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	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essentia Health Grace Home	116 West Second Street Graceville, MN 56240

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on observation, interview and document review, the facility failed to ensure care plan interventions were implemented for 1 of 3 resident (R1) reviewed who required the use of a transfer belt during transfers reviewed for falls. R1 sustained harm when staff failed to implement the use of a transfer belt during a transfer to the bathroom. R1 fell , sustained a bilateral nasal bone fracture, laceration on the forehead, was sent to the emergency department (ED) requiring medical treatment. The facility implemented corrective action prior to the survey so the deficient practice was issued at past non-compliance. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and no behaviors. She required substantial/maximal assistance with toileting hygiene, partial/moderate assistance with personal hygiene, upper and lower body dressing, sit to stand, chair/bed-to-chair and toilet transfers, and ambulation up to 50 feet. She used a walker and a wheelchair for mobility. She was frequently incontinent of bladder and always continent of bowel. Her diagnoses included congestive heart failure, renal failure, and arthritis. R1's medications included diuretic (reduces fluid buildup in the body and increases urination) and anticoagulant (decreases the clotting ability of the blood to prevent and treat blood clots such as deep venous thrombosis or pulmonary embolism). No falls identified. R1's care plan dated 1/7/25 identified at risk for falls due to past history of falls with injury, chronic cardiac conditions, history of urinary tract infections (UTIs), occasional vasovagal (vagus nerve is the largest nerve in the body and regulates key functions causing a sudden drop in heart rate, blood pressure, breathing, and digestion and could had caused lightheadedness, nausea, sweatiness, and may faint response). Staff were directed to re-educate her about importance of transfer belt use, safety, and a sign placed in her room for a reminder for a gait belt and a front wheeled walker to aid in safety with mobility. Staff may have used a mechanical lift as needed (PRN) for periods of increased difficulty with transfers. R1's discharge MDS dated [DATE], identified she had one previous fall without injury and one fall with major injury. R1's progress notes from 2/1/25 through 2/6/25, identified: (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245579	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Essentia Health Grace Home		STREET ADDRESS, CITY, STATE, ZIP CODE 116 West Second Street Graceville, MN 56240	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	-2/1/25 at 12:35 p.m. nursing assistant (NA) called over radio for assistance in R1's room. Nurse down [sic] and entered room. R1 is halfway out of bathroom and laid face down on the floor with walker underneath her. Noted blood pooling around her head. NAs assisting R1 and applied pressure to head wound. Nurse assessed resident and 911 was called to transport to hospital. Staff kept resident talking until sheriff and emergency medical technicians (EMTs) arrived. R1 place on gurney and went by ambulance to emergency room (ER) at about 1:00 p.m. -2/1/25 at 3:56 p.m. call received from hospital R1 will be kept overnight for observation. -2/2/25 at 1:14 p.m. (recorded as late entry on 2/4/25 at 7:18 a.m.) Vital signs stable. R1 visiting with son and grandson. Band aide intact on forehead. Bruising noted around eyes, nose, and upper lip, and upper lip swollen. Pupils equal and sluggish to react to light. R1 does not have a headache. -2/2/25 at 3:13 p.m. (recorded as a late entry on 2/4/25 at 3:19 p.m.) 72 hours post fall. R1 was alert and oriented and vital signs (VS) within limits 122/63, 89% Sa02, 71, and 18. Answers questions appropriately. Dressing on forehead clean, dry, and intact (CDI). No signs of bleeding. Moves all extremities without a difficulty. Adequate hydration, voiding, and no complaints of pain so far. Sleeping soundly. -2/2/25 at 2:20 p.m. R1 returned from hospital. New orders received and processed. Daughter-in-law returned R1 to facility and was aware of new orders. R1 had a 5 cm forehead laceration which was stitched up and covered with band aid and was to stay in place until provider came across to remove stitches to forehead. Nose broke on both sides, upper lip swollen and black, also bruised around eyes. Had old bruising to knees and shine [sic] from earlier fall. Staff will monitor bruising for changes and due [sic] [NAME] [sic] checks every shift. -2/2/25 at 6:44 p.m. called over to physical therapy to screen R1 for safe transfers. At this time, we are using Hoyer (total lift machine) lift on her due to fall with injuries yesterday and before coming back to nursing home she had a vagal response at local hospital. -2/3/25 at 10:33 a.m. suture removal dated scheduled for Thursday 2/6/25 at 10:00 a.m. Provider will come over to remove sutures from the clinic. -2/3/25 at 1:46 p.m. Interdisciplinary team (IDT) note identified: contributing cause of the fall: history (HX) of vagal responses has been dizzy over past week, no vagal responses over the past several days. R1 was standing up for perineal (peri) cares and fell forward over her walker, she did not feel that she was passing out but a little dizzy and had been declining more over the past month. Post fall concerns: pain and functional limitation. R1 was sent to ER for evaluation and treatment. Action/Plan/interventions implemented to prevent reoccurrence: upon return R1 was placed as a Hoyer for all transfers with two persons assist for bed mobility as well. No further falls. (continued on next page)

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	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essentia Health Grace Home	116 West Second Street Graceville, MN 56240

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0656

Level of Harm - Actual harm

Residents Affected - Few

-2/3/25 at 2:28 p.m. Physical Therapy (PT) evaluation completed. Due to increase in vagal episodes, recommend use of the Hoyer assist of two for all transfers. Leave sling under R1 for safety and skin protection of donning/doffing. Discharging occupational therapy (OT) orders as R1 required a Hoyer lift and assist of two for all ADLs as well. Physical therapy (PT) will continue to keep on for an assessment of safety with mobility and if possible, progress to EZ stand based on medical stability. Discussed with resident doing static stand at her walker in front of recliner with assist of two to continue to get weight through her legs and not fully loose strength. Discussed this could be part of a restorative program, and R1 refused to attempt.

-2/6/25 at 2:10 p.m. Sutures removed by provider today. R1 stated not feeling well. Vitals are within guidelines.

R1's Emergency Department (ED) notes dated 2/1/25 at 1:16 p.m. identified chief complaint: fall. She was a [AGE] year-old female who was being helped up from the toilet and wiped when she fell forward and struck her face and forehead. She denied neck pain and refused a cervical collar (C-collar) (a medical device used to support and immobilize a person's neck). Physical exam identified: her mouth had gingival bleeding along the gingival tooth junction (the area between the tooth surface and gum tissue), pale skin with a complex laceration (a tear in the skin and underlying tissue caused by blunt trauma) to the forehead, and nose appeared deformed from fall. R1's laceration located on forehead, involved the areolar tissue (loose connective tissue found in both the dermis and subcutaneous layers of the skin) and measured 9 centimeters (cm) by 0.5 cm was repaired with sutures. Review of the electrocardiogram (EKG) revealed a left bundle branch block (LBBB) and identified as new since 11/30/23. She was transferred to hospital.

R1's computed tomography (the use of x-rays and a computer to create 3D digital images of your organs, bones, and other tissues) (CT) scan dated 2/1/25, identified cannot exclude nondisplaced acute fracture involving the sternum (breastbone located in the central part of the chest and protects your organs and connects other bones and muscles).

R1's CT maxillofacial (bones of the face, including orbits, sinuses, jaw, and teeth) without (WO) contrast dated 2/1/25, identified facial blunt trauma, contusion/laceration overlying the frontal bones without underlying fracture, mildly comminuted (a bone that was broken in at least two placed usually after a very forceful event/trauma) and impacted bilateral (both sides) nasal bone fracture.

R1's hospital progress notes from 2/1/25 through 2/2/25, identified:

-2/1/25 at 12:58 p.m. R1 presented to ER with complaint of while standing with walker and receiving peri care. She was not aware of weakness coming on said she just went down. She was alert and orientated times four. Presented per ambulance on stretcher.

-2/2/25 at 2:34 a.m. R1 complained of nausea and a headache rated at 7 out of 10. Zofran 4 milligrams (mg) given at this time. Ice pack given to her for headache. She can have more Tylenol at 4:00 a.m.

-2/2/25 at 9:53 a.m. R1 took two steps to sit on commode. While on commode she had a spell where she passed out. She had dry heaves, passed much flatus but not bowel movement. Hoyer lift used to put her back to bed. She woke up while transferring to bed and positioned on her left side with pillow support.

(continued on next page)

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	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essentia Health Grace Home	116 West Second Street Graceville, MN 56240

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	-2/2/25 at 1:36 p.m. R1 was discharged back to nursing home via wheelchair. R1's discharge notes from local hospital dated 2/2/25, identified discharge diagnoses: near syncope (fainting or passing out and is a temporary loss of consciousness and muscle tone caused by a decrease in blood flow to the brain), ecchymosis (bruising) face and right lower leg, closed fracture of nasal bone, and forehead laceration. Sutures to be removed in five days. R1' fall risk assessment dated [DATE] identified high risk for falls. R1's physical therapy (PT) evaluation dated 2/3/25 at 2:27 p.m. identified R1 fell face first and landed on her walker while in bathroom with NA. R1 had been having increased vagal response episodes. R1's prior level of function: ambulated in room with assist of one and front wheeled walker, all cares and transfers assist of one, bed mobility assist of two, and wheelchair dependent for all hallway navigation. R1 was identified as fall risk with impaired mobility and gait. Observation of R1 identified posture in recliner: increased leaning to right side and slouched. R1's had generalized weakness, bruised face, and bandage in place over laceration on forehead. R1's current functional status: Hoyer assist of two with all transfers for safety and static (standing without balance loss with use of upper extremities and moderate support from a person) stand in front of recliner to keep strength in her legs with therapy. Discussed with R1 importance of static stand, declined. Reviewed with R1 Hoyer would be used for safety of her and staff due to frequent vagal responses. R1 upset and verbalized understanding. Facility investigation dated 2/4/25, identified R1 was one person assist with use of walker at time of fall. She had complained of episodes of dizziness over the past few weeks and had vagal responses frequently as part of her normal physiological stasis. On this day, she had no complaints of these symptoms. She was in the bathroom with NA-A and rose to be cleaned. NA-A stood behind her, attempted to clean her when she started to lean forward, fell over her walker through the bathroom doorway, landing face first on the floor. NA-A called for help and applied compression to the wound. LPN-A and NA-B entered the room and R1 laid face down with blood on the floor. LPN-A assisted with compression to laceration on forehead to stop bleeding. LPN-A confirmed when she entered R1's room no gait belt was on her. Call placed for transport to ER. CT scans showed fracture to nose. Investigation showed care plan was not followed, and gait belt was not placed on resident by NA caring for her at the time of the incident. During an observation/interview on 2/26/25 at 12:48 a.m. R1 sat in her recliner awake, call light positioned on her lap, blanket covering her legs and feet, fully dressed in shoes on. She had a tan with dark green trim lift sling positioned underneath her. She had a bruise below and above her right eye and on right check area. She stated she had a tendency of passing out and it happened again about three weeks ago while in the bathroom. An NA had taken her to the bathroom with the walker, she used the toilet, stood up, NA reached for some wipes, kind of lost her balance, fell forward onto the floor on top of the walker, and hit her head. She stated it was the worst fall yet, happened so fast, stitches were placed in her forehead, and broke her nose. She was unable to remember if a gait belt was used. Staff had transferred her with a lift machine since she returned from the hospital after the fall and used the bedpan while she laid in bed. (continued on next page)

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	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essentia Health Grace Home	116 West Second Street Graceville, MN 56240

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/26/25 at 1:45 p.m. licensed practical nurse (LPN)-A stated R1 was a high risk for falls and staff were expected to use a gait belt when they transferred her. While R1 sat on the toilet, had a history of vagal response, and would go out and faint. On 2/1/125, she arrived in the room and R1 laid face down on the floor with a pool of blood around her head. R1 had injured the center of her forehead when she face planted onto the floor. She called 911, R1 did not go unconscious, talked to staff until EMS arrived 5 to 7 minutes later. Emergency medical services (EMS) turned R1 over and moved her onto the gurney. She noticed R1 had bruising on her forehead, down to cheek bones on both sides of her face with a laceration in the middle of the forehead that required stitches. She had completed vitals and an assessment prior to EMS arrival. Changes were made on R1's care plan after the fall and staff were expected to use the Hoyer lift for all transfers. She had received mandatory education about 5 days ago that included safe resident transfers, mechanical transfers, use of gait belt, and required to take a test. During an interview on 2/26/25 at 2:20 p.m. NA-D stated R1 had vagal responses after having a bowel movement (BM) on the toilet. Our younger staff had not really understood what a vagal response was unless they had witnessed one. R1 was an assist of one, with walker and gait belt for transfers prior to the fall on 2/1/25. R1 was alert and oriented, used the call light, and could make her needs known. Staff were expected to have used a gait belt on R1 especially due to her vagal response. She stated when she arrived to the room R1 laid on the floor, head and upper body were located two feet out from bathroom doorway, face down in a pool of blood underneath the head. R1 had a laceration on the forehead that required stitches, middle of forehead at top of nose did not look right which resulted in a fractured nose. She talked to R1 while she applied cold wash clothes to her face to keep her awake. R1 had not lost consciousness. EMS arrived, moved R1 out of the bathroom, slowly rolled her over, and placed on the stretcher. During an interview on 2/27/25 at 9:02 a.m. physical therapist (PT)-A stated R1 had occasional vagal responses on the toilet and became unconscious. R1 refused further testing and did not want to be transferred out to another facility. Staff were aware of R1's vagal responses for months, were expected to follow care plan, gait belt applied during transfers for safety prior to when R1 lost her balance and could have helped control her movements. An assessment by PT was not completed after the 1/5/25 fall. When R1 refused the use of the gait belt, staff were expected to have placed the gait belt on or notified the charge nurse. A gait belt would have provided a safer transfer. After R1's fall on 2/1/25 a PT evaluation was completed and was deemed safer to transfer R1 with a Hoyer lift and assist of two. R1's care planned was updated after the 2/1/25 fall, R1 may stand assist of two in front of recliner with restorative therapy (PT) only. Staff were expected to use mechanical lift for transfers. During an interview on 2/27/25 at 9:41 a.m. registered nurse quality/safety supervisor (RN)-B stated R1 had a decline in the last month, not herself, less energy, generally not feeling well, and not happy or upbeat. Staff were expected to transfer R1 with assist of one to the bathroom with a gait belt per care plan. There were a few times she transferred R1 and was a bit nervous due to her age and walked bent over. The gait belt would have provided safety for R1 and the staff, may not have prevented R1 from going down, but staff could have grabbed the gait belt when she started to tilt, and guided R1 back to toilet or lowered her onto the floor. There were a couple of staff that did not use gait belts during transfers, provided mandatory education last week to approximately 95% of staff. She started random audits that included: all gait belts checked for damage/fraying, located in each resident room, and whether staff used a gait belt during transfers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245579	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Essentia Health Grace Home		STREET ADDRESS, CITY, STATE, ZIP CODE 116 West Second Street Graceville, MN 56240	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/27/25 at 10:14 a.m. RN-C stated R1 had vagal responses sporadically when she sat on the toilet and started about one year ago. She was unsure of what caused it, family and provider were notified and chose not to pursue any additional testing. R1's vagal responses became more frequent January 2025 and happened while R1 sat in her recliner. Staff were unaware when R1 would have a vagal response and most often happened while on the toilet. R1's care plan was not followed, and a gait belt was not used during the 2/1/25 transfer that resulted in a fall with injury. Staff were expected to use a gait belt with any resident that required partial/moderate or substantial/maximum assist and dependent upon staff assistance for transfers only if the resident walked or pivoted on care plan. R1 transfers were changed to Hoyer lift only with assist of two staff after return to facility from the hospital on 2/2/25. During an interview on 2/27/26 at 11:30 a.m. NA-A stated she aware of R1's vagal responses, last summer became unresponsive while on toilet for approximately one minute, called for help, and safely transferred to her recliner without a fall. She had worked on 2/1/25 when R1 placed call light on, and she responded to it. R1 sat in the recliner, stated she really had to go to the bathroom, removed her blanket, placed walker in front of her, stood up right away, and pushed the walker while she walked alongside her. She did not use a gait belt on R1 for this transfer. Staff were expected to follow the care plan and use a gait belt on any resident that required assistance of one with transfers. She stated completely had forgotten to use a gait belt and would have been important to use when she started to fall, could have lowered her down or redirected her back to the toilet. R1 had refused the use of gait belt in the past and staff were expected to try and distract them, placed gait belt on, and explain the reason it was needed. Gait belts were to be used to keep everyone safe and protected from falls. She had not realized the gait belt was not on R1 until she fell . R1 had a bowel movement on the toilet, stood up, while she stood on R1's left side, started to wipe her bottom when R1 fell forward, face planted on the floor right in front of the toilet. She used walkie and called for help. R1's face started gushing blood, both her and NA-D placed cold towels on her forehead and tried to stop the bleeding. She stayed with R1 and did not lose consciousness, talked to staff until EMS arrived 15 to 20 minutes later. She assisted EMS, rolled R1 over and onto a sheet, and lifted her onto a gurney. She received education from director of nursing (DON) regarding gait belt use, refusal of gait belt, and transfers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245579	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essentia Health Grace Home	116 West Second Street Graceville, MN 56240

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0656

Level of Harm - Actual harm

Residents Affected - Few

During an interview on 2/27/26 at 1:39 p.m. DON stated R1 rushed to get from one place to another. R1 had a history of vagal response for at least 2 1/2 years now. When R1 had vagal responses, staff were expected to have administered a sternal rub and assessment completed by the nurse. NA-A received training when she first started regarding a response to a vagal incident. R1 usually sat down prior to a vagal respond and unaware of what caused them. She had talked to R1 and informed her she felt dizzy a little bit, there was not a vagal response during the 2/1/25 fall. She expected staff to follow the care plan, had access to it on the medical records system on computer tablets, understood it and if they did not should have asked the nurse questions. Staff were expected to use a gait belt with any resident that required the assistance of one to safely provide care. The gait belt helped steady and/or lower the resident to the floor if they have fallen or lost their balance and provided safety for both the resident and the staff. She stated no gait belt was used for the transfer of R1 on 2/1/25 which resulted in a fall with injuries. NA-A could have placed R1 on toilet, grabbed gait belt and applied it prior to the transfer, NA-A did not think about that. R1 sustained a laceration center of forehead and required seven stitches, landed on her nose, and fractured /cracked both sides (not all the way through) bridge of nose, facial bruising across forehead down to eyes and extended down to the checks on both side of the face. DON stated R1's walker most likely helped avoid additional injuries. R1 stayed overnight at hospital for observation and came back the next day to the facility. She confirmed 36 out of 40 staff had received the mandatory education regarding gait belt use, transfers, lift transfers, and completed the required test afterwards. The remaining four staff were as needed staff (PRN) status and would be required to complete the mandatory education prior to the next shift worked.

Facility policy Transfer/Gait Belt, use of dated 8/6/19, identified the purpose of a transfer (gait) belt is to provide support to residents that maybe unsteady on their feet. The belt will protect the resident should they become weak or lose their balance when ambulating or transferring. All staff assigned to provide direct care will be expected to use a transfer belt while providing direct care as indicated in care plan. A transfer belt was to be used on a resident that was care planned to be: assist of one or two with transfers and ambulation.

Procedure:

1. Review care plan for resident ambulation status.

2. Identify resident and explain who you are and what you are about to do.

3. Wash hands and gather supplies: transfer belt and appropriate footwear.

4. Assist resident to put on appropriate footwear.

5. Fasten transfer belt securely around waist of properly clothed resident.

6. Grasp transfer belt at resident's side using the underhand grasp.

7. Using proper body mechanics, bend your knees while keeping your back straight and assist resident to a standing position.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245579	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER: Essentia Health Grace Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 116 West Second Street Graceville, MN 56240	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	8. Allow resident to get and maintain a standing balance. Observe for dizziness or weakness. 9. Grab transfer belt at resident's back and walk at side of resident, supporting hand and arm if necessary. 10. Walk resident as indicated on the care plan. 11. Assist resident to sitting position. 12. Report/record procedure, noting resident's tolerance and ability as needed. 13. Transfer belts are in resident room as well as at the nurse's stations and in the medication drawer room (MDR). Facility Care Plan/Care Conference policy dated 8/9/24, identified purpose of care plan was to ensure each resident had an individual plan of care to provide the necessary care to achieve and maintain the highest practicable level of physical, mental, and psychological well-being. Staff providing direct care were responsible for reviewing and understanding the individualized care plan for each resident.