



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 4, 2025

Administrator

Essentia Health Grace Home

116 WEST 2ND STREET

Graceville, MN 56240

RE: CCN: 245579

Cycle Start Date: July 1, 2025

Dear Administrator:

On July 31, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 4, 2025

Administrator
ESSENTIA HEALTH GRACE HOME

116 WEST SECOND STREET
GRACEVILLE, MN 56240

Re: Reinspection Results
Event ID: 97EO-H2

Dear Administrator:

On 07/31/2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on 07/01/2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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An equal opportunity employer.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 8, 2025

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

RE: CCN: 245579
Cycle Start Date: July 1, 2025

Dear Administrator:

On July 1, 2025, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by October 1, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 1, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the

Essentia Health Grace Home

July 8, 2025

Page 4

same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Sarah Lane".

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



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Electronically delivered
July 8, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 97EO11

Dear Administrator:

The above facility was surveyed on June 30, 2025 through July 1, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



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

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245579		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/01/2025	
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH GRACE HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET , GRACEVILLE, Minnesota, 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	
F0000	INITIAL COMMENTS On 6/30/25 to 7/1/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H55798168C(MN00114106), with a deficiency cited at F689. 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.		F0000				
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review,		F0689	F689 Grace Home strives to provide a safe and secure environment to all residents residing within the facility. The facility Elopement Prevention Policy has been reviewed and corrections made to include accurate monitoring of wander guard tags for weekly battery checks Completed-7/3/2025- All wander guards in use were assessed to ensure the batteries were active and meeting manufacturer's recommendations for use. Completion date-July 25th 2025.		07/25/2025	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245579	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2025
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F0689 SS = D	Continued from page 1 the facility failed to assesses and develop interventions for residents at risk for elopement (leave the facility without staff knowledge) for 1 of 3 residents (R1) reviewed for elopement. Further, the facility failed to test wanderguard (tags that alarm when a resident elopes) tags per manufacturer's recommendations for 3 of 3 residents (R1, R2, and R3) reviewed for elopement. Findings include: R1 R1's significant change Minimum Data Set (MDS) dated 4/7/25, identified R1 was cognitively impaired and had diagnoses which included dementia, arthritis, and anxiety disorder. Identified R1 required extensive assistance with activities of daily living (ADL's) which include toileting, and dressing. Identified R1 was able to ambulate independently and wandered. Identified wandering was worse since last assessment. R1's care plan revised 6/23/25, identified R1 had behavioral symptoms present related to dementia with psychotic and behavioral disturbances. Identified R1 wandered and paced throughout the facility daily. Identified R1 had an elopement from the facility on 6/23/25. Identified consulting to find a possible visual barrier to aid in redirection of wandering behavior and promote safety, altered 15 second time frame to 30 seconds for door egress, red banner with magnets that say STOP-DO NOT ENTER placed on door. Directed staff to check wanderguard placement daily. Care plan lacked direction on how often to check the battery of wanderguard tags. Care plan further lacked documentation of exit seeking behaviors which included pounding on the doors and standing at the exit doors. Further lacked interventions for R1 during exit seeking behaviors. R1's elopement risk assessment dated 4/4/25, identified R1 had a history of wandering and was at risk for elopement. R2 R2's annual MDS dated 5/2/25, identified R2 was	F0689	Continued from page 1 All licensed nursing staff will receive training on weekly wander guard checks and required documentation in the resident's medical record. Auditing Weekly x4 Monthly x2 Auditing results will be reviewed in QAPI for tracking and compliance. The facility's Elopement Prevention Policy has been reviewed, and corrections have been made to include accurate documentation of interventions for preventing elopement and exit-seeking behaviors Elopement Prevention Policy revised to include: 2. Specific monitoring and management requirements for at-risk residents to include exit seeking behaviors. 3. Weekly Wander Guard battery testing requirements per manufacturer recommendations 4. Documentation requirements for all elopement-related interventions to include follow up RCA with IDT. 5. Clear guidelines for individualized interventions in care plan. IDT reviewed care plans to identify specific trigger for exit seeking behaviors for R1, R2, and R3 and added to care plan. Interventions reviewed and added to R1, R2, and R3 care plans to ensure individualization for cares. All affected care plans reviewed & updated: 7/10/2025. Training of policy changes with staff to be completed by 7/25/2025 Auditing: 1. Care plans on all residents w/elopement risk for interventions and exit seeking behaviors.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245579		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/01/2025	
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F0689 SS = D	Continued from page 2 cognitively impaired and had diagnoses which included dementia, anemia, and anxiety disorder. Identified R2 required extensive assistance with ADL's which included transfers, toileting, and dressing. Identified R2 required a wheelchair and wandered. R2's care plan revised 5/15/25, identified R2 had behavioral symptoms with a history of physical and verbal behaviors towards others related to dementia. Identified R2 wandered daily. Identified when resident became agitated or had increased anxiety, staff were to offer objects of comfort such as stuffed animals and/or baby dolls. Attempt to provide diversion activities of resident's desired choices such as cards, music therapy of gospel music or classic country music, or 1:1 visits with reminiscing about fond memories or previous enjoyable events. Offer snacks and fluids as I enjoy sweets. Directed staff to check wander guard placement daily. Care plan lacked direction on how often to check the battery of wander guard tags. R2's elopement risk assessment dated 5/1/25, identified R2 had a history of wandering and was at risk for elopement. R3 R3's significant change MDS dated 5/15/25, identified R3 was cognitively impaired and had diagnoses which included dementia, anemia, and hypertension (elevated blood pressure). Identified R3 required extensive assistance with ADL's which include transfers, toileting, and dressing. Identified R3 wandered and R3's wandering was worse since last assessment. R3's care plan revised 6/11/25, identified R3 had behavioral symptoms with a history of physical and verbal behaviors towards others related to dementia. Identified R3 wandered and had a history of elopement and attempts at elopement. Identified behavioral symptoms with a history of physical and verbal behaviors towards others related to dementia. Identified R3 had periods of increased irritability towards others including verbal and physical behaviors. R3 may do better with individual activity verse group settings based on my mood at that time. When R3 was fixated on leaving, attempt redirection and distraction. R3 likes watching TV. In the past, calling my daughter and letting me speak to her seems to be			F0689	Continued from page 2 Weekly x4 2. Staff awareness of interventions and behaviors - Monthly x 2 Quarterly x2 Audit results will be reviewed in QAPI for tracking and compliance.		

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F0689 SS = D	Continued from page 3 effective in lessening anxiety and/or behaviors at that time. Approach: Encourage activity, watching TV in room, phone calls with family during periods of increased anxiety or behavior Approach: May need to re-approach or try alternative staff if having increased signs of anxiety, anger, irritability, or other physical or verbal behavioral symptoms towards others. Care plan directed staff to check wanderguard placement daily. Care plan lacked direction on how often to check the battery of wander guard tags. R3's elopement risk assessment dated 5/14/25, identified R3 had a history of wandering and was at risk for elopement. Review of R1, R2,and R3 treatment administration record (TAR) for the month of June 2025, identified placement of the wanderguard was being monitored every shift. TAR lacked evidence that the battery of R1, R2, and R3 wanderguard tag's were being tested. During an interview on 6/30/25 at 1:07 p.m., wanderguard rep stated the manufacturer expected the facility to be checking the batteries on the wanderguard tags that were placed on residents weekly to ensure proper functioning. Review of facility event report dated 6/23/25 at 12:55 p.m., identified R1 had an elopement from the facility and was found across the street on a porch rearranging the flowers. Identified R1 had elopement attempts in the past and wandered without a purpose and attempted to open doors. Interventions included staff assisted R1 back into the building and maintenance tested the wanderguard system and the door at the location of the elopement. Review of an inter-disciplinary team (IDT) progress note dated 6/25/25 at 1:27 p.m., identified R1 had a wanderguard in place due to elopements out of the building and further elopement attempts. Identified wanderguard continued to be checked for placement every shift, consulting with maintenance to find a barrier to		F0689				

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F0689 SS = D	Continued from page 4 be installed to redirect wandering behavior and promote safety for R1. Progress note lacked documentation of why R1 was attempting to elope from the facility or interventions placed related to the reason R1 was attempting to elope from the facility. Review of a progress noted dated 6/28/25 at 10:25 a.m., identified R1 was able to get through the doors and exited the building taking the DO NOT ENTER banner with her. R1 was intercepted immediately by a kitchen staff member and brought back into the building. Identified a black sheet was hung up and the door knob was removed from the nurses station which R1 had used to get to the north door where she eloped from. Identified R1 had been agitated, angry, aggressive all shift. Progress note lacked documentation of why R1 was attempting to elope from the facility or interventions placed related to the reason R1 was attempting to elope from the facility. During an observation on 6/30/25 at 9:30 a.m., R 1 had a wanderguard on her left ankle and was walking at a fast pace throughout the facility. During an interview on 6/30/25 at 12:57 maintenance (M)-A stated on 6/23/25 at approximately 1:00 p.m., he was mowing the lawn in front of the facility when he noticed R1 walking through the facility parking lot, across the street and onto the porch of a house and began rearranging the flowers.. MA stated R1 most likely came out through the door on the north side of the building. M-A stated he alerted nursing staff immediately and nursing assistant (NA)-A came outside immediately and assisted R1 back into the building. M-A stated he was unsure if anyone immediately asked R1 why she was outside or if anyone had recently tested the battery in R1's wanderguard tag. During an interview on 6/30/25 at 1:25 M-B stated he was called in to work on 6/28/25, after R1 had entered the nurses station and exited the building out the north door. M-B verified he was the one who checked the battery of the wander guard tags on the residents monthly. MB stated he did not document when he tested the battery of the wander guard tags however, knew they were last tested on 6/13/25, because he also tested all the doors at the same time monthly. MA-B stated he was unaware of how often the battery of the wander guard tags should have been tested.			F0689			

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F0689 SS = D	Continued from page 5 During an interview on 6/30/25 at 1:31 p.m., dietary aide (DA)-A stated she had been standing outside the door on 6/28/25, when R1 exited the building out of the north door. DA-A stated she immediately brought R1 back into the building. DA-A stated R1 told her that she wanted to go outside to work with the flowers. DA-A stated she had taken R1 outside once after her shift to work with the flowers and was unaware if staff had taken R1 out on a regular basis to work with the flowers. During an interview on 6/30/25 at 3:44 p.m., nursing assistant (NA)-A stated R1 was an elopement risk and had recently had an elopement from the facility. NA-A stated the intervention in R1's care plan was to check the placement of the wanderguard each shift. NA-A stated there were not any interventions in R1's care plan related to exit seeking behaviors. During an interview on 6/30/25 at 3:51 p.m., NA-B stated R1 was an elopement risk and had recently had an elopement from the facility. NA-B stated care planned interventions for R1 was the wanderguard. NA-A stated there were not many interventions in R1's care plan for when R1 was exit seeking. During an interview on 6/30/25 at 3:58 p.m., registered nurse (RN)-A stated R1 had eloped recently from the facility. RN-A stated staff had reviewed R1's elopement during IDT but the interventions were more focused on the door which R1 exited from and IDT had not attempted to find out why R1 was wanting out of the facility. RN-A verified there were very limited interventions in R1's care plan for when R1 was exit seeking. RN-A further stated maintenance staff tested the batteries on the wander guard tags monthly and that she was unsure how often the batteries on the wander guard tags had been tested. During an interview on 7/1/25 at 10:00 a.m., director of nursing (DON) verified R1 had eloped in the past week and was at risk for further elopements. DON stated the main focus was the doors and keeping R1 safe. DON stated staff had not assessed the reason R1 was continuing to want to go outside. DON stated R1's care plan lacked interventions for when R1 was exit seeking. DON stated the policy on elopement should be updated. DON stated the batteries of the wanderguard tags were being tested monthly and she was unaware the		F0689				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245579		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/01/2025	
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH GRACE HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 116 WEST SECOND STREET , GRACEVILLE, Minnesota, 56240			
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F0689 SS = D	Continued from page 6 manufacturer recommendations were to test the batteries weekly. DON further stated her expectation was that R1 would have had care planned interventions for exit seeking behaviors, elopement policy would have included monitoring and managing residents at risk for elopement and that manufacturer recommendations would have been followed for battery testing on all residents who have a wanderguard. Review of a facility manual titled Accutech Installation dated 1/2012, identified for maximum protection of residents or assets accutech recommended that Tags (Wanderguard) be tested on a weekly basis. Review of a facility policy titled Elopement prevention dated 8/7/24, identified all residents would have been assessed through the admission process and elopement precautions would have been initiated immediately for all residents deemed at high risk for elopement and a plan of preventive action would have been incorporated into the resident's plan of care. Policy lacked information regarding monitoring and managing residents at risk for elopement. Policy lacked direction on how often batteries of wanderguard tags were tested.			F0689			

Minnesota State Department of Health

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20000	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 6/30/25 to 7/1/25 , a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.		20000				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota State Department of Health

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20000	Continued from page 1 The following complaints were reviewed: H55798168C MN 00114106 with a licensing order issued at F689. 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 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. 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.		20000				
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident		20830	Acknowledged, plan of correction under federal tag F689 (attached).		07/25/2025	

Minnesota State Department of Health

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20830	Continued from page 2 assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to assesses and develop interventions for residents at risk for elopement (leave the facility without staff knowledge) for 1 of 3 residents (R1) reviewed for elopement. Further, the facility failed to test wanderguard (tags that alarm when a resident elopes) tags per manufacturer's recommendations for 3 of 3 residents (R1, R2, and R3) reviewed for elopement. Findings include: R1 R1's significant change Minimum Data Set (MDS) dated 4/7/25, identified R1 was cognitively impaired and had diagnoses which included dementia, arthritis, and anxiety disorder. Identified R1 required extensive assistance with activities of daily living (ADL's) which include toileting, and dressing. Identified R1 was able to ambulate independently and wandered. Identified wandering was worse since last assessment. R1's care plan revised 6/23/25, identified R1 had behavioral symptoms present related to dementia with psychotic and behavioral disturbances. Identified R1 wandered and paced throughout the facility daily. Identified R1 had an elopement from the facility on 6/23/25. Identified consulting to find a possible visual barrier to aid in redirection of wandering behavior and promote safety, altered 15 second time frame to 30 seconds for door egress, red banner with magnets that say STOP-DO NOT ENTER placed on door. Directed staff to check wanderguard placement daily. Care plan lacked direction on how often to check the battery of wanderguard tags. Care plan further lacked documentation of exit seeking behaviors which included pounding on the doors and standing at the exit doors. Further lacked interventions for R1 during exit seeking behaviors.		20830				

Minnesota State Department of Health

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20830	Continued from page 3 R1's elopement risk assessment dated 4/4/25, identified R1 had a history of wandering and was at risk for elopement. R2 R2's annual MDS dated 5/2/25, identified R2 was cognitively impaired and had diagnoses which included dementia, anemia, and anxiety disorder. Identified R2 required extensive assistance with ADL's which included transfers, toileting, and dressing. Identified R2 required a wheelchair and wandered. R2's care plan revised 5/15/25, identified R2 had behavioral symptoms with a history of physical and verbal behaviors towards others related to dementia. Identified R2 wandered daily. Identified when resident became agitated or had increased anxiety, staff were to offer objects of comfort such as stuffed animals and/or baby dolls. Attempt to provide diversion activities of resident's desired choices such as cards, music therapy of gospel music or classic country music, or 1:1 visits with reminiscing about fond memories or previous enjoyable events. Offer snacks and fluids as I enjoy sweets. Directed staff to check wander guard placement daily. Care plan lacked direction on how often to check the battery of wander guard tags. R2's elopement risk assessment dated 5/1/25, identified R2 had a history of wandering and was at risk for elopement. R3 R3's significant change MDS dated 5/15/25, identified R3 was cognitively impaired and had diagnoses which included dementia, anemia, and hypertension (elevated blood pressure). Identified R3 required extensive assistance with ADL's which include transfers, toileting, and dressing. Identified R3 wandered and R3's wandering was worse since last assessment. R3's care plan revised 6/11/25, identified R3 had behavioral symptoms with a history of physical and verbal behaviors towards others related to dementia. Identified R3 wandered and had a history of elopement		20830				

Minnesota State Department of Health

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20830	Continued from page 4 and attempts at elopement. Identified behavioral symptoms with a history of physical and verbal behaviors towards others related to dementia. Identified R3 had periods of increased irritability towards others including verbal and physical behaviors. R3 may do better with individual activity verse group settings based on my mood at that time. When R3 was fixated on leaving, attempt redirection and distraction. R3 likes watching TV. In the past, calling my daughter and letting me speak to her seems to be effective in lessening anxiety and/or behaviors at that time. Approach: Encourage activity, watching TV in room, phone calls with family during periods of increased anxiety or behavior Approach: May need to re-approach or try alternative staff if having increased signs of anxiety, anger, irritability, or other physical or verbal behavioral symptoms towards others. Care plan directed staff to check wanderguard placement daily. Care plan lacked direction on how often to check the battery of wander guard tags. R3's elopement risk assessment dated 5/14/25, identified R3 had a history of wandering and was at risk for elopement. Review of R1, R2,and R3 treatment administration record (TAR) for the month of June 2025, identified placement of the wanderguard was being monitored every shift. TAR lacked evidence that the battery of R1, R2, and R3 wanderguard tag's were being tested. During an interview on 6/30/25 at 1:07 p.m., wanderguard rep stated the manufacturer expected the facility to be checking the batteries on the wanderguard tags that were placed on residents weekly to ensure proper functioning. Review of facility event report dated 6/23/25 at 12:55 p.m., identified R1 had an elopement from the facility and was found across the street on a porch rearranging the flowers. Identified R1 had elopement attempts in the past and wandered without a purpose and attempted to open doors. Interventions included staff assisted R1 back into the building and maintenance tested the		20830				

Minnesota State Department of Health

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20830	Continued from page 5 wanderguard system and the door at the location of the elopement. Review of an inter-disciplinary team (IDT) progress note dated 6/25/25 at 1:27 p.m., identified R1 had a wanderguard in place due to elopements out of the building and further elopement attempts. Identified wanderguard continued to be checked for placement every shift, consulting with maintenance to find a barrier to be installed to redirect wandering behavior and promote safety for R1. Progress note lacked documentation of why R1 was attempting to elope from the facility or interventions placed related to the reason R1 was attempting to elope from the facility. Review of a progress noted dated 6/28/25 at 10:25 a.m., identified R1 was able to get through the doors and exited the building taking the DO NOT ENTER banner with her. R1 was intercepted immediately by a kitchen staff member and brought back into the building. Identified a black sheet was hung up and the door knob was removed from the nurses station which R1 had used to get to the north door where she eloped from. Identified R1 had been agitated, angry, aggressive all shift. Progress note lacked documentation of why R1 was attempting to elope from the facility or interventions placed related to the reason R1 was attempting to elope from the facility. During an observation on 6/30/25 at 9:30 a.m., R 1 had a wanderguard on her left ankle and was walking at a fast pace throughout the facility. During an interview on 6/30/25 at 12:57 maintenance (M)-A stated on 6/23/25 at approximately 1:00 p.m., he was mowing the lawn in front of the facility when he noticed R1 walking through the facility parking lot, across the street and onto the porch of a house and began rearranging the flowers.. MA stated R1 most likely came out through the door on the north side of the building. M-A stated he alerted nursing staff immediately and nursing assistant (NA)-A came outside immediately and assisted R1 back into the building. M-A stated he was unsure if anyone immediately asked R1 why she was outside or if anyone had recently tested the battery in R1's wanderguard tag. During an interview on 6/30/25 at 1:25 M-B stated he was called in to work on 6/28/25, after R1 had entered		20830				

Minnesota State Department of Health

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20830	Continued from page 6 the nurses station and exited the building out the north door. M-B verified he was the one who checked the battery of the wander guard tags on the residents monthly. MB stated he did not document when he tested the battery of the wander guard tags however, knew they were last tested on 6/13/25, because he also tested all the doors at the same time monthly. MA-B stated he was unaware of how often the battery of the wander guard tags should have been tested. During an interview on 6/30/25 at 1:31 p.m., dietary aide (DA)-A stated she had been standing outside the door on 6/28/25, when R1 exited the building out of the north door. DA-A stated she immediately brought R1 back into the building. DA-A stated R1 told her that she wanted to go outside to work with the flowers. DA-A stated she had taken R1 outside once after her shift to work with the flowers and was unaware if staff had taken R1 out on a regular basis to work with the flowers. During an interview on 6/30/25 at 3:44 p.m., nursing assistant (NA)-A stated R1 was an elopement risk and had recently had an elopement from the facility. NA-A stated the intervention in R1's care plan was to check the placement of the wanderguard each shift. NA-A stated there were not any interventions in R1's care plan related to exit seeking behaviors. During an interview on 6/30/25 at 3:51 p.m., NA-B stated R1 was an elopement risk and had recently had an elopement from the facility. NA-B stated care planned interventions for R1 was the wanderguard. NA-A stated there were not many interventions in R1's care plan for when R1 was exit seeking. During an interview on 6/30/25 at 3:58 p.m., registered nurse (RN)-A stated R1 had eloped recently from the facility. RN-A stated staff had reviewed R1's elopement during IDT but the interventions were more focused on the door which R1 exited from and IDT had not attempted to find out why R1 was wanting out of the facility. RN-A verified there were very limited interventions in R1's care plan for when R1 was exit seeking. RN-A further stated maintenance staff tested the batteries on the wander guard tags monthly and that she was unsure how often the batteries on the wander guard tags had been tested.		20830				

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20830	Continued from page 7 During an interview on 7/1/25 at 10:00 a.m., director of nursing (DON) verified R1 had eloped in the past week and was at risk for further elopements. DON stated the main focus was the doors and keeping R1 safe. DON stated staff had not assessed the reason R1 was continuing to want to go outside. DON stated R1's care plan lacked interventions for when R1 was exit seeking. DON stated the policy on elopement should be updated. DON stated the batteries of the wanderguard tags were being tested monthly and she was unaware the manufacturer recommendations were to test the batteries weekly. DON further stated her expectation was that R1 would have had care planned interventions for exit seeking behaviors, elopement policy would have included monitoring and managing residents at risk for elopement and that manufacturer recommendations would have been followed for battery testing on all residents who have a wanderguard. Review of a facility manual titled Accutech Installation dated 1/2012, identified for maximum protection of residents or assets accutech recommended that Tags (Wanderguard) be tested on a weekly basis. Review of a facility policy titled Elopement prevention dated 8/7/24, identified all residents would have been assessed through the admission process and elopement precautions would have been initiated immediately for all residents deemed at high risk for elopement and a plan of preventive action would have been incorporated into the resident's plan of care. Policy lacked information regarding monitoring and managing residents at risk for elopement. Policy lacked direction on how often batteries of wanderguard tags were tested. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to elopement and managing residents at risk for elopement..The DON or designee could also and ensure appropriate interventions including checking wander guard tags per manufactures recommendations were developed and implemented for all residents with the potential to be affected. The DON or designee could re-educate all staff on policies and procedures, changes to care plans, and the results of assessments for those identified at risk. The DON or designee could develop a system for evaluating and monitoring consistent implementation of policies and procedures and audit to prevent potential elopement. The results of those measurable audits should be routinely brought to the facility's Quality Assurance Performance		20830				

Minnesota State Department of Health

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20830	Continued from page 8 Improvement (QAPI) committee to determine ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20830			