Electronically Submitted
October 13, 2021

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

RE: CCN: 245579
Cycle Start Date: September 23, 2021

Dear Administrator:

On September 23, 2021, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On September 23, 2021, the situation of immediate jeopardy to potential health and safety cited at F 803 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 28, 2021.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 28, 2021, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 28, 2021, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 23, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 23, 2022 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of

substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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 plan of correction. A copy of the Department's informal

dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
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

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 _____	C 09/23/2021

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 On 9/16/21 through 9/23/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5579019C (MN76587), with a deficiency cited at F803. The survey resulted in an Immediate Jeopardy (IJ) at F803 when the facility failed to ensure the correct diet was served to 3 of 3 residents (R1, R2, R3) reviewed for diet. This resulted in an immediate jeopardy for R1, who was served bite sized fruit larger than ½ inch in size per physician orders which caused R1 to choke and had to be walked to the Emergency Department where R1 self-expelled a piece of fruit 2.7 by 2.0 cm in size. Additionally, R2 and R3 were served food against physician orders. The IJ began on 9/17/21, and the immediacy was removed on 9/23/21, at 1:45 p.m. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		

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

Electronically Signed | 10/20/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245579	A. BUILDING _____ B. WING _____	C 09/23/2021

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 803 SS=J	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the correct diet was served to 3 of 3 residents (R1, R2, R3) reviewed for diet. This resulted in an immediate jeopardy for R1, who was served bite sized fruit larger than ½ inch in size per physician orders which caused R1 to choke and had to be walked to the Emergency Department where R1 self-expelled a piece of fruit 2.7 by 2.0 cm in size.	F 803	R1, R2 and R3 were evaluated by speech therapy for safest appropriate diet textures. Reeducation and re-training provided for cooks on tools and equipment, accuracy of diet ordered and production policy, International dysphasia diet standardization initiative diet textures (IDDSI).	10/22/21

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 _____	C 09/23/2021

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 803	Continued From page 2 Additionally, R2 and R3 were served food against physician orders. The immediate jeopardy began on 9/9/21, when R1 was served bite sized fruit larger than ½ inch in size per physician orders, which resulted in R1 choking. R1 ate the fruit, and had a choking episode, however, did not require the Heimlich maneuver, due to being able to talk at the time of the incident. The administrator, director of nursing and certified dietary manager were notified of the immediate jeopardy at 3:16 p.m. on 9/17/21. The immediate jeopardy was removed on 9/23/21, at 1:45 p.m. but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's quarterly Minimal Data Set (MDS) dated 7/12/21, indicated R1 had diagnoses which included diabetes, dementia and had severe cognitive impairment. Further review of MDS, R1 required extensive assistance of one staff member for most activities of daily living (ADLS) and required supervision after set up for eating. R1's care plan printed 9/17/21, identified R1 was a safety risk due to history of choking and required reminders to alternate bites and fluids while eating. R1's nutrition interventions included supervision by staff for cueing and all foods cut into ½ inch in size bites or smaller. R1's diet order per order summary as of 1/18/21, indicated mechanical soft and cut all food into ½ inch in size bites with staff to encourage	F 803	Facility reviewed 100% of all resident diet orders. 100% of all dietary tray cards have been reviewed to ensure accuracy with physician orders. Speech therapy screened all residents receiving modified diet textures for the safest and appropriate diet textures. The facility reviewed and revised accuracy of diet ordered and production policy. Reeducation and re-training provided to cooks on tools and equipment, accuracy of diet ordered and production policy, International dysphasia diet standardization initiative diet textures (IDDSI). Education was provided to designated personnel that will dish and pass meals on the revised accuracy of diet ordered and production policy and standard work followed by competency evaluation. Audits will be completed at mealtime daily x 7 days, then randomly x two weeks, then monthly to ensure the diet ordered is consistent with the meal served. Results of these audits will be reported to the QAPI committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245579	A. BUILDING _____ B. WING _____	C 09/23/2021

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 803	Continued From page 3	F 803		

alternating food and fluid and to eat slowly.

R1's dietary card as of 9/9/21, indicated regular, soft and bite sized foods cut in ½ inch size bites.

Review of R1's progress notes:
-On 9/9/21, "Resident choked on cut up cantaloupe at dinner. States feels like something stuck in throat. Noting poor air exchange. Will send to ER and notify family."
- On 9/9/21, "Resident returned from hospital and was able to clear obstruction per self."
- On 9/10/21, "Review of choking episode on 9-9-21. SLP [speech language pathologist] screen requested for swallowing and for appropriate diet textures."
- On 9/16/21, "Resident seen by speech today new orders recommended for diet change. Will recommend diet of minced and moist and to continue with thin liquids."

Review facility report dated 9/9/21, R1 was eating "cut up" cantaloupe and "started to choke." R1 was able to cough up phlegm and some cantaloupe but continued to state some was still stuck in R1's throat. R1 was walked to the Emergency Room (ER) by facility staff.

Review of Emergency Department Provider Notes dated 9/9/21, indicated R1 was brought to the ER due to "concern for food obstruction." R1 did present to the ER sounding hoarse and attempting to clear throat. R1 received an X-ray which showed there was a 2.7 cm by 2.0 cm "cube-shaped density projecting in the hypopharynx". R1 was able to expel a piece of cantaloupe while in the ER at 2:45 p.m. which a repeat X-ray was completed and showed "resolution of foreign body."

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 _____	C 09/23/2021

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 803	Continued From page 4	F 803		

On 9/16/21, at 1:33 p.m. nursing assistant (NA)-A indicated dietary cook (DC)-A and dietary director (DD) worked in the kitchen during the noon meal on 9/9/21. NA-A indicated she was at the dining room table with R1 on 9/9/21, when R1 began to choke on a piece of cantaloupe. NA-A stated, "I could tell something was lodged in her throat by the way she was talking" and NA-A called for licensed practical nurse (LPN)-A to respond. NA-A indicated R1 continued to wheeze and was brought over to the ER. In addition, NA-A indicated she was across the table from R1 and "I just figured they [dietary] are the ones serving. They served it [cantaloupe] and dished it so it should be right. I would hope that the kitchen would get it right."

On 9/16/21, at 1:56 p.m. LPN-A indicated R1 required supervision "because she wants to shovel everything in" and NA-A was assisting with cues for R1 on 9/9/21, the day of the choking incident. LPN-A indicated R1 had "a bowl of cantaloupe cut up she was eating. She can have cantaloupe if it is cut small enough. I don't think it was cut small enough because she got one stuck." LPN-A indicated she was called down to the dining room by NA-A, and LPN-A then noted R1 was "coughing and couldn't breathe" but was still talking so the Heimlich maneuver was not performed. R1 went back to her room and continued to try to cough it up but was unsuccessful, so R1 was brought to the ER since "we couldn't do anything to get it out."

On 9/16/21, at 4:02 p.m. NA-B stated R1 required supervision with cues to slow down while eating and her diet order is soft and ½ inch bite sized foods. Further, NA-B indicated the dietary cook

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 _____	C 09/23/2021

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 803	Continued From page 5	F 803		

will cut up the resident's food if there is a physician's order (i.e. ½ inch bite). NA-B indicated R1 had a "choking episode" when R1 consumed cantaloupe "which it was not soft that day at all and I would say bigger than ½ inch bites. They looked like regular sized bites given to everyone not specifically cut up for her [R1]."

On 9/16/21, at 5:01 p.m. when asked about the process for serving and dishing of meal trays, dietary aid (DA)-A indicated the dietary cook (DC) will plate the foods and the dietary aid will deliver the food to the residents in the dining room. Further, DA-A indicated the DC will reference the diet card that is on the tray with the specific resident's diet order while plating the food to ensure appropriate food is dished and then the DA will take the card with the tray and plate of food to the identified resident and check "to make sure everything matches up." In addition, DA-A indicated she had heard R1 had a choking incident but was unsure of any other details and confirmed there has been no education since the incident.

On 9/16/21, at 5:14 p.m. when asked what the facility's process was for serving meals, DC-A indicated the DC will "dish the plate and the aids will pass the plate to the resident. We have cards that tell you what diet for each resident and what mechanically altered foods they need. The cook cuts up the food if they are soft and bite sized prior to going out to the resident." However, DC-A stated, "a bite size is about one half inch piece and we just cut it with a knife into small bite sized pieces. It is just eyeball or guess, I guess. They don't have a tool or measuring device to cut things." DC-A confirmed she cut up R1's cantaloupe that day into "smaller pieces" and DD

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 _____	C 09/23/2021

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 803	Continued From page 6	F 803		

passed out the cups of fruit and did not ask DC-A which cup was R1's. In addition, DC-A indicated she was not aware that R1 had choked and there has not been any education provided "since the beginning of summer".

On 9/17/21, at 9:00 a.m. social service designee (SSD) indicated she completed the internal investigation for the report that was made regarding R1's choking incident. SSD indicated she interviewed LPN-A and NA-A on the incident and followed up with the ER as well. SSD indicated monitoring was initiated for R1 upon her return from the ER, to ensure no aspiration was noted after the choking incident. Further, SSD indicated at the time of the incident, R1's care plan was followed for her diet order. SSD confirmed she read the ER provider note dated 9/9/21, and when asked if the 2.7 cm by 2.0 cm piece of cantaloupe that was expelled from R1 at the ER was a ½ inch bite, SSD stated "oh yes, it is smaller." However, surveyor and SSD converted the cm into inches, SSD then stated, "with that being said, the care plan was not followed. I guess I didn't do the math conversion." In addition, SSD stated there was no education provided to staff and "just focused on in report carrying over the importance of diet texture and being aware of what resident's current diets are."

On 9/17/21, at 9:16 a.m. when asked what facility's process for serving meals was DD indicated the DC will set up the tray by dishing the food onto the plates and the DC was "responsible for mechanically altered textured foods. The food should be cut by the cook for one half inch pieces. We [dietary] don't have a tape measure or ruler it would just be smaller pieces than the rest approximately one half inch in size." Further, DD

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 _____	C 09/23/2021

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 803	Continued From page 7	F 803		

indicated R1 was prescribed a soft and bite sized diet related to a history of choking. DD indicated NA-A informed him of R1's choking incident on 9/9/21, and "it was reported she had multiple pieces in her mouth." R1 was brought to the ER because "she felt like there was still another piece she couldn't get up." DD indicated at the time of the incident, R1's care plan was being followed and indicated the food she consumed was bite sized pieces. DD confirmed he had not reviewed the ER provider note from 9/9/21. When surveyor converted 2.7 cm by 2.0 cm was into inches with DD, DD stated "it seems that piece would have been slightly larger than what it should have been." In addition, DD indicated since R1's choking incident there was no education provided to dietary staff "other than communication sheet that they should be following appropriateness for texture and preferences" however, DD confirmed the communication sheet was not specific to R1 or R2's incidents of receiving the wrong diet order. At approximately 10:34 a.m. DD indicated staff were expected to follow the resident's diet cards.

On 9/17/21, at 10:39 a.m. director of nursing (DON) indicated SSD completed the investigation after it was reported R1 choked on a piece of cantaloupe. DON indicated the root cause of the incident was related to R1 not chewing the cantaloupe causing her to choke. Further, DON indicated at the time of the incident R1's care plan was being followed. When asked if she reviewed the ER provider note dated 9/9/21, DON stated "I never seen the full details of the note until today. I reviewed it all today and I know what you are referring to about the size of the piece that was observed and it was 2.7 cm by 2.0 cm which is larger than a half inch." In addition, DON

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 _____	C 09/23/2021

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 803	Continued From page 8	F 803		

then confirmed R1's care plan was not being followed at the time of the incident. DON indicated staff are expected to ensure ½ inch pieces are ½ inch pieces and the importance of following resident's diet for the resident's safety.

R2's quarterly MDS dated 7/22/21, indicated R2's diagnoses included stroke and moderately impaired cognitive skills. Further review of MDS, R2 required extensive assist of one staff member for most ADLs which included toileting, hygiene, dressing and required supervision while eating.

R2's care plan printed 9/17/21, indicated R2 was independent with eating after set up. Further review of care plan, indicated R2's diet order as of 8/31/21, was regular soft and bite sized foods.

R2's diet card in the morning of 9/17/21, identified regular soft and bite sized food.

Review of R2's progress notes:
-On 8/31/21, during a dietary observation R2 consumed chicken breast cut into bite size pieces and did well. "Resident ate 100% of chicken breast 8/26 and 8/27 and bacon for breakfast 8/26. Discusses plan of care with dietary staff for use of plates and offering bacon daily."
-On 9/9/21, "resident has shown interest in consuming bacon daily at breakfast."
-On 9/17/21, at 9:14 a.m. "provider updated on resident's increased interest in chicken breast and bacon. SLP orders obtained to eval [evaluate], treat and follow their recommendations for appropriate diet modifications."
-On 9/17/21, at 9:17 a.m. "left message for hospice to call back for update on SLP new

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 _____	C 09/23/2021

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 803	Continued From page 9	F 803		

orders."
-On 9/17/21, at 9:25 a.m. "therapy notified of SLP eval [evaluation] orders."
-On 9/17/21, at 9:30 a.m. "hospice returned call and okay with SLP orders for diet modifications."

On 9/17/21, at 8:40 a.m. R2 was observed sitting in her wheelchair in the doorway of her room with her bedside table in front of her and her breakfast tray on top. R2's tray contained one plate with a pastry cut into small pieces, and a second plate that contained strips of bacon that appeared to be cut in half and crispy. However, R2 was not observed consuming any of the food on her tray at that time.

On 9/17/21, at 8:45 a.m. when asked what R2's diet order was, NA-C looked at R2's diet card on breakfast tray and stated, "it is regular soft and bite sized." Further, when asked about the crispy bacon on R2's plate, NA-C began to cut up the bacon into bite sized pieces and confirmed bacon was not cut into bite sized pieces and was not soft per physician's orders. In addition, NA-C left the plate of bacon in front of R2 and walked away to assist another resident with their meal.

On 9/17/21, at 8:53 a.m. when asked about R2's diet order, DON confirmed R2 requires regular soft and bite sized pieces. Further, DON stated "they [dietary] have been doing a trial with her. I believe they have consulted with hospice on the trial." DON indicated dietary staff were aware of the trial but was "unsure" if the physician was aware or if there was an order to upgrade R2's diet. However, the plate continued to remain on R2's tray table but R2 was not observed eating the crispy bacon.

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 _____	C 09/23/2021

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 803	Continued From page 10	F 803		

On 9/17/21, at 9:16 a.m. DD indicated R2's diet order was soft and bite sized textured foods. Further, DD stated "I have trialed food items with her per her request." At approximately 1:25 p.m. DD stated "crispy bacon is not part of her diet." Further, DD indicated the process for upgrading a resident's diet was for the resident to be screened by a speech language pathologist (SLP) prior to giving the resident any food out of their diet order. DD confirmed that prior observation of R2 receiving the wrong diet order for breakfast on 9/17/21, there had been no communication with R2's hospice staff, physician, or SLP. In addition, DD stated he expected staff to complete a screen form for SLP to evaluate the resident prior to providing the resident with the food due to risk of swallowing and chewing difficulties.

On 9/17/21, at 12:59 p.m. DON indicated during the incident observed on 9/17/21, R2's diet order was regular soft and bite sized "solids" and confirmed "the bacon that was served today was not following her diet." Further, DON indicated staff were expected to follow the facility policy "which is to complete a request for a therapy screen and follow the recommendations prior to giving them against their [resident's] diet orders"

On 9/17/21, at 1:09 p.m. SLP indicated she was notified on 9/17/21, by facility staff, who requested a speech evaluation for R2, due to R2 requesting bacon "which was not part of her soft and bite sized diet."

R3's quarterly MDS dated 7/29/21, indicated R3 had diagnoses which included diabetes, dementia and moderate cognitive impairment. Further review of MDS, indicated R3 was independent

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 _____	C 09/23/2021

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 803	Continued From page 11	F 803		

with ADLS and eating after setting up only.

R3's care plan printed 9/17/21, indicated R3 receives a therapeutic diet due to diagnoses of chronic heart failure and diabetes with interventions that included "canned fruit ok", independent with eating in main dining room and minced and moist textured food.

Review of R3's dietary card printed on 9/17/21, indicated R3's diet order was minced and moist textures and disliked cantaloupe.

On 9/16/21, at 1:33 a.m. NA-A indicated on 9/9/21, which was the same day R1 had a choking episode, when she was picking up room trays after the noon meal, she observed R3 was served a cup of cut up cantaloupe and noted on R3's diet card it indicated R3 was minced and moist textured foods. NA-B indicated the cantaloupe appeared to not be consumed by R3 due to R3 disliking cantaloupe NA-B notified DD immediately after discovering R3 was served the wrong texture diet. NA-B stated to DD "this is the exact reason [R1] is in the ER".

On 9/16/21, at 4:02 p.m. NA-B indicated R2 was served cantaloupe that was not "minced and moist" on 9/9/21. NA-B indicated she reported it to the DD with NA-A immediately.

On 9/17/21, at 9:16 a.m. DD indicated he was aware R3 received cut up cantaloupe on 9/9/21. Further, DD stated R3's diet was ordered as minced and moist and was "approved" to have toast and canned fruit. DD indicated he was unsure who gave R3 the cup of cut up cantaloupe on 9/9/21, but indicated he "addressed it to the staff that the care plan was not followed" and R3

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 _____	C 09/23/2021

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 803	Continued From page 12	F 803		

should have received a cup of canned fruit instead.

Review of facility policy titled Notification and Documentation of Nutritional Cares dated 6/19, indicated "Nursing and Dietary Staff will monitor for nutritional changes. Recommended changes to diet plan will be assessed by completing a Screen to Therapies. Documentation of changes will be made in Progress notes and/or screenings and these changes will be addressed in residents care plan."

The immediate jeopardy that began on 9/17/21, at 3:16 p.m. was removed on 9/23/21, at 1:45 p.m. when it was verified by observation, interview and document review the facility reviewed and implemented new dietary policies on accuracy of diet ordered and production and the facility trained dietary aids and nursing staff on the need to ensure dietary tickets were checked prior to a resident being served food.

Implementations included:
-Staff education was provided to dietary staff and nursing staff via video on diet orders and mechanically altered diet types. Staff were to complete a competency quiz as well.
-Policy titled Accuracy of Diet Ordered and Production was reviewed.
-Process developed for dishing and serving meals.
-Audits were completed on compliance of current diet order.
-Residents who received a mechanically altered diet were reviewed and dietary cards were reviewed to ensure accuracy with physician's orders.
-Residents who received a mechanically altered

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 _____	C 09/23/2021

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 803	Continued From page 13 diet were evaluated by a speech language pathologist and modifications were made to diets as needed.	F 803		

Electronically delivered
October 13, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: 23JW11

Dear Administrator:

The above facility was surveyed on September 16, 2021 through September 23, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
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

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 _____	C 09/23/2021

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) COMPLETE DATE
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: On 9/16/21 through 9/23/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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 _____	C 09/23/2021

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) COMPLETE DATE
2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5579019C (MN76587) with a licensing order issued at 1050. 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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 _____	C 09/23/2021

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) COMPLETE DATE
2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21050	MN Rule 4658.0625 Subp. 1 Menus; Meal Planning Subpart 1. Menu planning. All menus must be planned in advance, dated, and followed. Any changes in the meals actually served must be of equal nutritional value. The general menu for a seven-day period must be posted prior to the start of that seven-day period at a location readily accessible to residents, and any changes to the general menu must be noted on that posted menu. All menus and any changes for the current and following seven-day periods must be posted in the dietary area. Records of menus and of foods purchased must be filed for six months. A variety of foods must be provided. A file of tested recipes adjusted to a yield appropriate for the size of the home must be maintained. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the correct diet was served to 3 of 3 residents (R1, R2, R3) reviewed for diet. This resulted in an immediate jeopardy for R1, who was served bite sized fruit larger than ½ inch in size per physician orders which caused R1 to choke and had to be walked to the Emergency Department where R1 self-expelled a piece of fruit 2.7 by 2.0 cm in size. Additionally, R2 and R3 were served food against	21050	Corrected	10/22/21

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 _____	C 09/23/2021

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) COMPLETE DATE
21050	Continued From page 3 physician orders. The immediate jeopardy began on 9/9/21, when R1 was served bite sized fruit larger than ½ inch in size per physician orders, which resulted in R1 choking. R1 ate the fruit, and had a choking episode, however, did not require the Heimlich maneuver, due to being able to talk at the time of the incident. The administrator, director of nursing and certified dietary manager were notified of the immediate jeopardy at 3:16 p.m. on 9/17/21. The immediate jeopardy was removed on 9/23/21, at 1:45 p.m. but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's quarterly Minimal Data Set (MDS) dated 7/12/21, indicated R1 had diagnoses which included diabetes, dementia and had severe cognitive impairment. Further review of MDS, R1 required extensive assistance of one staff member for most activities of daily living (ADLS) and required supervision after set up for eating. R1's care plan printed 9/17/21, identified R1 was a safety risk due to history of choking and required reminders to alternate bites and fluids while eating. R1's nutrition interventions included supervision by staff for cueing and all foods cut into ½ inch in size bites or smaller. R1's diet order per order summary as of 1/18/21, indicated mechanical soft and cut all food into ½ inch in size bites with staff to encourage alternating food and fluid and to eat slowly.	21050		

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 _____	C 09/23/2021

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) COMPLETE DATE
21050	Continued From page 4	21050		

R1's dietary card as of 9/9/21, indicated regular, soft and bite sized foods cut in ½ inch size bites.

Review of R1's progress notes:
-On 9/9/21, "Resident choked on cut up cantaloupe at dinner. States feels like something stuck in throat. Noting poor air exchange. Will send to ER and notify family."
- On 9/9/21, "Resident returned from hospital and was able to clear obstruction per self."
- On 9/10/21, "Review of choking episode on 9-9-21. SLP [speech language pathologist] screen requested for swallowing and for appropriate diet textures."
- On 9/16/21, "Resident seen by speech today new orders recommended for diet change. Will recommend diet of minced and moist and to continue with thin liquids."

Review facility report dated 9/9/21, R1 was eating "cut up" cantaloupe and "started to choke." R1 was able to cough up phlegm and some cantaloupe but continued to state some was still stuck in R1's throat. R1 was walked to the Emergency Room (ER) by facility staff.

Review of Emergency Department Provider Notes dated 9/9/21, indicated R1 was brought to the ER due to "concern for food obstruction." R1 did present to the ER sounding hoarse and attempting to clear throat. R1 received an X-ray which showed there was a 2.7 cm by 2.0 cm "cube-shaped density projecting in the hypopharynx". R1 was able to expel a piece of cantaloupe while in the ER at 2:45 p.m. which a repeat X-ray was completed and showed "resolution of foreign body."

On 9/16/21, at 1:33 p.m. nursing assistant (NA)-A indicated dietary cook (DC)-A and dietary director

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 _____	C 09/23/2021

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) COMPLETE DATE
21050	Continued From page 5	21050		

(DD) worked in the kitchen during the noon meal on 9/9/21. NA-A indicated she was at the dining room table with R1 on 9/9/21, when R1 began to choke on a piece of cantaloupe. NA-A stated, "I could tell something was lodged in her throat by the way she was talking" and NA-A called for licensed practical nurse (LPN)-A to respond. NA-A indicated R1 continued to wheeze and was brought over to the ER. In addition, NA-A indicated she was across the table from R1 and "I just figured they [dietary] are the ones serving. They served it [cantaloupe] and dished it so it should be right. I would hope that the kitchen would get it right."

On 9/16/21, at 1:56 p.m. LPN-A indicated R1 required supervision "because she wants to shovel everything in" and NA-A was assisting with cues for R1 on 9/9/21, the day of the choking incident. LPN-A indicated R1 had "a bowl of cantaloupe cut up she was eating. She can have cantaloupe if it is cut small enough. I don't think it was cut small enough because she got one stuck." LPN-A indicated she was called down to the dining room by NA-A, and LPN-A then noted R1 was "coughing and couldn't breathe" but was still talking so the Heimlich maneuver was not performed. R1 went back to her room and continued to try to cough it up but was unsuccessful, so R1 was brought to the ER since "we couldn't do anything to get it out."

On 9/16/21, at 4:02 p.m. NA-B stated R1 required supervision with cues to slow down while eating and her diet order is soft and ½ inch bite sized foods. Further, NA-B indicated the dietary cook will cut up the resident's food if there is a physician's order (i.e. ½ inch bite). NA-B indicated R1 had a "choking episode" when R1 consumed cantaloupe "which it was not soft that day at all

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 _____	C 09/23/2021

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) COMPLETE DATE
21050	Continued From page 6 and I would say bigger than ½ inch bites. They looked like regular sized bites given to everyone not specifically cut up for her [R1]." On 9/16/21, at 5:01 p.m. when asked about the process for serving and dishing of meal trays, dietary aid (DA)-A indicated the dietary cook (DC) will plate the foods and the dietary aid will deliver the food to the residents in the dining room. Further, DA-A indicated the DC will reference the diet card that is on the tray with the specific resident's diet order while plating the food to ensure appropriate food is dished and then the DA will take the card with the tray and plate of food to the identified resident and check "to make sure everything matches up." In addition, DA-A indicated she had heard R1 had a choking incident but was unsure of any other details and confirmed there has been no education since the incident. On 9/16/21, at 5:14 p.m. when asked what the facility's process was for serving meals, DC-A indicated the DC will "dish the plate and the aids will pass the plate to the resident. We have cards that tell you what diet for each resident and what mechanically altered foods they need. The cook cuts up the food if they are soft and bite sized prior to going out to the resident." However, DC-A stated, "a bite size is about one half inch piece and we just cut it with a knife into small bite sized pieces. It is just eyeball or guess, I guess. They don't have a tool or measuring device to cut things." DC-A confirmed she cut up R1's cantaloupe that day into "smaller pieces" and DD passed out the cups of fruit and did not ask DC-A which cup was R1's. In addition, DC-A indicated she was not aware that R1 had choked and there has not been any education provided "since the beginning of summer".	21050		

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 _____	C 09/23/2021

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) COMPLETE DATE
21050	Continued From page 7 On 9/17/21, at 9:00 a.m. social service designee (SSD) indicated she completed the internal investigation for the report that was made regarding R1's choking incident. SSD indicated she interviewed LPN-A and NA-A on the incident and followed up with the ER as well. SSD indicated monitoring was initiated for R1 upon her return from the ER, to ensure no aspiration was noted after the choking incident. Further, SSD indicated at the time of the incident, R1's care plan was followed for her diet order. SSD confirmed she read the ER provider note dated 9/9/21, and when asked if the 2.7 cm by 2.0 cm piece of cantaloupe that was expelled from R1 at the ER was a ½ inch bite, SSD stated "oh yes, it is smaller." However, surveyor and SSD converted the cm into inches, SSD then stated, "with that being said, the care plan was not followed. I guess I didn't do the math conversion." In addition, SSD stated there was no education provided to staff and "just focused on in report carrying over the importance of diet texture and being aware of what resident's current diets are." On 9/17/21, at 9:16 a.m. when asked what facility's process for serving meals was DD indicated the DC will set up the tray by dishing the food onto the plates and the DC was "responsible for mechanically altered textured foods. The food should be cut by the cook for one half inch pieces. We [dietary] don't have a tape measure or ruler it would just be smaller pieces than the rest approximately one half inch in size." Further, DD indicated R1 was prescribed a soft and bite sized diet related to a history of choking. DD indicated NA-A informed him of R1's choking incident on 9/9/21, and "it was reported she had multiple pieces in her mouth." R1 was brought to the ER because "she felt like there was still another piece	21050		

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 _____	C 09/23/2021

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) COMPLETE DATE
21050	Continued From page 8	21050		

she couldn't get up." DD indicated at the time of the incident, R1's care plan was being followed and indicated the food she consumed was bite sized pieces. DD confirmed he had not reviewed the ER provider note from 9/9/21. When surveyor converted 2.7 cm by 2.0 cm was into inches with DD, DD stated "it seems that piece would have been slightly larger than what it should have been." In addition, DD indicated since R1's choking incident there was no education provided to dietary staff "other than communication sheet that they should be following appropriateness for texture and preferences" however, DD confirmed the communication sheet was not specific to R1 or R2's incidents of receiving the wrong diet order. At approximately 10:34 a.m. DD indicated staff were expected to follow the resident's diet cards.

On 9/17/21, at 10:39 a.m. director of nursing (DON) indicated SSD completed the investigation after it was reported R1 choked on a piece of cantaloupe. DON indicated the root cause of the incident was related to R1 not chewing the cantaloupe causing her to choke. Further, DON indicated at the time of the incident R1's care plan was being followed. When asked if she reviewed the ER provider note dated 9/9/21, DON stated "I never seen the full details of the note until today. I reviewed it all today and I know what you are referring to about the size of the piece that was observed and it was 2.7 cm by 2.0 cm which is larger than a half inch." In addition, DON then confirmed R1's care plan was not being followed at the time of the incident. DON indicated staff are expected to ensure ½ inch pieces are ½ inch pieces and the importance of following resident's diet for the resident's safety.

R2's quarterly MDS dated 7/22/21, indicated R2's

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 _____	C 09/23/2021

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) COMPLETE DATE
21050	Continued From page 9	21050		

diagnoses included stroke and moderately impaired cognitive skills. Further review of MDS, R2 required extensive assist of one staff member for most ADLs which included toileting, hygiene, dressing and required supervision while eating.

R2's care plan printed 9/17/21, indicated R2 was independent with eating after set up. Further review of care plan, indicated R2's diet order as of 8/31/21, was regular soft and bite sized foods.

R2's diet card in the morning of 9/17/21, identified regular soft and bite sized food.

Review of R2's progress notes:
-On 8/31/21, during a dietary observation R2 consumed chicken breast cut into bite size pieces and did well. "Resident ate 100% of chicken breast 8/26 and 8/27 and bacon for breakfast 8/26. Discusses plan of care with dietary staff for use of plates and offering bacon daily."
-On 9/9/21, "resident has shown interest in consuming bacon daily at breakfast."
-On 9/17/21, at 9:14 a.m. "provider updated on resident's increased interest in chicken breast and bacon. SLP orders obtained to eval [evaluate], treat and follow their recommendations for appropriate diet modifications."
-On 9/17/21, at 9:17 a.m. "left message for hospice to call back for update on SLP new orders."
-On 9/17/21, at 9:25 a.m. "therapy notified of SLP eval [evaluation] orders."
-On 9/17/21, at 9:30 a.m. "hospice returned call and okay with SLP orders for diet modifications."

On 9/17/21, at 8:40 a.m. R2 was observed sitting in her wheelchair in the doorway of her room with her bedside table in front of her and her breakfast

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 _____	C 09/23/2021

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) COMPLETE DATE
21050	Continued From page 10	21050		

tray on top. R2's tray contained one plate with a pastry cut into small pieces, and a second plate that contained strips of bacon that appeared to be cut in half and crispy. However, R2 was not observed consuming any of the food on her tray at that time.

On 9/17/21, at 8:45 a.m. when asked what R2's diet order was, NA-C looked at R2's diet card on breakfast tray and stated, "it is regular soft and bite sized." Further, when asked about the crispy bacon on R2's plate, NA-C began to cut up the bacon into bite sized pieces and confirmed bacon was not cut into bite sized pieces and was not soft per physician's orders. In addition, NA-C left the plate of bacon in front of R2 and walked away to assist another resident with their meal.

On 9/17/21, at 8:53 a.m. when asked about R2's diet order, DON confirmed R2 requires regular soft and bite sized pieces. Further, DON stated "they [dietary] have been doing a trial with her. I believe they have consulted with hospice on the trial." DON indicated dietary staff were aware of the trial but was "unsure" if the physician was aware or if there was an order to upgrade R2's diet. However, the plate continued to remain on R2's tray table but R2 was not observed eating the crispy bacon.

On 9/17/21, at 9:16 a.m. DD indicated R2's diet order was soft and bite sized textured foods. Further, DD stated "I have trialed food items with her per her request." At approximately 1:25 p.m. DD stated "crispy bacon is not part of her diet." Further, DD indicated the process for upgrading a resident's diet was for the resident to be screened by a speech language pathologist (SLP) prior to giving the resident any food out of their diet order. DD confirmed that prior observation of R2

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 _____	C 09/23/2021

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) COMPLETE DATE
21050	Continued From page 11	21050		

receiving the wrong diet order for breakfast on 9/17/21, there had been no communication with R2's hospice staff, physician, or SLP. In addition, DD stated he expected staff to complete a screen form for SLP to evaluate the resident prior to providing the resident with the food due to risk of swallowing and chewing difficulties.

On 9/17/21, at 12:59 p.m. DON indicated during the incident observed on 9/17/21, R2's diet order was regular soft and bite sized "solids" and confirmed "the bacon that was served today was not following her diet." Further, DON indicated staff were expected to follow the facility policy "which is to complete a request for a therapy screen and follow the recommendations prior to giving them against their [resident's] diet orders"

On 9/17/21, at 1:09 p.m. SLP indicated she was notified on 9/17/21, by facility staff, who requested a speech evaluation for R2, due to R2 requesting bacon "which was not part of her soft and bite sized diet."

R3's quarterly MDS dated 7/29/21, indicated R3 had diagnoses which included diabetes, dementia and moderate cognitive impairment. Further review of MDS, indicated R3 was independent with ADLS and eating after setting up only.

R3's care plan printed 9/17/21, indicated R3 receives a therapeutic diet due to diagnoses of chronic heart failure and diabetes with interventions that included "canned fruit ok", independent with eating in main dining room and minced and moist textured food.

Review of R3's dietary card printed on 9/17/21, indicated R3's diet order was minced and moist

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 _____	C 09/23/2021

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) COMPLETE DATE
21050	Continued From page 12 textures and disliked cantaloupe. On 9/16/21, at 1:33 a.m. NA-A indicated on 9/9/21, which was the same day R1 had a choking episode, when she was picking up room trays after the noon meal, she observed R3 was served a cup of cut up cantaloupe and noted on R3's diet card it indicated R3 was minced and moist textured foods. NA-B indicated the cantaloupe appeared to not be consumed by R3 due to R3 disliking cantaloupe NA-B notified DD immediately after discovering R3 was served the wrong texture diet. NA-B stated to DD "this is the exact reason [R1] is in the ER". On 9/16/21, at 4:02 p.m. NA-B indicated R2 was served cantaloupe that was not "minced and moist" on 9/9/21. NA-B indicated she reported it to the DD with NA-A immediately. On 9/17/21, at 9:16 a.m. DD indicated he was aware R3 received cut up cantaloupe on 9/9/21. Further, DD stated R3's diet was ordered as minced and moist and was "approved" to have toast and canned fruit. DD indicated he was unsure who gave R3 the cup of cut up cantaloupe on 9/9/21, but indicated he "addressed it to the staff that the care plan was not followed" and R3 should have received a cup of canned fruit instead. Review of facility policy titled Notification and Documentation of Nutritional Cares dated 6/19, indicated "Nursing and Dietary Staff will monitor for nutritional changes. Recommended changes to diet plan will be assessed by completing a Screen to Therapies. Documentation of changes will be made in Progress notes and/or screenings and these changes will be addressed in residents care plan."	21050		

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 _____	C 09/23/2021

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) COMPLETE DATE
21050	Continued From page 13 The immediate jeopardy that began on 9/17/21, at 3:16 p.m. was removed on 9/23/21, at 1:45 p.m. when it was verified by observation, interview and document review the facility reviewed and implemented new dietary policies on accuracy of diet ordered and production and the facility trained dietary aids and nursing staff on the need to ensure dietary tickets were checked prior to a resident being served food. Implementations included: -Staff education was provided to dietary staff and nursing staff via video on diet orders and mechanically altered diet types. Staff were to complete a competency quiz as well. -Policy titled Accuracy of Diet Ordered and Production was reviewed. -Process developed for dishing and serving meals. -Audits were completed on compliance of current diet order. -Residents who received a mechanically altered diet were reviewed and dietary cards were reviewed to ensure accuracy with physician's orders. -Residents who received a mechanically altered diet were evaluated by a speech language pathologist and modifications were made to diets as needed. SUGGESTED METHOD OF CORRECTION: The administrator or designee could education all staff who serve resident meal trays, in the main dining room or room trays, on verifying the resident's diet order on the diet card to ensure the appropriate diet is served to the resident. The administrator or designee could update/create policies and procedures, and educate staff on these changes related to serving meals and	21050		

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 _____	C 09/23/2021

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) COMPLETE DATE
21050	Continued From page 14 following diet orders. The administrator or designee could perform audits periodically, determined by QAPI, to ensure all diets are being served per physician's orders for all meals. The facility could report audit findings to QAPI for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21050		