review of R41's significant change Nutritional Screening and Assessment dated 5/2/17, indicated R41 was on a regular diet with nutritional interventions of super potatoes, super cereal and ate in the main dining room. R41's current height 58 in and weight 89.5 lbs. R41's body mass index (BMI) 18.7 low end of health status. Review of R41's quarterly Nutritional Screening and Assessment dated 7/27/17, indicated R41 was on a regular diet, small portions, with nutritional interventions of super potatoes, super cereal and ate in the main dining room. R41's current height 58 in and weight 87.5 lbs. R41's BMI 18.4 under weight status and continue with plan of care. Review of R41's Resident Progress Notes on 8/16/17 by the registered dietician (RD) revealed R41's current weight 86.5 lbs which is stable and current BMI 18.4 which is underweight. Family reports weight at home 85 lbs. Diet is regular with small portions, intake at breakfast 76-100 percent (%), 25 to 50% for lunch and dinner. R41 receives additional calories and protein through super cereal, super potatoes and two tablespoons of peanut butter at meals. R41's care plan revised on 8/7/17, identified R41 was at risk for BMI continuing in underweight status due to history of weight loss and prior to admit under body weight. The care plan identified R41 was independent with eating and needed set up help from staff at times. The care plan listed	F 325	plans, etc. The cook will also initial to acknowledge that the recommendations have been completed by CDM. Staff will be educated on the updated policies and procedures by at least on of the following 1:1 meetings, standups, or scheduled meetings with competency evaluations following education. DON or designee will complete compliance monitoring daily X 1 week of various meal times to see that appropriate nutritional interventions are provided as care planned and then weekly X3 weeks. Results will be reviewed with the Quality Assurance Performance Improvement committee.	

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F 325	Continued From page 40	F 325		

several intervention such as: provide regular, small portion diet as ordered per medical doctor, provide super cereal at breakfast and super potatoes at dinner to aid with weight maintenance and record and monitor intake. When revised on 8/7/17, offering peanut butter at meals for bread/toast was added to the plan of care.

Review of R41's dietary cards revealed she was receiving a regular diet with small portions, super cereal for breakfast and super potatoes for lunch. R41's dietary card did not identify the need for two tablespoons of peanut butter with meals.

On 9/13/17, at 9:38 a.m. R41 was seated at the dining room table with a plate in front of her which contained a bowel of super cereal, scrambled eggs, toast, half of a banana, half glass of orange juice, half a glass of milk and a cup of coffee. Registered nurse (RN)-A was assisting R41 by opening her package of brown sugar and putting it on her cereal. At 9:43 a.m. R41 sliced up her banana into her cereal and began to eat independently. At 10:05 a.m. dietary staff asked R41 if she was done eating, R41 indicated she was, so dietary staff took her tray and dishes to the kitchen area and left her milk and juice for her to finish. R41 ate everything on her plate except for a small piece of crust from her toast. At 10:21 a.m. dietary manager (DM) asked R41 if she was done with her drinks, R41 indicated she was and DM took the glasses from the table. R41 drank all of her juice and milk. During the breakfast meal observation R41 was not offered or provided any peanut butter during her breakfast meal.

On 9/13/17, at 11:53 a.m. R41 was seated at the dining room table with a clothing protector on her chest area. R41 had a plate of food in front of her

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which contained a piece of breaded chicken, super potatoes with gravy, half slice of white bread, half glass of cranberry juice, glass of water and coffee. At this time dietary manager asking R41 if she would like a bowl of soup instead, R41 indicated she wanted a bowl of soup and crackers. R41 had taken a few bites of her potatoes and her breaded chicken. R41 indicated her stomach was out of whack today. At 11:57 a.m. R41 continued to take sips of her coffee and a few more bites of her potatoes. At 12:07 p.m. R41 had a bowl of chicken noodle soup with crackers. At 12:29 p.m. R41 was not eating her soup with crackers. At 12:47 p.m. R41 continued to not to eat her soup or crackers stating she didn't feel like eating. During the meal R41 was not offered or provided any peanut butter during her meal.

Review of the VitalReport weights for R41 from 5/1/17 to 9/13/17, revealed:
- 5/18/17 weight 88.5 lbs
- 6/15/17 weight-87 lbs
- 7/19/17 weight 88.5 lbs
- 8/16/17 weight 86.5 lbs
- 9/13/17 weight 86 lbs

On 9/13/17, at 8:55 a.m. dietary aid (DA)- A reviewed R41's current diet from her dietary card and indicated she was not aware R41 was supposed to receive peanut butter with her meals. DA-A indicated that R41 liked peanut butter and would occasionally ask for it. DA-A further stated "no I am not aware of this, that's a new one for us."

On 9/13/17, at 9:41 a.m. dietary cook (DC)-A verified R41 did not have two tablespoons of peanut butter with meals listed on her dietary card

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F 325	Continued From page 42	F 325		

and stated "no I was not aware of this." DC-A indicated the DM would write it in the communication book and list it on the dietary cards so staff would know of the changes. DC-A stated "I might of missed this, not aware of this, I guess we are in the dark."

On 9/13/17, at 12:22 p.m. nursing assistant (NA)-B indicated R41 was independent with eating and needed staff assistance with opening packages and cutting up her food. NA-B indicated she had to tell the kitchen to give R41 small portions, otherwise R41 would get overwhelmed by the amount of food given. NA-B indicated R41 was not a big eater but more of a snacker and told staff when she wanted something to eat.

On 9/13/17, at 12:48 p.m. clinical dietary manager (DM) confirmed R41's current care plan and diet. The DM verified R41 was currently receiving super cereal for breakfast and super potatoes for dinner. The DM could not verify if R41 was receiving peanut butter with meals and stated "I am thinking I did not carry through with the peanut butter." The DM confirmed R41's BMI was borderline under weight and indicated she was the one that would update the care plan, let staff know of changes in resident's diets, updated the menu cards for staff to follow and further stated "the peanut butter got missed." The DM confirmed R41 had lost more weight, R41's current weight was 86 lbs and indicated she should have followed through with the peanut butter. The DM indicated she would expect staff to follow the care plan and follow the resident's menu cards. The DM confirmed staff was unaware of R41's peanut butter with meals and indicated it was "human error."

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F 325	Continued From page 43 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.	F 325		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or	F 329		10/24/17

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F 329	Continued From page 44 (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to monitor laboratory levels related to the lipid lowering medications (Simvastatin and Zetia) and thyroid medication (Levothyroxine) for 1 of 5 residents (R10) reviewed for unnecessary medications. Finding include: R10's signed physician orders dated 8/14/17, identified diagnoses including: hyperlipidemia (high cholesterol), and hypothyroidism. The	F 329	Labs obtained for (R10) results reviewed by her provider with no changes to (R10) medications or treatments made. Reviewed and revised transcription of physician orders policy and procedure. Reviewed and revised standing physician orders. Reviewed all lab orders from 2017 and verified all have been drawn as ordered. Night charge nurse will review "lab due"	

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F 329	Continued From page 45 orders also included a current order for Simvastatin 40 milligrams (mg) by mouth once an evening for hyperlipidemia, Zetia 10 mg by mouth once an evening for hyperlipidemia and Levothyroxine 50 micrograms (mcg) by mouth once a morning for hypothyroidism. Further review of the signed physician orders indicated R10 was to have a lipid profile and thyroid stimulating hormone (TSH) labs completed every twelve months. Review of R10's medical record did not include evidence a recent lipid profile or TSH had been completed to monitor the efficacy of medications. The most recent lipid profile and TSH were not in R10's medical record but obtained from the hospital by staff upon request. The labs were dated 6/9/16; R10's triglyceride (a type of fat found in the blood) level was noted to be high at 241 (reference range: 10-200) and her HDL cholesterol (good cholesterol) level was noted to be low at 23 (reference range: 40-60). R10's TSH level on 6/9/16, was noted to be at 1.77 (reference range: 0.40-3.99). On 9/14/17, at 2:13 p.m. the director of nursing (DON) confirmed R10 was to have her lipid profile and TSH checked yearly per signed doctors orders. The DON verified the last time R10 had her lipid profile and TSH checked was on 6/9/16. The DON indicated her expectations of staff was to make sure the labs are done per the doctors signed orders. The DON indicated the lab orders get entered into Matrix (electronic medical record), the system automatically sent the lab orders to the lab department and generated the lab work to be done every Wednesday in the facility. The DON indicated she thought another order over rode the original lab orders and that's	F 329	report daily to see if any labs are due. Routine lab day is Wednesday. The lab tech will give the charge nurse a "lab due" report whenever they are here to draw any labs and verify the labs are drawn. Licensed staff and lab department will be educated by at least one of the following 1:1 meetings, stand-ups, or scheduled meetings on this new process. DON or designee will review weekly X 4 weeks that all ordered labs are drawn as ordered. Results of this audit will be reviewed with QAPI committee.	

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F 329	Continued From page 46 maybe why R10's labs did not get done. On 9/14/17, at 2:22 p.m. a message was left for the consulting pharmacist (CP). On 9/18/17, at 9:10 a.m. the CP returned the phone call and stated if the medical doctor ordered follow up labs to be done yearly, she expected staff to make sure the labs were being done. The CP stated "they should be done yearly." The CP indicated labs were reviewed during the monthly pharmacy reviews and indicated if the resident was within their goals, no recommendations would be made. The CP indicated a TSH should be done yearly with this age group and if a resident had abnormal labs, follow up labs should be done as well and with health changes. The CP indicated she would have given recommendation for abnormal labs and said "I would have addressed this" to see if the medical doctor wanted any changes or labs repeated. Review of facility policy titled, Physician Orders, Transcription Of revised on 10/11 indicated under laboratory/x-ray indicated staff was to fill out appropriate lab or x-ray requisition in Matrix, notify lab or x-ray if something needs to be done immediately or at a specific time and date and place resident name and lab to be drawn on lab draw calendar at prospective nurses station.	F 329		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		10/24/17

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F 428	Continued From page 47 (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time	F 428		

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F 428	Continued From page 48 frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the consulting pharmacist identified and reported incomplete lab monitoring for lipid lowering medications (Simvastatin and Zetia) and a thyroid medication (Levothyroxine) for 1 of 5 residents (R10) reviewed for unnecessary medications. Findings include: R10's signed physician orders dated 8/14/17, identified diagnoses including: hyperlipidemia (high cholesterol), and hypothyroidism. The orders also included a current order for Simvastatin 40 milligrams (mg) by mouth once an evening for hyperlipidemia, Zetia 10 mg by mouth once an evening for hyperlipidemia and Levothyroxine 50 micrograms (mcg) by mouth once a morning for hypothyroidism. Further review of the signed physician orders indicated R10 was to have a lipid profile and thyroid stimulating hormone (TSH) labs completed every twelve months. Review of R10's medical record did not include evidence a recent lipid profile or TSH had been completed to monitor the efficacy of medications. The most recent lipid profile and TSH were not in R10's medical record but obtained from the hospital by staff upon request. The labs were dated 6/9/16; R10's triglyceride (a type of fat found in the blood) level was noted to be high at 241 (reference range: 10-200) and her HDL	F 428	Labs obtained for (R10) results were reviewed by her provider and no changes in her medications or treatments were made. Reviewed and revised pharmacist drug regimen policy. Reviewed and revised transcription of physician orders policy and procedure. 10/3/17 Monthly consultant pharmacist will review every residents records including labs. Staff reviewed all lab orders from 2017 and verified all have been drawn and results are in residents chart. Reviewed and revised physician standing orders. Night charge nurse will review "lab due" report daily to see if any labs are due. Routine lab day is Wednesday. The lab tech will give the charge nurse a "lab due" report whenever they are here to draw any labs and verify the labs are drawn. Licensed staff and lab department will be educated by at least one of the following; 1:1 meetings, stand-ups, or scheduled meetings on this new process. DON or designee will review weekly X 4 weeks that all ordered labs are drawn as ordered. Results of this audit will be reviewed with QAPI committee.	

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cholesterol (good cholesterol) level was noted to be low at 23 (reference range: 40-60). R10's TSH level on 6/9/16, was noted to be at 1.77 (reference range: 0.40-3.99).

Review of the Pharmacist Drug Regimen Reviews dated 1/17 through 8/31/17, identified no recommendations for laboratory monitoring related to the use of Simvastatin, Zetia or Levothyroxine.

On 9/14/17, at 2:22 p.m. a message was left for the consulting pharmacist (CP). On 9/18/17, at 9:10 a.m. the CP returned the phone call and stated if the medical doctor ordered follow up labs to be done yearly, she expected staff to make sure the labs were being done. The CP stated "they should be done yearly." The CP indicated labs were reviewed during the monthly pharmacy reviews and indicated if the resident was within their goals, no recommendations would be made. The CP indicated a TSH should be done yearly with this age group and if a resident had abnormal labs, follow up labs should be done as well and with health changes. The CP indicated she would have given recommendation for abnormal labs and said "I would have addressed this" to see if the medical doctor wanted any changes or labs repeated.

On 9/14/17, at 2:13 p.m. the director of nursing (DON) confirmed R10 was to have her lipid profile and TSH checked yearly per signed doctors orders. The DON verified the last time R10 had her lipid profile and TSH checked was on 6/9/16. The DON indicated her expectations of staff was to make sure the labs are done per the doctors signed orders. The DON indicated the lab orders get entered into Matrix (electronic medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245579	A. BUILDING _____ B. WING _____	09/14/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 50 record), the system automatically sent the lab orders to the lab department and generated the lab work to be done every Wednesday in the facility. The DON indicated she thought another order over rode the original lab orders and that's maybe why R10's labs did not get done. Review of the facility policy titled, Pharmacy Services revised on 2/17/17, indicated each residents drug/mediation regimen shall be managed and monitored to: help promote or maintain the resident's highest practicable mental, physical and psychosocial well-being, as defined by the resident and representative in collaboration with the attending physician and facility staff. The consultant pharmacist reviews each residents drug regimen monthly to ensure compliance with applicable state and federal guidelines.	F 428		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);	F 441		10/24/17

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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 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.	F 441		

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F 441	Continued From page 52 (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program which included comprehensive surveillance of resident infections to identify and analyze possible patterns of infection in the facility. This deficient practice had the potential to affect all 39 residents who resided in the facility. Findings include: Review of the facility's infection control surveillance program was conducted on 9/14/17. The facility utilized Grace Home Monthly Infection Reports, which included Infection Maps (facility floor plan showing resident rooms and dining room) from 9/16 through 9/17. The Grace Home Monthly Infection Report included the following areas: resident name, room number, physician, admission date, onset date, symptoms, infection site, date of culture, culture results, antibiotic ordered, start date, discontinue date, resolved or ongoing, care plan updated, and comments/follow up. The monthly logs included residents with infections for which antibiotics were prescribed, however, did not consistently include culture results and no colony counts recorded. Logs also lacked if the infections were community acquired or nosocomial. Additionally, the logs failed to identify resident symptoms/infections that were	F 441	1.The facility Infection Control Policy was reviewed and revised on 10-3-17. 2.Reviewed the Urinary Tract Infection checklist policy on 10-3-17. 3.Track all symptoms/infections on the Infection Log, including infections that are or are not being treated with antibiotics. 4.Update Infection Control Logs "Added a section to track whether the infection was community acquired or if it is a nosocomial infection on 10-4-17. "Infection Preventionist or designee will ensure that culture results are documented on Infection Control Logs in the culture results section, when the log is updated. 5.Events are opened for all new signs and symptoms of infection. 6.MatrixCare added Infection to the problem category so we can care plan infections through matrix care. The facility will start care planning infections in MatrixCare starting 10-4-17. Corrective Action Plan: 1.The infection preventionist will meet with the physicians from the affiliated hospital and inform them how the facility plans to implement infection surveillance using McGeer□s criteria.	

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F 441	Continued From page 53 not treated with antibiotics. Review of Monthly Infection Report from 3/17 through 8/17, included: 3/17: There was an entry for urinary symptoms with two symptoms identified of increased incontinence and mood/personality change. There was no date of culture, or culture results. Ciprofloxacin (antibiotic) was started. Another entry was made for an urinary infection with no listed symptoms. There was a culture result and an antibiotic was ordered. The entry did not specify if the infection was resolved or ongoing and did not indicate if the plan of care was updated. 4/17: An entry was made for a potential urinary tract infection (UTI) with one symptom of mood changes prior to the physician order for urinary analysis. Order received for urinary analysis and started antibiotic on 4/11/17. Culture results indicated E. coli, but did not indicate a colony count. There was another entry for a potential UTI with no symptoms tracked. The entry did not specifiy if the infection was resolved or ongoing and did not identify if the plan of care was updated. A third entry was made for a potential UTI with one symptom of mood changes prior to order for urinary analysis. Resident started on Bactrim DS on 4/3/17, the same day the urinalysis was completed with the culture results showing only mixed contaminants (usually means a contaminated sample and the test should be repeated). 5/17: There was one entry for a potential UTI with two symptoms which included elevated blood	F 441	2.Facility□s Infection Preventionist has an APIC Basic Infection Prevention Course training Scheduled for October 18-20, 2017. The course is taught individuals who have a Certification in Infection Control. This is an interactive course that will offer a comprehensive foundation for professionals specializing in infection prevention. The course learning outcomes includes having the participants: "Examine the elements of effective infection prevention programs and the resources that support them. "Gain understanding of how evidenced-based recommendations are used to implement best practices to prevent infections. "Sharpen networking skills with colleagues to share experience and to gain access to additional resources. "Increase awareness of Centers for Medicare and Medicaid□s conditions of participation to qualify for 3rd party reimbursement. "Expand knowledge of compliance with state and national regulatory standards that impact the facility□s licensure or accreditation. "Improve understanding of the impact of infection prevention strategies to support the mission and goals of your healthcare system. 4.The infection preventionist or designee will audit orders of prescribed antibiotics x30 days starting 10-4-17, seeing if the orders follow McGeer□s criteria. 5.Inservices are scheduled for October. Nursing staff will be educated on the UTI	

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F 441	Continued From page 54 sugars and lethargy. A urinalysis was ordered. Culture results identified Escherichia coli (E. coli), but 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 antibiotics for UTI, but no further information available. There was no indication of whether the infection was resolved or ongoing. 7/17: An entry was made for a potential UTI, with two symptoms identified of fatigue and weakness prior to order for urinary analysis. Culture results show E. coli, but no information on colony counts, 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-B confirmed the Grace Home Monthly Infection Report logs tracked only those infections which	F 441	checklist policy and procedure and McGeer□s criteria by at least one of the following: 1:1 meetings, stand-ups, or scheduled meetings. Competency evaluations will be given following the meetings 6.The Facility□s Infection Preventionist will report to the Quality Assurance Performance Improvement committee for review and further recommendations.	

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F 441	Continued From page 55 were treated with antibiotics. RN-B indicated the facility had been taking part in the Infection Control Assessment and Response (ICAR) program (a program to improve infection control capacity across Minnesota). The ICAR representative in the past had suggested the facility add non-antibiotic treated infections to their Monthly Infection Report logs. This would ensure tracking of potential viral infections (such as influenza, shingles) as well. RN-B indicated the facility had not yet implemented tracking of viral infections within the facility.	F 441		

DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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.

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 Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00762	A. BUILDING: _____ B. WING _____	09/14/2017

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

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 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 statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN 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: R11's care plan, revised on 9/12/17, identified R11 had potential for self care deficit related to hospice patient, weakness, decrease cognition, manifested by needing more assistance with personal hygiene. R11's care plan indicated R11 had his own teeth with cavities. The care plan directed staff to provide set up and supervision for oral care. On 9/13/17, from 8:19 a.m. to 8:46 a.m. R11 was	2 565	R41 care plan and meal tray card was reviewed for accuracy and communication book updated in the dietary department. Individual peanut butter packets also placed in the condiments container on R41 table. Reviewed and revised comprehensive care plan and oral hygiene policies. Also, reviewed nutritional care policy and it is appropriate and accurate. Identified all residents needing assist with oral cares in the facility and all the identified residents care plans were reviewed for accuracy. Hartman publishing training video on providing oral cares will be used to assist with educating appropriate staff with competency evaluation following the training video.	10/31/17

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2 565	Continued From page 3 observed to receive morning cares. R11 did not receive assistance with oral cares during this time. At 9:15 a.m. R11 indicated he wanted to lay down. NA-B assisted R11 with toileting services, washing his face, and lying down. NA-B left the room at 9:29 a.m. R11 was not offered or provided oral cares by NA-B during this time. On 9/13/17, at 12:13 p.m. NA-B confirmed R11 was currently a hospice patient and needed assistance with all of his ADL's including oral hygiene. NA-B indicated she had not offered or attempted oral cares with R11 recently because R11 got upset. NA-B further stated "he does not have good teeth." NA-B verified she did not offer oral cares to R11 further stating she "forgot to, but he gets mad at times, so I quite trying." On 9/14/17, at 3:09 p.m. R11 was noted to have no teeth on the top of his mouth and four teeth on the bottom, which were badly decayed and discolored black/gray/yellow in color. On 9/14/17, at 9:35 a.m. RN-A confirmed R11 was currently a hospice patient and needed assistance with all of his ADL's including oral hygiene. RN-A indicated staff should be following the care plan and stated staff "should be offering dental care even if he refuses it." On 9/14/17, at 10:19 p.m. the director of nursing (DON) confirmed R11's care plan stating R11 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's care plan, revised on 8/14/17, identified R10 had potential for alteration in mouth and oral	2 565	DON or designee will complete monitoring daily X 1 week of either am or hs shifts to see that appropriate oral hygiene is being provided as care planned to identified residents as well as others at risk for this alleged deficient practice and then weekly X3 weeks. Results will be reviewed with the Quality Assurance Performance Improvement committee. DON or designee will complete compliance monitoring daily X 1 week of various meal times to see that appropriate nutritional interventions are provided as care planned and then weekly X3 weeks. Results will be reviewed with the Quality Assurance Performance Improvement committee.	

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2 565	Continued From page 4 mucosa related to needing assistance with oral cares and history of resistance to ADL's including personal hygiene. The care plan identified staff to encourage and assist with oral cares at least two times a day, if she will allow. On 9/13/17, from 7:45 a.m. to 8:10 a.m. R10 was observed to receive morning cares. Following morning cares, R10 was assisted to breakfast and at 9:36 was observed to wait for church service. At 10:21 a.m. R10 was in the activity room eating popcorn and drinking coffee independently. R10 was not offered or provided oral cares during this 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. On 9/14/17, at 3:10 p.m. R10 was noted to have her own natural teeth on the top and bottom which had several fillings and some of her teeth were noted to be discolored yellow/gray. On 9/14/17, at 9:43 a.m. RN-A confirmed R10 needed assistance with all of her ADL's including oral hygiene. RN-A confirmed the care plan directions, and indicated staff should follow the care plan. RN-A stated "she [R10] does not know to ask." On 9/14/17, at 10:27 a.m. the DON confirmed R10's care plan and verified R10 needed assistance with oral hygiene. The DON indicated staff should follow the care plan and stated "I would expect staff to assist her with oral cares	2 565		

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	00762	A. BUILDING: _____ B. WING _____	09/14/2017

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2 565	Continued From page 5 and to offer it and to encourage her." R47 was not provided oral care as directed by the care plan. R47's care plan, revised on 9/1/17, identified the dental care plan indicated there was a potential for oral problems due to R47 having her own teeth and upper partials. The care plan identified staff to provide assistance with oral cares daily. During observation of morning cares on 9/13/17, from 9:12 a.m. to 9:44 a.m. nursing assistant (NA)-C assisted R47 was not assisted with nor offered the opportunity for completion of oral cares. R47's natural teeth were observed with areas of white matter build up between them and on her right, lower lip. Further, R47's upper partial was not in place prior to breakfast. At 9:53 a.m. R47 was observed eating a banana, scrambled egg and toast independently. R47 did not have her upper right partial in place during the breakfast meal. On 9/13/17, at 9:44 a.m. NA-C verified she was finished with R47's morning cares. NA-C reported R47 required assist of one staff for all ADL's, including oral care. NA-C confirmed R47 had natural teeth and utilized an upper partial. NA-C verified she did not provide, nor offer oral cares or provide R47's partial prior to breakfast and should have done so. 09/13/17, at 10:36 a.m. registered nurse (RN)-B confirmed R47 should have been offered oral cares prior to breakfast, including the partial placed in R47's mouth. 09/14/17, at 11:26 a.m., registered nurse (RN)-A verified R47 should have been provided oral cares and given partial prior to breakfast, and	2 565		

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2 565	Continued From page 6 confirmed R47 required staff assistance of one for oral cares. 09/14/17, at 12:42 p.m. the DON verified R47 required staff assistance of one for all ADL's. The DON confirmed staff are expected to ensure R47's partial was in place and provided oral cares prior to breakfast. The DON stated she expected all staff to follow R47's care plan. The facility's Care Plans-Comprehensive policy dated 8/17, indicated an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. R41 was not provided calorie dense foods, which included peanut butter with meals. R41's care plan revised on 8/7/17, identified R41 was at risk for BMI continuing in underweight status due to history of weight loss and prior to admit under body weight. The care plan listed the intervention of offering peanut butter at meals for bread/toast. During observations of breakfast on 9/13/17, from 9:38 a.m. to 10:20 a.m. R41 was observed to eat her entire breakfast but had been provided no peanut butter for her toast. On 9/13/17, from 11:53 a.m. to 12:27 p.m. R41 was observed to eat her dinner meal. Although R41 had bread and crackers at her meal, R41 was not offered or provided any peanut butter during her dinner meal. On 9/13/17, at 8:55 a.m. dietary aid (DA)-A confirmed R41 current diet from her dietary card and indicated she was not aware R41 was	2 565		

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2 565	Continued From page 7 supposed to receive peanut butter with her meals. DA-A indicated that R41 liked peanut butter and would occasionally ask for it. On 9/13/17, at 9:41 a.m. dietary cook (DC)-A stated R41's current dietary card did not have two tablespoons of peanut butter with meals identified. DC-A stated "no I was not aware of this." DC-A indicated the dietary manager (DM) would right it in the communication book and list it on the dietary cards. "I might of missed this, not aware of this, I guess we are in the dark." On 9/13/17 at 12:48 p.m. clinical dietary manager (DM) confirmed R41's current care plan and diet. The DM could not verify if R41 was receiving peanut butter with meals. The DM stated "I am thinking I did not carry through with the peanut butter." The DM confirmed R41's BMI was borderline under weight and indicated "the peanut butter got missed." The DM confirmed R41 had lost more weight, R41's current weight was 86 lbs, and indicated she should of followed through with the peanut butter. The DM confirmed staff was unaware of R41's peanut butter with meals and indicated it was human error. On 9/14/17 at 9:04 a.m. register dietician (RD) confirmed R41 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 received bread. The RD indicated staff should be following the care plan as directed and per recommendations. 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	2 565		

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2 565	Continued From page 8 staff was already offering it to R41. Review of facility policy titled, Care Plan Use Of revised on 4/15, indicated the care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure ongoing compliance. The auditing results could be reviewed with the quality improvement group. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary care and services to maintain oral hygiene for 3 of 3 residents (R11, R10, R47), reviewed for	2 920	Reviewed and revised oral hygiene policy. Identified all residents needing assist with oral cares in the facility, all the identified residents care plans were reviewed for	10/31/17

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2 920	Continued From page 9 activities of daily living (ADLs). Findings included R11's significant change in status Minimum Data Set (MDS) dated 8/29/17, identified diagnoses including anemia, heart failure, and renal insufficiency. The MDS identified R11 was on hospice care, had severe cognitive impairment and needed limited assistance of one staff to perform personal hygiene including oral hygiene. R11's care plan, revised on 9/12/17, identified R11 had potential for self care deficit related to hospice patient, weakness, decreased cognition, manifested by needing more assistance with personal hygiene. R11's care plan indicated R11 had his own teeth with cavities. On 9/13/17, at 8:19 a.m. R11 was observed lying in bed when nursing assistant (NA)-B entered the room to answer R11's call light. R11 indicated he needed to go to the bathroom. NA-B called for assistance and put R11's shoes on while waiting for help. R11 was wearing a long sleeve shirt and a white incontinent brief. At 8:23 a.m. NA-B again called for assistance on her walkie talkie again and placed the transfer belt around R11's waist. Registered nurse (RN)-A entered the room and assisted NA-B with transferring R11 to his wheelchair. NA-B placed the urinal while R11 voided. At 8:31 a.m. NA-C entered the room with standing mechanical lift and assisted NA-B with cleaning, emptying R11's colostomy bag. At 8:35 a.m. NA-C assisted R11 to wash and dry his face, placed a blanket on his lap and left at 8:39 a.m. NA-B moved R11 to the middle of the room so he could watch TV, placed the bedside table in front of him with the call light, combed R11's hair and left the room. At 8:42 a.m. NA-B returned with a	2 920	accuracy. Hartman publishing training video on providing oral cares will be used to assist with educating appropriate staff with competency evaluation following the training video. DON or designee will complete monitoring daily X 1 week of either am or hs shifts to see that appropriate oral hygiene is being provided as care planned to identified residents as well as others at risk for this alleged deficient practice and then weekly X3 weeks. Results will be reviewed with the Quality Assurance Performance Improvement committee.	

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2 920	Continued From page 10 breakfast tray, placed a clothing protector on R11's chest area, set him up to eat breakfast and R11 began to eat independently. NA-B left the room at 8:46 a.m. During the observation of morning cares, R11 was not offered or provided oral cares from staff. On 9/13/17, at 9:11 a.m. R11's call light was on, family was in visiting. At 9:15 a.m. NA-B entered the room, and R11 indicated he wanted to lay down. NA-B obtained the standing mechanical lift. NA-B hooked R11 to the standing mechanical lift and assisted R11 to clean his face. NA-B stood R11, provided peri cares and placed a clean incontinent brief. NA-B transferred R11 to his bed and assisted R11 to lay down in bed. At 9:29 a.m. NA-B left R11's room after collecting the dirty linen and garbage, and returned to remove the breakfast tray. During the observation R11 was not offered or provided oral cares by staff. On 9/13/17, at 12:13 p.m. NA-B confirmed R11 was currently on hospice patient and needed assistance with all of his ADL's including oral hygiene. NA-B indicated she had not offered or attempted oral cares with R11 recently because R11 would get upset. NA-B further stated "he does not have good teeth." NA-B verified she did not offer oral cares to R11 and stated she "forgot to, but he gets mad at times, so I quite trying." NA-B indicated she would have to start trying to provide oral cares to R11. On 9/14/17, at 3:09 p.m. R11 was noted to have no teeth on the top of his mouth and four teeth on the bottom, which were badly decayed and discolored black/gray/yellow in color. On 9/14/17, at 9:35 a.m. RN-A identified R11 was currently on hospice and needed assistance with	2 920		

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2 920	Continued From page 11 all ADL's including oral hygiene. RN-A stated staff should be following the care plan 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 asked R10 if she was ready to get up for breakfast, and R10 agreed. At 7:49 a.m. NA-B assisted R10 to sit up, stand, and walk to to the bathroom. At 7:53 a.m. NA-B toileted R10 and assisted her to get washed up and dressed for the day. At 8:05 a.m. NA-B assisted R10 to stand with a walker, provided peri cares, and pulled up R10's pants. At At 8:08 a.m. NA-B assisted R10 to walk to the dining room area for breakfast. At	2 920		

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2 920	Continued From page 12 8:11 a.m. R10 sat down at the breakfast table, NA-B removed gait belt form her waist and placed a clothing protector on her chest area. At 8:52 a.m. R10 ate her breakfast independently. At 9:36 a.m. R10 was done with breakfast and sitting in the chapel area waiting for church to begin. At 10:21 a.m. R10 was in the activity room eating popcorn and drinking coffee independently. During the observation R10 was not offered or provided oral cares by staff. On 9/13/17, at 8:13 a.m. NA-B confirmed R10 needed assistance with all of her ADL's including oral hygiene due to increased confusion and not following commands. NA-B indicated she forgot to do R10's oral cares and stated "I forgot about her mouth care this morning." NA-A indicated that R10 has an electric toothbrush and does need assistance to use it and stated "I forgot running behind." On 9/14/17, at 3:10 p.m. R10 was noted to have her own natural teeth on the top and bottom which had several fillings and some of her teeth were noted to be discolored yellow/gray. On 9/14/17, at 9:43 a.m. RN-A stated R10 needed assistance with all of her ADL's including oral hygiene. RN-A confirmed the current care plan, indicated staff should be following the care plan and further stated "she [R10] does not know to ask." RN-A indicated she would expect staff to offer dental care and stated "she [R10] would not do this on her own." On 9/14/17, at 10:27 a.m. the DON confirmed 10's care plan, and verified she needed assistance with all of her ADL's including oral hygiene. The DON indicated R10's cognition has been getting worse and she does not follow	2 920		

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2 920	Continued From page 13 commands. The DON indicated staff should be following the care plan and stated "I would expect staff to assist her with oral cares and to offer it and to encourage her." Review of facility policy, Oral Hygiene reviewed in 10/07, indicated nursing staff will provide all residents with mouth care every morning, night and as needed. Mouth care would be given every two hours for those residents on NPO (nothing by mouth). 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. R47's care plan, revised on 9/1/17, identified R47 had potential for increasing self care deficit related to Alzheimer's disease, dementia, COPD and weakness. R47's dental care plan indicated there was a potential for oral problems due to R47 having her own teeth and upper partials. The care plan listed various interventions including staff to provide assistance with oral cares daily. On 9/13/17, from 9:12 a.m. to 9:44 a.m. nursing assistant (NA)-C assisted R47 with morning personal cares which included washing her face, perineal cares and dressing. During this observation, R47 was not assisted with nor offered the opportunity for completion of oral cares. R47's natural teeth were observed with areas of white matter build up between them and	2 920		

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2 920	Continued From page 14 on her right, lower lip. Further, R47's upper partial was not in place prior to breakfast. At 9:44 a.m. following the observation of morning cares, NA-C assisted R47 to the dining room table. NA-C stated she was finished with R47's morning cares. NA-C reported R47 required assist of one staff for all ADL's, including oral care. NA-C confirmed R47 had natural teeth and utilized an upper partial. NA-C verified she did not provide, nor offer oral cares or provide R47's partial prior to breakfast and should have done so. At 9:53 a.m. R47 was observed eating a banana, scrambled egg and toast independently. R47 did not have her upper right partial in place during the breakfast meal. On 9/13/17, at 10:36 a.m. registered nurse (RN)-B confirmed R47 should have been offered oral cares prior to breakfast, including the partial placed in R47's mouth. On 9/14/17, at 11:26 a.m., registered nurse (RN)-A verified R47 should have been provided oral cares and given partial prior to breakfast, and confirmed R47 required staff assistance of one for oral cares. On 9/14/17, at 12:42 p.m. the DON verified R47 required staff assistance of one for all ADL's. The DON confirmed staff was expected to ensure R47's partial was in place and provided oral cares prior to breakfast. The DON stated she expected all staff to follow R47's care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents unable to carry out activities of daily	2 920		

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2 920	Continued From page 15 living to assure they are receiving the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. The results of the audits could be brought to the quality improvement for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement nutritional interventions related to the provision of calorie dense foods which included peanut butter with meals in order to prevent further weight loss for 1 of 3 residents (R41) reviewed for nutrition. Findings include: R41's quarterly Minimum Data Set (MDS) dated 7/27/17, identified R41 had diagnosis which	2 965	R41care plan and meal tray card were reviewed for accuracy and communication book updated in the dietary department. Individual peanut butter packets also placed in the condiment container on R41 table. Reviewed nutritional care policy and it is appropriate and accurate. Identified all residents needing assist with oral cares in the facility and all the identified residents	10/31/17

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2 965	Continued From page 16 included dementia, depression and anxiety. The MDS identified R41 had severe cognitive impairment, needed limited assistance of one staff for activities of daily living (ADL's) and was independent with eating after set up help from staff. The MDS further indicated R41 was 58 inches (in), weighed 88 pounds (lbs), had no weight loss, no eating problems and had a therapeutic diet. Review of R41's significant change Nutritional Screening and Assessment dated 5/2/17, indicated R41 was on a regular diet with nutritional interventions of super potatoes, super cereal and ate in the main dining room. R41's current height 58 in and weight 89.5 lbs. R41's body mass index (BMI) 18.7 low end of health status. Review of R41's quarterly Nutritional Screening and Assessment dated 7/27/17, indicated R41 was on a regular diet, small portions, with nutritional interventions of super potatoes, super cereal and ate in the main dining room. R41's current height 58 in and weight 87.5 lbs. R41's BMI 18.4 under weight status and continue with plan of care. Review of R41's Resident Progress Notes on 8/16/17 by the registered dietician (RD) revealed R41's current weight 86.5 lbs which is stable and current BMI 18.4 which is underweight. Family reports weight at home 85 lbs. Diet is regular with small portions, intake at breakfast 76-100 percent (%), 25 to 50% for lunch and dinner. R41 receives additional calories and protein through super cereal, super potatoes and two tablespoons of peanut butter at meals. R41's care plan revised on 8/7/17, identified R41	2 965	care plans were reviewed for accuracy. Following RD monthly visits any recommendations that may have been made will be documented on the dietician referral flow sheet, the CDM will make appropriate updates to tray cards, care plans, etc. The cook will also initial to acknowledge that the recommendations have been completed by CDM. DON or designee will complete compliance monitoring daily X 1 week of various meal times to see that appropriate nutritional interventions are provided as care planned and then weekly X3 weeks. Results will be reviewed with the Quality Assurance Performance Improvement committee.	

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	00762	A. BUILDING: _____ B. WING _____	09/14/2017

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2 965	Continued From page 17 was at risk for BMI continuing in underweight status due to history of weight loss and prior to admit under body weight. The care plan identified R41 was independent with eating and needed set up help from staff at times. The care plan listed several intervention such as: provide regular, small portion diet as ordered per medical doctor, provide super cereal at breakfast and super potatoes at dinner to aid with weight maintenance and record and monitor intake. When revised on 8/7/17, offering peanut butter at meals for bread/toast was added to the plan of care. Review of R41's dietary cards revealed she was receiving a regular diet with small portions, super cereal for breakfast and super potatoes for lunch. R41's dietary card did not identify the need for two tablespoons of peanut butter with meals. On 9/13/17, at 9:38 a.m. R41 was seated at the dining room table with a plate in front of her which contained a bowel of super cereal, scrambled eggs, toast, half of a banana, half glass of orange juice, half a glass of milk and a cup of coffee. Registered nurse (RN)-A was assisting R41 by opening her package of brown sugar and putting it on her cereal. At 9:43 a.m. R41 sliced up her banana into her cereal and began to eat independently. At 10:05 a.m. dietary staff asked R41 if she was done eating, R41 indicated she was, so dietary staff took her tray and dishes to the kitchen area and left her milk and juice for her to finish. R41 ate everything on her plate except for a small piece of crust from her toast. At 10:21 a.m. dietary manager (DM) asked R41 if she was done with her drinks, R41 indicated she was and DM took the glasses from the table. R41 drank all of her juice and milk. During the breakfast meal observation R41 was not offered or provided any peanut butter during her breakfast meal.	2 965		

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2 965	Continued From page 18 On 9/13/17, at 11:53 a.m. R41 was seated at the dining room table with a clothing protector on her chest area. R41 had a plate of food in front of her which contained a piece of breaded chicken, super potatoes with gravy, half slice of white bread, half glass of cranberry juice, glass of water and coffee. At this time dietary manager asking R41 if she would like a bowl of soup instead, R41 indicated she wanted a bowl of soup and crackers. R41 had taken a few bites of her potatoes and her breaded chicken. R41 indicated her stomach was out of whack today. At 11:57 a.m. R41 continued to take sips of her coffee and a few more bites of her potatoes. At 12:07 p.m. R41 had a bowl of chicken noodle soup with crackers. At 12:29 p.m. R41 was not eating her soup with crackers. At 12:47 p.m. R41 continued to not to eat her soup or crackers stating she didn't feel like eating. During the meal R41 was not offered or provided any peanut butter during her meal. Review of the VitalReport weights for R41 from 5/1/17 to 9/13/17, revealed: - 5/18/17 weight 88.5 lbs - 6/15/17 weight-87 lbs - 7/19/17 weight 88.5 lbs - 8/16/17 weight 86.5 lbs - 9/13/17 weight 86 lbs On 9/13/17, at 8:55 a.m. dietary aid (DA)- A reviewed R41's current diet from her dietary card and indicated she was not aware R41 was supposed to receive peanut butter with her meals. DA-A indicated that R41 liked peanut butter and would occasionally ask for it. DA-A further stated "no I am not aware of this, that's a new one for us."	2 965		

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2 965	Continued From page 19 On 9/13/17, at 9:41 a.m. dietary cook (DC)-A verified R41 did not have two tablespoons of peanut butter with meals listed on her dietary card and stated "no I was not aware of this." DC-A indicated the DM would write it in the communication book and list it on the dietary cards so staff would know of the changes. DC-A stated "I might of missed this, not aware of this, I guess we are in the dark." On 9/13/17, at 12:22 p.m. nursing assistant (NA)-B indicated R41 was independent with eating and needed staff assistance with opening packages and cutting up her food. NA-B indicated she had to tell the kitchen to give R41 small portions, otherwise R41 would get overwhelmed by the amount of food given. NA-B indicated R41 was not a big eater but more of a snacker and told staff when she wanted something to eat. On 9/13/17, at 12:48 p.m. clinical dietary manager (DM) confirmed R41's current care plan and diet. The DM verified R41 was currently receiving super cereal for breakfast and super potatoes for dinner. The DM could not verify if R41 was receiving peanut butter with meals and stated "I am thinking I did not carry through with the peanut butter." The DM confirmed R41's BMI was borderline under weight and indicated she was the one that would update the care plan, let staff know of changes in resident's diets, updated the menu cards for staff to follow and further stated "the peanut butter got missed." The DM confirmed R41 had lost more weight, R41's current weight was 86 lbs and indicated she should have followed through with the peanut butter. The DM indicated she would expect staff to follow the care plan and follow the resident's menu cards. The DM confirmed staff was unaware of R41's peanut butter with meals and	2 965		

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2 965	Continued From page 20 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.	2 965		

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21375	Continued From page 21	21375		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program which included comprehensive surveillance of resident infections to identify and analyze possible patterns of infection in the facility. This deficient practice had the potential to affect all 39 residents who resided in the facility. Findings include: Review of the facility's infection control surveillance program was conducted on 9/14/17. The facility utilized Grace Home Monthly Infection Reports, which included Infection Maps (facility floor plan showing resident rooms and dining room) from 9/16 through 9/17. The Grace Home Monthly Infection Report included the following areas: resident name, room number, physician, admission date, onset date, symptoms, infection site, date of culture, culture results, antibiotic ordered, start date, discontinue date, resolved or ongoing, care plan updated, and comments/follow up. The monthly logs included residents with infections for which antibiotics were prescribed, however, did not consistently include culture results and no colony counts recorded. Logs also lacked if the infections were community acquired or nosocomial. Additionally, the logs failed to	21375	1.The facility Infection Control Policy was reviewed and revised on 10-3-17. 2.Reviewed the Urinary Tract Infection checklist policy on 10-3-17. 3.Track all symptoms/infections on the Infection Log, including infections that are or are not being treated with antibiotics. 4.Update Infection Control Logs "Added a section to track whether the infection was community acquired or if it is a nosocomial infection on 10-4-17. "Infection Preventionist or designee will ensure that culture results are documented on Infection Control Logs in the culture results section, when the log is updated. 5.Events are opened for all new signs and symptoms of infection. 6.MatrixCare added Infection to the problem category so we can care plan infections through matrix care. The facility will start care planning infections in MatrixCare starting 10-4-17. Corrective Action Plan: 1.The infection preventionist will meet with the physicians from the affiliated hospital and inform them how the facility plans to implement infection surveillance using	10/31/17

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21375	Continued From page 22 identify resident symptoms/infections that were not treated with antibiotics. Review of Monthly Infection Report from 3/17 through 8/17, included: 3/17: There was an entry for urinary symptoms with two symptoms identified of increased incontinence and mood/personality change. There was no date of culture, or culture results. Ciprofloxacin (antibiotic) was started. Another entry was made for an urinary infection with no listed symptoms. There was a culture result and an antibiotic was ordered. The entry did not specify if the infection was resolved or ongoing and did not indicate if the plan of care was updated. 4/17: An entry was made for a potential urinary tract infection (UTI) with one symptom of mood changes prior to the physician order for urinary analysis. Order received for urinary analysis and started antibiotic on 4/11/17. Culture results indicated E. coli, but did not indicate a colony count. There was another entry for a potential UTI with no symptoms tracked. The entry did not specifiy if the infection was resolved or ongoing and did not identify if the plan of care was updated. A third entry was made for a potential UTI with one symptom of mood changes prior to order for urinary analysis. Resident started on Bactrim DS on 4/3/17, the same day the urinalysis was completed with the culture results showing only mixed contaminants (usually means a contaminated sample and the test should be repeated). 5/17: There was one entry for a potential UTI with two symptoms which included elevated blood	21375	McGeer□s criteria. 2.Facility□s Infection Preventionist has an APIC Basic Infection Prevention Course training Scheduled for October 18-20, 2017. The course is taught individuals who have a Certification in Infection Control. This is an interactive course that will offer a comprehensive foundation for professionals specializing in infection prevention. The course learning outcomes includes having the participants: "Examine the elements of effective infection prevention programs and the resources that support them. "Gain understanding of how evidenced-based recommendations are used to implement best practices to prevent infections. "Sharpen networking skills with colleagues to share experience and to gain access to additional resources. "Increase awareness of Centers for Medicare and Medicaid□s conditions of participation to qualify for 3rd party reimbursement. "Expand knowledge of compliance with state and national regulatory standards that impact the facility□s licensure or accreditation. "Improve understanding of the impact of infection prevention strategies to support the mission and goals of your healthcare system. 4.The infection preventionist or designee will audit orders of prescribed antibiotics x30 days starting 10-4-17, seeing if the orders follow McGeer□s criteria. 5.Inservices are scheduled for October. Nursing staff will be educated on the UTI	

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21375	Continued From page 23 sugars and lethargy. A urinalysis was ordered. Culture results identified Escherichia coli (E. coli), but 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 antibiotics for UTI, but no further information available. There was no indication of whether the infection was resolved or ongoing. 7/17: An entry was made for a potential UTI, with two symptoms identified of fatigue and weakness prior to order for urinary analysis. Culture results show E. coli, but no information on colony counts, 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-B confirmed the Grace Home Monthly Infection Report logs tracked only those infections which were treated with antibiotics. RN-B indicated the	21375	checklist policy and procedure and McGeer□s criteria by at least one of the following: 1:1 meetings, stand-ups, or scheduled meetings. Competency evaluations will be given following the meetings 6.The Facility□s Infection Preventionist will report to the Quality Assurance Performance Improvement committee for review and further recommendations.	

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21375	Continued From page 24 facility had been taking part in the Infection Control Assessment and Response (ICAR) program (a program to improve infection control capacity across Minnesota). The ICAR representative in the past had suggested the facility add non-antibiotic treated infections to their Monthly Infection Report logs. This would ensure tracking of potential viral infections (such as influenza, shingles) as well. RN-B indicated the facility had not yet implemented tracking of viral infections within the facility. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the facility has developed and implemented an infection control program designed to meet the current standards of practice based on recommendations from a qualified organization such as the CDC or MDH. The administrator, director of nursing, or designee could develop a system to educate staff and a monitoring system to ensure ongoing compliance. The facility could report to the quality assurance performance improvement (QAPI) committee for review and further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service	21530		10/31/17

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21530	Continued From page 25 Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the consulting pharmacist identified and reported incomplete lab monitoring for lipid lowering medications (Simvastatin and	21530	Labs obtained for (R10) results were reviewed by her provider and no changes in her medications or treatments were made.	

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21530	Continued From page 26 Zetia) and a thyroid medication (Levothyroxine) for 1 of 5 residents (R10) reviewed for unnecessary medications. Findings include: R10's signed physician orders dated 8/14/17, identified diagnoses including: hyperlipidemia (high cholesterol), and hypothyroidism. The orders also included a current order for Simvastatin 40 milligrams (mg) by mouth once an evening for hyperlipidemia, Zetia 10 mg by mouth once an evening for hyperlipidemia and Levothyroxine 50 micrograms (mcg) by mouth once a morning for hypothyroidism. Further review of the signed physician orders indicated R10 was to have a lipid profile and thyroid stimulating hormone (TSH) labs completed every twelve months. Review of R10's medical record did not include evidence a recent lipid profile or TSH had been completed to monitor the efficacy of medications. The most recent lipid profile and TSH were not in R10's medical record but obtained from the hospital by staff upon request. The labs were dated 6/9/16; R10's triglyceride (a type of fat found in the blood) level was noted to be high at 241 (reference range: 10-200) and her HDL cholesterol (good cholesterol) level was noted to be low at 23 (reference range: 40-60). R10's TSH level on 6/9/16, was noted to be at 1.77 (reference range: 0.40-3.99). Review of the Pharmacist Drug Regimen Reviews dated 1/17 through 8/31/17, identified no recommendations for laboratory monitoring related to the use of Simvastatin, Zetia or Levothyroxine.	21530	Reviewed and revised pharmacist drug regimen policy. Reviewed and revised transcription of physician orders policy and procedure. 10/3/17 Monthly consultant pharmacist will review every residents records including labs. Staff reviewed all lab orders from 2017 and verified all have been drawn and results are in residents chart. Reviewed and revised physician standing orders. Night charge nurse will review "lab due" report daily to see if any labs are due. Routine lab day is Wednesday. The lab tech will give the charge nurse a "lab due" report whenever they are here to draw any labs and verify the labs are drawn. Licensed staff and lab department will be educated by at least one of the following; 1:1 meetings, stand-ups, or scheduled meetings on this new process. DON or designee will review weekly X 4 weeks that all ordered labs are drawn as ordered. Results of this audit will be reviewed with QAPI committee.	

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21530	Continued From page 27 On 9/14/17, at 2:22 p.m. a message was left for the consulting pharmacist (CP). On 9/18/17, at 9:10 a.m. the CP returned the phone call and stated if the medical doctor ordered follow up labs to be done yearly, she expected staff to make sure the labs were being done. The CP stated "they should be done yearly." The CP indicated labs were reviewed during the monthly pharmacy reviews and indicated if the resident was within their goals, no recommendations would be made. The CP indicated a TSH should be done yearly with this age group and if a resident had abnormal labs, follow up labs should be done as well and with health changes. The CP indicated she would have given recommendation for abnormal labs and said "I would have addressed this" to see if the medical doctor wanted any changes or labs repeated. On 9/14/17, at 2:13 p.m. the director of nursing (DON) confirmed R10 was to have her lipid profile and TSH checked yearly per signed doctors orders. The DON verified the last time R10 had her lipid profile and TSH checked was on 6/9/16. The DON indicated her expectations of staff was to make sure the labs are done per the doctors signed orders. The DON indicated the lab orders get entered into Matrix (electronic medical record), the system automatically sent the lab orders to the lab department and generated the lab work to be done every Wednesday in the facility. The DON indicated she thought another order over rode the original lab orders and that's maybe why R10's labs did not get done. Review of the facility policy titled, Pharmacy Services revised on 2/17/17, indicated each residents drug/mediation regimen shall be managed and monitored to: help promote or maintain the resident's highest practicable	21530		

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	00762	A. BUILDING: _____ B. WING _____	09/14/2017

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

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21530	Continued From page 28 mental, physical and psychosocial well-being, as defined by the resident and representative in collaboration with the attending physician and facility staff. The consultant pharmacist reviews each residents drug regimen monthly to ensure compliance with applicable state and federal guidelines. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for proper monitoring of medication usage. Appropriate nursing staff could be educated on these systems. The DON or designee, could develop an auditing system to ensure ongoing compliance. The audits could be reviewed with the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending	21540		10/31/17

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21540	Continued From page 29 physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to monitor laboratory levels related to the lipid lowering medications (Simvastatin and Zetia) and thyroid medication (Levothyroxine) for 1 of 5 residents (R10) reviewed for unnecessary medications. Finding include: R10's signed physician orders dated 8/14/17, identified diagnoses including: hyperlipidemia (high cholesterol), and hypothyroidism. The orders also included a current order for Simvastatin 40 milligrams (mg) by mouth once an evening for hyperlipidemia, Zetia 10 mg by mouth once an evening for hyperlipidemia and Levothyroxine 50 micrograms (mcg) by mouth once a morning for hypothyroidism. Further review of the signed physician orders indicated R10 was to have a lipid profile and thyroid stimulating hormone (TSH) labs completed every twelve months. Review of R10's medical record did not include evidence a recent lipid profile or TSH had been completed to monitor the efficacy of medications. The most recent lipid profile and TSH were not in R10's medical record but obtained from the	21540	Labs obtained for (R10) results were reviewed by her provider and no changes in her medications or treatments were made. Reviewed and revised pharmacist drug regimen policy. Reviewed and revised transcription of physician orders policy and procedure. 10/3/17 Monthly consultant pharmacist will review every residents records including labs. Staff reviewed all lab orders from 2017 and verified all have been drawn and results are in residents chart. Reviewed and revised physician standing orders. Night charge nurse will review "lab due" report daily to see if any labs are due. Routine lab day is Wednesday. The lab tech will give the charge nurse a "lab due" report whenever they are here to draw any labs and verify the labs are drawn. Licensed staff and lab department will be educated by at least one of the following; 1:1 meetings, stand-ups, or scheduled meetings on this new process. DON or designee will review weekly X 4 weeks that all ordered labs are drawn as ordered. Results of this audit will be	

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21540	Continued From page 30 hospital by staff upon request. The labs were dated 6/9/16; R10's triglyceride (a type of fat found in the blood) level was noted to be high at 241 (reference range: 10-200) and her HDL cholesterol (good cholesterol) level was noted to be low at 23 (reference range: 40-60). R10's TSH level on 6/9/16, was noted to be at 1.77 (reference range: 0.40-3.99). On 9/14/17, at 2:13 p.m. the director of nursing (DON) confirmed R10 was to have her lipid profile and TSH checked yearly per signed doctors orders. The DON verified the last time R10 had her lipid profile and TSH checked was on 6/9/16. The DON indicated her expectations of staff was to make sure the labs are done per the doctors signed orders. The DON indicated the lab orders get entered into Matrix (electronic medical record), the system automatically sent the lab orders to the lab department and generated the lab work to be done every Wednesday in the facility. The DON indicated she thought another order over rode the original lab orders and that's maybe why R10's labs did not get done. On 9/14/17, at 2:22 p.m. a message was left for the consulting pharmacist (CP). On 9/18/17, at 9:10 a.m. the CP returned the phone call and stated if the medical doctor ordered follow up labs to be done yearly, she expected staff to make sure the labs were being done. The CP stated "they should be done yearly." The CP indicated labs were reviewed during the monthly pharmacy reviews and indicated if the resident was within their goals, no recommendations would be made. The CP indicated a TSH should be done yearly with this age group and if a resident had abnormal labs, follow up labs should be done as well and with health changes. The CP indicated she would have given recommendation for	21540	reviewed with QAPI committee.	

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21540	Continued From page 31 abnormal labs and said "I would have addressed this" to see if the medical doctor wanted any changes or labs repeated. Review of facility policy titled, Physician Orders, Transcription Of revised on 10/11 indicated under laboratory/x-ray indicated staff was to fill out appropriate lab or x-ray requisition in Matrix, notify lab or x-ray if something needs to be done immediately or at a specific time and date and place resident name and lab to be drawn on lab draw calendar at prospective nurses station. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for unnecessary medications. Appropriate nursing staff could be educated on the systems. The DON or designee, could audit unnecessary medication systems to ensure ongoing compliance. The audit results could be brought to the quality assurance group for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by:	21805		10/31/17

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21805	Continued From page 32 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 food in front of her. Licensed practical nurse (LPN)-A was observed standing next to the bedside table with R7 on the left side. LPN-A had a white bowl in her left hand, a silver spoon in her right hand and was giving R7 bites of hot cereal. At 8:55 a.m. LPN-A took a white covered plastic 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	21805	Reviewed and revised Residents right policy. Taller chair was made aware available for staff to use to sit and assist during mealtimes if resident is in higher wheelchair. Staff will be educated by at least one of the following; 1:1 meetings, stand-ups, or scheduled meetings on F241 and interpretive guidelines with competency evaluations following education. (this is not al all-inclusive list): a) "Dignity" means that their interactions with residents, staff carries out activities that assist the resident to maintain and enhance his/her self-esteem and self-worth. Some examples include (but not limited to): - Grooming as the resident wishes to be groomed. - Promoting independence and dignity in dining experience such as to avoidance of: I. Day-to day use of plastic cutlery; II. Staff standing over residents while assisting them to eat; III. Staff interacting/ conversing only with each other rather that with residents while assisting residents; b) Respecting residents by speaking respectfully. addressing the resident with a name of their choice, etc. Training video on assisting resident to eat will be used to assist in educating staff along with competency evaluation following the training video. Training wil be completed by 10/20/17 All residents have the potential to be affected by the alleged deficient practice. The entire dinning service will be	

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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 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 know they are supposed to be seated while 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.	21805	monitored to assure no other residents were affected. No other concerns have been noted. Yearly staff education on residents rights with the Ombudsman is scheduled to be held on 11/9/17. Compliance Monitoring will be done daily at various meals X 1 week and then weekly X3 weeks. Results will be reviewed with the Quality Assurance Performance Improvement committee.	

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21805	Continued From page 34 SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and implement systems to ensure resident dignity is maintained. The facility could educate all staff on these systems. Random audits for dignity could be done to ensure ongoing compliance. The administrator or designee could take that audit results to the quality assurance group for review and further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure private care information was not accessible to the public for 1 of 1 residents (R1) reviewed for privacy. Findings include: During afternoon care observations on 9/11/17, at	21855	Reviewed the Notice of Privacy Practices policy and is accurate and up to date. 9/14/17 Poster that was posted in R1 room with verbal consent was removed. R1 individual care plan was reviewed and updated. Future type information will be documented on individual "All about me" sheets and updated in the care plan.	10/31/17

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21855	Continued From page 35 4:03 p.m., R1's bathroom was observed to have a bright, colored pink 8 1/2 x 11 inch poster with private care information affixed to the wall, directly next to the bathroom door jam. The poster included R1's first name, and stated (in black letters), staff just a friendly reminder to take your time with me when using the lift, thank you. R1 shared a room with another resident in the facility. The poster was visible from the hallway when R1's bathroom and bedroom door were open. On 9/12/17, at 3:44 p.m., the poster was observed from the hallway, and visitors walked past R1's door. On 9/13/17, at 7:53 a.m and again at 12:15 p.m. the poster was visible from the hallway. R1's care plan dated 3/16/17, indicated R1 needed an EZ stand (mechanical lift) for transfers with staff assist related to weakness. During interview on 9/14/17, at 9:52 a.m. nursing assistant (NA)-A confirmed R1 received visitors, and shared a room with another resident. NA-A indicated each staff member was made aware of each resident's needs by the resident care sheets, the care plans, and identified staff received updated information at the beginning of the shift during report. NA-A reported R1 required assist of one staff and the mechanical lift, and at times would swing her arms out during the transfers. NA-A felt the sign was placed to remind staff to operate the lift slower during the transfer. NA-A confirmed the information on the poster was easily visible to the hallway, and it contained personal care information that should be kept in a private place. During interview on 9/14/17, at 10:00 a.m. nursing assistant (NA)-B confirmed the poster with private care information was affixed to R1's	21855	This was reviewed at Resident Council on 10/2/17. A facility walk thru to assess all areas of the building for any other private health information was posted in view of others. Staff will be re-educated on residents rights and privacy in October by at least one of the following; 1:1 meetings, stand-ups, or scheduled meetings with competency evaluations following education. Yearly staff education on residents rights with the Ombudsman is scheduled to be held on 11/9/17. DON or designee will complete Random monthly facility audits X 3 months to ensure compliance. Audit information will be presented to Quality Assurance and Performance Improvement Committee.	

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21855	Continued From page 36	21855		

bathroom wall. NA-B identified the sign was visible to visitors in the hallway and those that were in the room. NA-B stated the poster was placed on the wall to remind staff to slow down with R1's cares.

During interview on 9/14/17, at 10:36 a.m. registered nurse (RN)-A identified the information on the poster regarding R1 was visible to visitors in the hallway.

During interview on 9/14/17, at 12:49 p.m. the director of nursing (DON) stated the sign was placed on R1's wall following an allegation from R1 that staff had been rough with her. The DON explained after the initial information was collected, R1 denied abuse or mistreatment, and clarified she felt staff had used the mechanical lift too fast when transferring her in and out of the bathroom. The DON stated the poster was then placed on the wall to remind staff to slow down when using the mechanical lift. The DON stated the posted information was direct care information and visible to people in the hallway and visitor's in R1's room. The DON further stated the information should have been placed on the resident care sheet or care plan.

The facility's Notice of Privacy Practices dated 9/2013, indicated staff would protect resident privacy while handling health information. Health information means any information, whether oral, electronic or paper, which is created or received by facility and is related to health care or payment for the provision of medical services.

SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure resident's right to privacy are maintained. The

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21855	Continued From page 37 administrator or designee could educate all staff on thesesystems. The administrator or designee could develop monitoring systems to ensure ongoing compliance. The audit results could be reviewed with the quality assurance group for review and further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21855		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on record review and interview, the facility failed to immediately report to the state agency (SA), and thoroughly investigate observed physical abuse for 1 of 1 resident (R24), an elopement for 1 of 1 resident (R48) and a resident to resident altercation involving 2 of 2 residents (R48, R20). In addition, the facility failed to report to an allegation of physical abuse to the SA in a timely manner for 1 of 1 residents (R24) reviewed for abuse prohibition. Findings include:	21995	SA was notified of all omitted events of allegations of abuse and elopement for R48, R24, R20 and thoroughly investigated in accordance with state laws. Reviewed and revised the VA policy. Staff will be educated on reporting requirements for alleged violations involving abuse, neglect, or mistreatment. Licensed staff will be educated regarding the requirement to initiate an event report when an incident of potential abuse/mistreatment occurs and to report	10/31/17

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21995	Continued From page 38 R24's admission Minimum Data Set (MDS) dated 7/24/17, indicated R24 required limited assistance with activities of daily living (ADL's), and identified moderately impaired cognition and no behaviors. The MDS included diagnoses of depression, anxiety and strain of left Achilles tendon. R24's care plan dated 8/4/17, indicated R24 had a self-care deficit related to surgery on the left Achilles tendon, and required limited assistance of one staff for ADL's. R24's care plan indicated the potential for physical and verbal abuse by others and infliction of abuse on other vulnerable adults. R24's care plan listed various interventions including to encourage R24 to tell of such behavior at time of occurrence, refer to progress note dated 7/24/17 in regards to R24's father. R24's progress notes indicated the following: 7/23/17, at 3:48 p.m.: The note identified R24 was tearful after a telephone conversation and reported to the nurse that her dad was "verbally abusive" to her. R24 stated she did not want him visiting her at the facility. The nurse told R24 her wishes would be communicated to staff. R24 was directed to put her call light on if her dad came to the facility. Staff would could remove her or her dad. R24 agreed to the plan. The nurse informed R24 she would speak with the social service designee (SSD) on 7/24/17. 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	21995	alleged violations of abuse/mistreatment immediately to the Administrator. Licensed staff will also be re-educated to initiate an OHFC report immediately upon notification of a potential abuse/neglect/mistreatment report, investigate any allegations, and report results of the investigation and corrective actions taken to the appropriate officials in accordance with state law. Staff education/ training will be by at least one of the following; 1:1, standups or scheduled meetings held in October, 2017. All new hires will be educated on VA policy during orientation and through SABA -facility electronic education and annually there after and PRN. Reviewed at resident council meeting on 10/2/17 VA policy, if any residents feel unsafe at anytime to report to staff. The Ombudsmen is scheduled to hold education for staff, residents and families in November, 2017. All residents have the potential to be affected if alleged violations are not reported immediately and thoroughly investigated in accordance with state law, through established procedures. IDP team will review daily events for appropriate reporting and on-call RN will review on weekends. Reconciliation of all 2017 events to VA log was completed all omissions have since been submitted to the SA. Social Service or designee will complete weekly audit X3 weeks and monthly X 3 results to be reviewed with QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00762	A. BUILDING: _____ B. WING _____	09/14/2017

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

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21995	Continued From page 39 her safety. Nursing staff was to observe for visitors and R24 was to use call light if she needed assistance due to an unwanted visitor. 8/12/17, at 3:35 p.m.: R24 reported to the nurse that her dad was pushing her outside in the wheelchair. When she asked him to stop pushing her, he hit her on top of the head. R24 stated she was not hurt. The note identified "nurse will continue to watch for her dad, at this time her dad is not here." 8/13/17, at 11:40 a.m.: R24 was in the dining room waiting for dinner when her father approached her. R24 was uncomfortable from the incident on 8/12/17. R24 agreed to sit by the medication cart. When her father came over to the medication cart R24 told her dad she didn't want him to come around so much. R24's father stated he didn't care, he was still her father. Her dad was observed to swat R24 on the side of the arm and then on her thigh. Her dad then laughed and walked away. The nurse told R24 staff would talk to the SSD on 8/14/17. The allegation of physical abuse reported to facility staff on 8/12/17, at 3:35 p.m. was submitted to the SA by the facility on 8/13/17, at 1:35 p.m.. An investigative report was completed and submitted to the SA on 8/17/17, at 2:27 p.m. The physical altercation observed by facility staff on 8/13/17, at 11:40 a.m. between R24 and her father was not reported to the SA. Additionally, the facility did not thoroughly investigate the incident. On 9/14/17, at 1:57 p.m. the social service designee (SSD) verified she was in charge of the abuse prohibition program in the facility. The SSD	21995	committee.	

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21995	Continued From page 40 stated all allegations of abuse are expected to be reported to the SA within two hours, and confirmed R24's reported allegation on 8/12/17 was submitted to the SA late. The SSD indicated R24 had an on again off again relationship with her father. R24 dictated whether or not she wanted him to visit her throughout her stay. The SSD identified R24 was alert and oriented, a reliable historian, and capable of making her needs and desires known. The SSD stated she was not aware of the incident from 8/13/17, at 11:40 a.m. until she got to work on 8/14/17. The SSD verified the incident on 8/13/17, at 11:40 a.m. was not reported to the SA or investigated. The SSD said there was a delay in reporting the incident to her, and the facility needed to revisit the vulnerable adult guidelines. On 9/14/17, at 2:21 p.m. the director of nursing (DON) verified all alleged abuse incidents should be reported to the SA within two hours. The DON verified the report submitted to the SA on 8/13/17 was late. Further, the DON stated there should have been an event report completed which would have confirmed what time the DON, administrator and medical doctor were notified of the 8/12/17, incident. The DON stated she was not aware of the physical altercation between R24 and her father witnessed by facility staff on 8/13/17, until asked by the surveyor on 9/14/17, at 2:30 p.m. The DON then reviewed progress notes stating she did not see much follow up of the 8/13/17, incident. The DON reported staff visited with the SSD and directed R24's dad not to visit. The DON verified the facility did not report the event from 8/13/17, to the SA or complete a thorough investigation. The DON stated the staff member should have followed the vulnerable adult policy. On 9/14/17, 2:35 p.m. the administrator stated she heard about both of R24's incidents, on	21995		

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21995	Continued From page 41 8/12/17, and 8/13/17. The administrator confirmed staff updated her on the situation as soon as they were able and stated it was timely. The administrator verified she expected staff to report observed and alleged abuse within two hours to the SA, after protecting the resident. The administrator identified staff was then to complete a thorough investigation as outlined in the vulnerable adult policy. 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 adminstrator or SA notification. Additionally, the progress notes failed to identify completion of a thorough investigation. R48's significant change MDS dated 6/22/17,	21995		

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21995	Continued From page 42	21995		

indicated R48 had diagnoses which included Alzheimer's disease, dementia, anxiety and depression. R48's MDS identified R48 was severely cognitively impaired and ambulated without a device with supervision. R48's MDS also indicated R48 wandered daily, placing R48 at significant risk of getting to a potentially dangerous place and intruding on the privacy or activities of others.

R48's behavioral symptoms Care Area Assessment (CAA) dated 6/27/17, indicated R48 wandered through out the facility and attempted to exit the facility. The CAA also indicated R48 wore a bracelet on her ankle to alert staff when she was leaving the building.

R48's nursing progress note created by registered nurse (RN)-A dated 7/24/17, indicated the north door alarm sounded and when a nursing assistant (NA)-F walked outside R48 was not seen, but noted the back door to the house immediately north of the facility was closing. R48 was located inside the house and was reluctant to accompany NA-F back to the facility.

Safety Events-Essentia Elopement (11/2010), dated 7/24/17, indicated R48 exited the facility through the north door, walked across a parking lot and entered the back door of a neighboring house. Staff went out to get R48 but was unable to see her right away. Staff noted the back door to the house immediately north of the facility was closing. R48 was inside the house and "reluctantly" accompanied staff back to the facility. The report indicated R48 often talked about "getting out of here" and going home. R48 attempted to go out doors and sometimes made it outside. A wanderguard was in place and worked properly. R48 was very difficult to redirect related

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21995	Continued From page 43 to impaired short term memory and inattention. The report did not indicate if the SA was notified of the vulnerable adult incident. During interview on 9/14/17, at 1:19 p.m. RN-A stated she was working the day of 7/23/17, and was the charge nurse for the facility. RN-A recalled the elopement and stated R48 was really active that day and she just couldn't settle down. R48 walked out the north door, the alarm went off and a nursing assistant saw the back door of the neighboring house closing. The nursing assistant went to the house and returned with R48. RN-A could not recall if she reported the elopement to anyone. RN-A confirmed she did not make a vulnerable adult report with the SA regarding this elopement. During an interview on 9/14/17, at 2:33 p.m. the DON confirmed that R48 eloped from the building on 7/23/17, and walked into the neighboring house. The DON stated R48 was at risk for elopement and depended on facility staff for safety, because R48 lacked safety awareness. The DON confirmed an elopement assessment was completed on R48 upon admission and a wanderguard was applied. She confirmed she was made aware of the elopement on during an interdisciplinary meeting review of the event on 7/25/17. The DON stated a vulnerable adult report was not completed for this elopement. The DON indicated she would expect nursing staff to report an elopement off property to the SA within two hours of the elopement. The DON could not identify if the administrator was updated on this elopement. R20 and R48 had an altercation which was not immediately reported to the SA or thoroughly investigated.	21995		

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21995	Continued From page 44 R20's progress note dated 8/19/17, indicated R20 was hit in the back by another resident (R48) that evening and to see incident report for further information. R20's admission MDS dated 7/3/17, indicated R20 had diagnoses which included a non-displaced fracture of the fifth metatarsal of the right foot, type II Diabetes Mellitus with diabetic polyneuropathy (damage to peripheral nerves that causes weakness, numbness and burning pain), and depression. R20's MDS indicated R20 was cognitively intact. R20's MDS identified she had daily verbal behaviors that put her at risk for physical injury and significantly interfered with her social interactions. Behavior and Mood Events Essentia Aggressive/Combative Behavior (11/2010) dated 8/19/17, indicated R48 hit R20 on the mid-back area. Prior to R48's aggressive/combative behavior R48 was wandering around in the North Day Room. Event report indicated R48's mental function varied over the course of the day, was usually on the move physically, had anxiety, restlessness, and behaviors throughout each day. The report also indicated R48 was easily annoyed with other residents and very difficult to redirect. The event report indicated R48 had physical behavior symptoms directed toward others on four to six days a week, verbal behaviors daily, and other behavioral symptoms not directed towards others like pacing/rummaging daily that put others at significant risk for physical injury. The report stated R20 was "angry" and upset that R48 hit her. Progress notes indicated on 8/21/17, the interdisciplinary team (IDT) reviewed the behavior of R48. The IDT's indicated they would continue to encourage rummaging and activities	21995		

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21995	Continued From page 45	21995		

in safe areas to attempt to occupy R48's time and attention. It also indicated that a discussion with R48's physician about medications and possible placement in behavioral health facility for medication management. Another progress note for R20 dated 8/29/17, indicated that SSD-A discussed the event with R20. R20 stated "I went to the kitchen to throw away my ice cream cup. When I stood up she was behind me and hit my backside. It didn't hurt it just startled me. I thought [R48] was still by the other doors, she sure moves fast."

On 9/14/17, at 2:45 p.m., the DON stated the event of aggressive/combative behavior on 8/19/17, appeared to be R48 hitting another resident (R20) on the back. The normal response by the facility to a resident to resident altercation would be to immediately intervene to make sure each resident was safe and file a vulnerable adult (VA) report. The DON confirmed a VA report was not filed for this resident to resident altercation. The DON confirmed the adminstrator was not updated. The DON identified she would expect a resident to resident altercation to be reported to the administrator and SA immediately. The DON stated R48 was at risk for physical and verbal abuse from others due to her wandering.

On 9/14/17, at 2:55 p.m., the administrator stated if an event occurred requiring a vulnerable adult report, the administrator would expect to be notified immediately.

The facility's Combined Vulnerable Adult Policy Adult Abuse Prevention Plan Reporting Procedures Policy dated 1/19/17, indicated all abuse, neglect and misappropriation of resident property would be reported to the administrator and state agencies immediately.

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21995	Continued From page 46 SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise abuse/neglect systems. The administrator or designee could ensure all staff are educated on the system for Abuse/Neglect reporting. The administrator or designee could establish a system to audit to ensure all allegations are properly reported and investigated. The administrator or designee could report audit results to the quality assurance performance improvement (QAPI) committee for review and further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21995		

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	245579	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/12/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Essentia Health - Grace Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000		

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

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.

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Essentia Health - Grace Home is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1976 and was determined to be of Type II(111) construction. In 1998, 3 additions were added to the southeast, northeast and northwest that were determined to be of Type II(111)construction. Because the original building and the addition meet the construction types allowed for existing buildings, the facility was surveyed as one building. The building is protected by a complete fire sprinkler system. The facility has a fire alarm system with smoke detection by the smoke barrier doors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 45 beds and had a census of 35 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 920 SS=C	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure a multiple outlet connection was in accordance with the 2012 edition of NFPA 99 section 10.2.3.6 item 2 for total ampacity. This deficient practice could cause an overload of a circuit which could cause a power outage to necessary equipment or cause a	K 920	Medical equipment in room 37 has been removed from power strip and plugged directly into a wall outlet. Completed 9/15/17 Refrigerator in room 13 has been removed from power strip and plugged	10/31/17

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K 920	Continued From page 3 fire. This could affect 15 of the 35 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 09/12/2017 observations and staff interview revealed: 1) Resident room 13 a refrigerator plugged into a power strip. 2)Resident room 37 medical equipment was plugged into a power strip. This deficient practice was verified by the Maintenance Manager.	K 920	directly into a wall outlet. completed 10/4/17 All resident rooms have been inspected so that there are no problems with outlets and power strips. completed 9/19/17 Flyers were distributed to highlight the importance of electrical safety, use of power strips and emergency outlets. completed 10/3/17 Resident rooms will be put on a monthly walk through to inspect outlets and power strips. The information will be recorded in a log. Tom Montonye, maintenance supervisor or designee will be responsible to see that the work is completed. The repair information will be submitted to the safety committee and Quality Assurance Performance Improvement committee for review.	