

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 01/15/2025
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40550</p> <p>Based on observation, interview and document review, the facility failed to ensure professional standards of practice were followed during medication set-up and administration of insulin with a Novolog insulin pen (rapid-acting insulin, used to improve blood sugar control in people with diabetes mellitus) for 1 of 2 residents (R12) who received insulin without the pen primed according to manufacturer's recommendations.</p> <p>Findings include:</p> <p>R12's quarterly Minimum Data Set (MDS) dated [DATE], identified R12 had intact cognition and had a diagnosis of diabetes mellitus (DM) and received injections of insulin.</p> <p>R12's care plan revised 12/1/24, identified staff were to administer medications as prescribed.</p> <p>R12's Order Summary Report signed 12/11/24, identified Novolog Flex Pen U-100 inject 5 units Subcutaneously (an injection just under the skin into the fatty tissue) three times daily for DM.</p> <p>During an observation of medication pass on 1/14/25 at 5:30 p.m., registered nurse (RN)-A prepared R12's medication which included her 5:00 p.m., Novolog insulin. RN-A removed the Novolog insulin pen from the medication cart, removed the tip, attached a needle to the end of the pen, dialed the dose to the ordered 5 units, picked up an alcohol wipe, went to R12's room and administered the 5 units of insulin to R12. RN-A then removed the needle from the end of the pen, placed it in the sharps container and sanitized her hands. RN-A did not prime the pen (waste 2 units of insulin to remove the air bubbles) per manufacturer's instructions prior to drawing up the 5 units of insulin.</p> <p>During an interview on 1/14/25 at 5:324 p.m., RN-A verified she had not primed the insulin pen prior to dialing up the 5 units of Novolog for R12 per manufacturer's recommendations. RN-A stated she was aware the insulin pen should have been primed prior to dialing up the insulin to ensure the accurate dosage of insulin was administered.</p> <p>During an interview on 1/15/25 at 9:15 a.m., consultant pharmacist (CP) stated it was important to always prime an insulin pen prior to drawing up the dosage to ensure the residents received the correct dosage of insulin.</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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/15/25 at 9:23 a.m., director of nursing (DON) stated her expectation was that the insulin pen would have been primed prior to dialing up the insulin dose for R12 to ensure the proper dose of insulin was administered.</p> <p>Review of the Novolog insulin manufacture's package insert dated 2023, identified the need to perform an airshot before each injection to ensure the any air bubbles were removed. The process directed: Attach a new needle, Select a dose of 2 units on the dosage selector, hold the pen with the needle pointing upward, tap the insulin reservoir to move any air bubbles to the top of the reservoir, press the injection button all the way in, and check to see if insulin comes out of the needle tip. Repeat if no insulin comes from the needle, then dial the selector to the ordered insulin dose and administer as ordered.</p> <p>Review of a facility policy titled Medication Administration revised 7/23, identified staff would follow appropriate standards and protocols when administering medications.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844</p> <p>Based on observation, interview and document review, the facility failed to implement appropriate donning/doffing of personal protective equipment (PPE) practices to prevent the spread of infection for 1 of 3 residents (R21) observed for enhanced barrier precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). This deficient practice had the potential to affect all 22 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of Centers for Disease Control and Prevention (CDC) guidance dated 4/1/24, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions included: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing.</p> <p>R21's significant change Minimum Data Set (MDS) dated [DATE], identified R21 had moderate cognitive impairment and diagnoses which included diabetes mellitus (DM), renal insufficiency, and hypertension (elevated blood pressure). Identified R21 required extensive assistance with activities of daily living (ADL's) which included toileting, transferring, and dressing.</p> <p>R21's care plan revised 12/20/24, indicated R21 had a catheter related to bladder outlet obstruction. Care plan directed staff to assist with emptying catheter every shift.</p> <p>During an observation on 1/13/25 at 11:02 a.m., there was a sign on R21's door that stated Enhanced Barrier Precautions; Everyone must clean their hands, including before entering and when leaving the room. Wear gloves and gown for the following high contact resident activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. In addition, the sign contained a picture of hand sanitizer, a gown, and gloves. There were no gowns located inside or outside R21's room.</p> <p>During an observation on 1/13/25 at 1:01 p.m., occupational therapy assistant (OTA) entered R21's bathroom, sanitized hands, applied gloves and informed R21 she was there to assist her off the toilet. OTA used toilet paper to wipe R21's perineal area, removed gloves, pulled up R21's pants and washed hands. OTA proceeded to walk along side of R21 in to the therapy room. The only PPE OTA wore while assisting R21 off the toilet was gloves.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on 1/13/25 at 2:56 p.m., nursing assistant (NA)-A entered R21's room, sanitized hands, applied a gait belt around R21's waist and walked with R21 to the bathroom while holding on to the gait belt. NA-A applied gloves and pulled R21's pants down as R21 sat down on the toilet. NA-A used toilet paper to wipe R21's perineal area, removed gloves, pulled up R21's pants and washed hands. NA-A walked with R21 to her recliner while holding on to the gait belt. The only PPE NA-A was wearing while assisting R21 on the toilet was gloves.</p> <p>During an interview on 1/13/25 at 3:01 p.m., NA-A verified the only PPE she had used while toileting R21 was gloves. NA-A stated the only time she needed to wear a gown was when she was working with R21's catheter.</p> <p>During an interview on 1/14/25 at 11:42 a.m., OTA verified the only PPE she had used while toileting R21 was gloves. OTA stated her understanding of EBP was that she only needed to wear a gown when she was working with R21's catheter.</p> <p>During an interview on 1/15/25 at 8:30 a.m., infection preventionist (IP) verified R21 had a catheter and was on EBP. IP stated her understanding of EBP had been that staff only needed to wear a gown if they were caring for R21's catheter. IP stated now that she was aware of when a gown should be used, her expectation was that staff would wear a gown when indicated per Centers for Disease Control (CDC) guidance while caring for any resident who was on EBP.</p> <p>During an interview on 1/15/25 at 9:21 a.m., director of nursing (DON) stated her expectation was that PPE would have been readily available to use for any residents in EBP and staff would have worn a gown and gloves while caring for R21.</p> <p>Review of a facility policy titled Standard and Transmission Based Precautions (TBP) revised 11/2/23, identified TBP were special precautions for the care of patients with diseases or conditions of epidemiological significance that are transmitted by contact. Identified gowns were to be worn to protect skin and prevent soiling of clothing during patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions or causing soiling of clothing.</p>		