

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  07/01/2025
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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and document review, the facility failed to assess 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.</p> <p>Findings include:</p> <p>R1</p> <p>R1's significant change Minimum Data Set (MDS) dated [DATE], 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.</p> <p>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.</p> <p>R1's elopement risk assessment dated [DATE], identified R1 had a history of wandering and was at risk for elopement.</p> <p>R2</p> <p>R2's annual MDS dated [DATE], 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.</p> <p>(continued on next page)</p>

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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>R2's elopement risk assessment dated [DATE], identified R2 had a history of wandering and was at risk for elopement.</p> <p>R3</p> <p>R3's significant change MDS dated [DATE], 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.</p> <p>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 effective in lessening anxiety and/or behaviors at that time.</p> <p>Approach: Encourage activity, watching TV in room, phone calls with family during periods of increased anxiety or behavior</p> <p>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.</p> <p>R3's elopement risk assessment dated [DATE], identified R3 had a history of wandering and was at risk for elopement.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 [DATE], 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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		