Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 9, 2026

Administrator
ESSENTIA HEALTH VIRGINIA CARE CENT
901 9TH STREET NORTH
VIRGINIA, MN 55792

RE: CCN:245458
Cycle Start Date: March 26, 2026

Dear Administrator:

On March 26, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

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 June 26, 2026 (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 September 26, 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 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have 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

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Electronically delivered
April 9, 2026

Administrator
ESSENTIA HEALTH VIRGINIA CARE CENT
901 9TH STREET NORTH
VIRGINIA, MN 55792

Re: State Nursing Home Licensing Orders
Event ID: 1E3E40-H1

Dear Administrator:

The above facility survey was completed on March 26, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245458**	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 0...** B. WING	(X3) DATE SURVEY COMPLETED **03/24/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH VIRGINIA CARE CENT	**901 9TH STREET NORTH , VIRGINIA, Minnesota, 55792**

(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
K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on March 24, 2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Essentia Health Virginia Care Center, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K0000		04/09/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245458**	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 0...** B. WING	(X3) DATE SURVEY COMPLETED **03/24/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH VIRGINIA CARE CENT	**901 9TH STREET NORTH , VIRGINIA, Minnesota, 55792**

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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. Building Info: Essentia Virginia Regional Medical Center is a 4-story building with full basement. The original building was constructed in 1936 and additions constructed in 1976 and 1999, all of Type II(222). The nursing home occupies the 3rd floor. A 3 story hospital of the same construction type adjoins the nursing home, and is separated by a 2 hour fire rated barrier, with 1&1/2 hour rated self closing doors. Therefore, the nursing home was inspected as one building. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a capacity of 77 beds and had a census of 15 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0311 SS = A	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire	K0311		04/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245458**	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 0...** B. WING	(X3) DATE SURVEY COMPLETED **03/24/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH VIRGINIA CARE CENT	**901 9TH STREET NORTH , VIRGINIA, Minnesota, 55792**

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K0311 SS = A	Continued from page 2 resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to the ceiling and openings in accordance with the Life Safety Code NFPA 101 - 2012 edition (8.6, 19.3.1.1 through 19.3.1.6). This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 03/24/2026, at 10:14 AM, observations and staff interview revealed that there were ceiling tiles missing in room U335 and 3 penetrations in stairwell G (1-8x8, 1 4x4 and 1-wire penetration) that were not sealed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0311		
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source	K0353	Plan of Correction Deficient Practice: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 25 (2011 edition) (5.2.2.2). On 3/24/2026 at 10:15 AM, wires were observed resting on the sprinkler system above the ceiling in room 312. Immediate Corrective Action: On 3/26/2026, the wires were secured/tied back and the insulation was opened to verify that the sprinkler pipe was not being contacted or obstructed by the wires. No damage to the sprinkler line was identified. Systemic Correction: The facility will conduct quarterly rounds that include random ceiling inspections in designated areas to	04/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245458**	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 0...** B. WING	(X3) DATE SURVEY COMPLETED **03/24/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH VIRGINIA CARE CENT	**901 9TH STREET NORTH , VIRGINIA, Minnesota, 55792**

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K0353 SS = F Bldg. 01	Continued from page 3 ____________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 25 (2011 edition) (5.2.2.2). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 3/24/2026, at 10:15 AM, it was revealed by observation, wires were resting on the sprinkler system above the ceiling at room 312. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353	Continued from page 3 identify any items, wires, materials, or obstructions that may be in contact with or improperly stored near sprinkler piping or sprinkler heads. Any deficiencies identified during rounds will be corrected in real time whenever possible. If immediate correction cannot be completed, a work order will be generated and tracked for timely completion. Monitoring Plan: The Environment of Care Committee will review quarterly inspection results, compliance findings, and any corrective actions taken. Trends or repeated concerns will be addressed through additional staff education, follow-up inspections, and further corrective action as needed. Assurance of Ongoing Compliance: Compliance will be monitored through the quarterly inspection process and reported to the Environment of Care Committee.	

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Electronically Delivered
June 9, 2026

Administrator
ESSENTIA HEALTH VIRGINIA CARE CENT
901 9TH STREET NORTH
VIRGINIA, MN 55792

RE: CCN: 245458
Cycle Start Date: March 26, 2026

Dear Administrator:

On May 1, 2026, the Minnesota Departments of Health and Public Safety 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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Electronically delivered

June 9, 2026

Administrator
ESSENTIA HEALTH VIRGINIA CARE CENT
901 9TH STREET NORTH
VIRGINIA, MN 55792

Re: Reinspection Results
Event ID: 1E3E40-H2

Dear Administrator:

On May 1, 2026 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 March 26, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245458	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER: ESSENTIA HEALTH VIRGINIA CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE: 901 9TH STREET NORTH , VIRGINIA, Minnesota, 55792	

(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
E0000	Initial Comments On 3/23/26 to 3/26/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		04/09/2026
F0000	INITIAL COMMENTS On 3/23/26 to 3/26/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54588882C (iQIES #1135936). NO deficiencies were cited. 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 substantial compliance with the regulations has been attained.	F0000		04/09/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F0812	F0812 1. How the deficient practice was identified: On 3/23/26, during kitchen and dining area observation, surveyors identified six cans of pasta sauce and six cans of tomato paste without discernible expiration dates, five cans of carrots with	04/16/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245458**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/26/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH VIRGINIA CARE CENT	**901 9TH STREET NORTH , VIRGINIA, Minnesota, 55792**

(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
F0812 SS = F	Continued from page 1 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to date opened products, dispose of expired products, and failed to have a process to ensure stored food was labeled with an expiration date that staff could understand. This deficient practice had the potential to affect all 15 residents who received food from facility kitchen. Findings include: During the initial kitchen tour on 3/23/26 at 1:27 p.m., nutrition services manager (NSM) stated products were dated when opened. The following was observed during the tour: Dry storage: 6 cans of pasta sauce had no discernible expiration date. 6 cans of tomato paste had no discernible expiration date. 5 cans of carrots had an expiration date of 12/28/25. Cold storage: In cooler 3, there was an open, undated half gallon of heavy cream. In freezer 1, beef stew tray had no expiration date.	F0812	Continued from page 1 an expiration date of 12/28/25, an open undated half-gallon of heavy cream in Cooler C3, a beef stew tray in Freezer F1 without a visible expiration date, an open undated liquid egg carton, seven open undated spices, and open undated ketchup bottles in the resident dining room. The Nutrition Services Manager confirmed the facility used Julian dates for some products but did not have a reliable process to translate them into a staff-understandable discard date. 2. Root cause analysis: The facility did not have an effective food labeling and storage oversight process to ensure all products were labeled in a staff-understandable format, opened items were dated, and expired food was consistently removed from service. Staff training did not reliably ensure understanding of manufacturer date codes, opened product dating, or discard requirements. 3. Immediate corrective actions: On 3/23/26, expired, undated, and improperly labeled items were removed from service or discarded. The cans of carrots dated 12/28/25 were discarded. Open items were corrected, labeled, or removed from use as appropriate. 4. Systemic corrective actions: A standardized Date Labeling Policy was reissued to Nutrition Services staff. Instructions for deciphering manufacturer date codes were posted in the can storage area. All Nutrition Services staff were re-educated on 3/24/26 regarding food labeling, date-code interpretation, opened product dating, storage requirements, and discard timelines. Opened products must now be labeled with the date opened. New staff will receive this training during onboarding. The Nutrition Services Supervisor or designee will complete audits two times a week for 4 weeks, every 2 weeks for 4 weeks, and monthly for 2 months. Any item with a missing, unreadable, or expired date will be removed immediately, and non-compliance will result in immediate re-education and corrective action. Completion Date: 3/24/2026	04/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245458**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/26/2026**
NAME OF PROVIDER OR SUPPLIER **ESSENTIA HEALTH VIRGINIA CARE CENT**		STREET ADDRESS, CITY, STATE, ZIP CODE **901 9TH STREET NORTH , VIRGINIA, Minnesota, 55792**	

(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
F0812 SS = F	Continued from page 2 Kitchen cooking line: Small fridge on kitchen line had an open, undated liquid egg carton. 7 open, undated spices. In addition, there were no discernable expiration dates on the spices. Resident dining room on 3rd floor: Open, undated ketchup bottles on 9 tables. In addition, there were no discernable expiration dates on the bottles. During an interview on 3/24/26 at 1:26 p.m., cook (C)-A stated they discard canned goods when beyond the expiration date. C-A was unable to locate the pasta sauce and tomato cans and stated they would need to ask their supervisor to determine the expiration date. During an interview on 3/24/26 at 1:39 p.m., NSM stated the canned goods in dry storage had Julian dates on them and stated they had to look them up on computer. NSM's expectation was that staff would discard expired products but confirmed that the products had not been dated in a way that staff could identify the expiration date. They stated there was no facility process to identify an expiration date (in Gregorian calendar format) for products that were delivered with a Julian calendar expiration date. NSM stated the concern with not discarding expired food was the potential for residents to become sick if it was served. During an interview on 3/25/26 at 2:07 p.m., the facility administrator stated the kitchen monitors expiration dates until it comes to the dining room or nursing kitchenette. They expect foods would be discarded when expired. Facility Food Storage Chart – Food Storage Guidelines, revised 4/7/25, identifies the following product discard after opening guidelines: cream – refrigerate 3 – 4 days catsup – open 1 month ground spices – 6 months Facility food storage policy requested but not received.	F0812		04/16/2026

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F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to only leave medications at bedside when there was order to and the resident wanted to self adminster medications. This affected 1 of 1 residents (R5) reviewed for self administration of medication. Findings include: R5's quarterly Minimum Data Set (MDS) dated 3/20/26, indicated R5 was cognitively intact. Diagnoses included diabetes and cerebral vascular accident (CVA)(stroke). R5's Assessment for Resident Self-Administration of Medications/Treatments dated 3/16/26, indicated R5 did not want to self-administer medications and/or treatments (SAM). R5's Physician Order Report (POR) dated 3/26/26 indicated R5 received acetaminophen 500 milligrams (mg), 2 tablets three times a day by mouth. The POR lacked orders for Tums antacids. No staff were in the room. R5's care plan undated, lacked a care plan related to self-administration of medication. During an observation on 3/23/26 at 2:13 p.m., two tylenol were observed in a medicine cup sitting on R5's bedside table along with a second medicine cup which held four tums, and a bottle of tums. During a second observation on 3/25/26 at 2:09 p.m., 4 tums were again observed in a medicine cup, along with the bottle of tums on R5's bedside table. No staff were present. During an interview on 3/25/26 at 2:10 p.m.,	F0554	F0554 1. How the deficient practice was identified: During survey observation and record review on 3/23/26 and 3/25/26, medications were observed at R5's bedside, including acetaminophen and Tums, without an order authorizing bedside medication storage and without documentation that R5 wanted to self-administer medications. Record review showed R5 did not want to self-administer medications. Licensed staff confirmed medications should not be left at bedside without a provider order and completed self-administration assessment. 2. Root cause analysis: The facility lacked a reliable admission and medication oversight process to ensure resident medications, including over-the-counter medications, were not left at bedside unless the resident had been assessed as clinically appropriate for self-administration and had a provider order. 3. Immediate corrective actions: On 3/26/26, medications found at R5's bedside were removed. R5 was re-educated regarding the facility's medication policy. 4. Systemic corrective actions: Effective immediately, a Resident Medication Acknowledgment Form will be included in the admission packet and signed by the resident and/or resident representative acknowledging that all medications, including OTC medications, must be disclosed to facility staff; medications may not be brought into the facility or kept at bedside without staff knowledge and review; and medications may only be left at bedside when clinically appropriate, with a provider order and completed self-administration assessment. Nursing staff were re-educated on the facility policy related to self-administration of medications and the revised admission process. The Director of Nursing or designee will audit new admissions weekly for 4 weeks, then monthly for 3 months, to verify acknowledgment form completion, medication review, provider orders, and self-administration assessment completion when applicable. Completion Date: 4/16/2026	04/16/2026

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NAME OF PROVIDER OR SUPPLIER: ESSENTIA HEALTH VIRGINIA CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE: 901 9TH STREET NORTH , VIRGINIA, Minnesota, 55792	

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F0554 SS = D	Continued from page 4 licensed practical nurse (LPN)-A stated if medications were left at bedside there needed to be an order to leave them at bedside, an order for the medication that is left at beside, and the SAM needed to be fill out and would indicate the resident wanted to self-administer medication and the resident was safe to self-administer medications along with leaving them at bedside. During an interview on 3/26/26 at 8:11a.m., the director of nursing stated an expectation of orders in place and the SAM filled out prior to medications being left at resident bedside. Facility policy Medication Self-Administration last reviewed 9/4/25, indicated medication would never be left unattended with a resident without appropirate assessment and order for self-administration.	F0554		04/16/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F0880	F0880 1. How the deficient practice was identified: On 3/23/26 and 3/24/26, surveyors observed staff entering R11's contact precaution room without wearing the required gown and gloves. R11's room had signage indicating contact precautions. RN-B entered the room twice with gloves but without a gown. NA-A also entered the room without gown and gloves while assisting the resident to the bathroom. Staff interviews confirmed confusion regarding when PPE was required. 2. Root cause analysis: The facility did not consistently ensure staff understood and followed contact precaution PPE requirements. The system failed to reliably reinforce the expectation that gown and gloves must be worn when entering a contact precaution room. There was insufficient oversight to confirm compliance with transmission-based precaution procedures. 3. Immediate corrective actions: On 3/23/26 and 3/24/26, staff were immediately re-educated regarding the proper use of PPE for residents on contact precautions. R11's signage and PPE availability were verified. 4. Systemic corrective actions: The Infection Preventionist and nursing leadership re-educated staff on contact precaution	04/16/2026

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F0880 SS = D	Continued from page 5 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to wear appropiriate personnal protective equipment (PPE) for a resident on contact precautions. This affected 1 of 1 resident (R11) reviewed for infection control. Findings include:	F0880	Continued from page 5 requirements, including the requirement to wear gown and gloves prior to entering a contact precaution room. The facility’s Contact Precautions policy was reviewed and reinforced. Staff were instructed to verify resident precaution status and required PPE before room entry. Education completed 4/15/26. The Infection Preventionist or designee will conduct PPE audits twice weekly for 3 weeks, then every other week for 2 months, then monthly for 2 months. Audit findings will be reviewed with nursing leadership, and any non-compliance will result in immediate re-education and corrective action. Results will be reviewed through the QA/QAPI process. Completion Date: 4/15/2026	04/16/2026

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F0880 SS = D	Continued from page 6 R11's quarterly Minimum Data Set (MDS) dated 2/10/26, identified R11 as cognitively intact. R11's diagnoses included ataxia following cerebral infarction, diabetes mellitus type 2, paroxysmal atrial fibrillation, hypertension, and legal blindness. R11's care plan revised 2/24/26, identified left eye blepharoconjunctivitis infection: will resolve infection incurred and not spread same to others. It instructed to implement contact precautions. R11's provider orders dated 3/25/26 identified contact precautions through duration of eye drops and duration of left eye symptoms. During dining observations on 3/23/26 at 5:10 p.m., R11's door had an isolation sign on it which indicated R11 was on contact precautions. The sign indicated gown, and gloves had to always be worn when staff entered the room. Registered nurse (RN)-B was observed taking R11 the dinner tray in. RN-B placed gloves on but did not put a gown on and entered R11's room. During a second observation on 3/23/26 at 5:39 p.m., RN-B again entered R11's room with gloves on but without a gown on. During an interview on 3/23/26 at 5:39 p.m., RN-B stated gown and gloves needed to be worn while in a contact isolation room when staff would come in contact with the resident or the items in the resident's room. If contact was not made, like taking in a food tray, then staff only had to wear gloves in the isolation room. During an observation on 3/24/26 at 9:31 a.m., R11's door had an isolation sign on it which indicated R11 was on contact precautions. The sign instructed that gown and gloves always had to be worn when staff entered the room. Nursing assistant (NA)-A was observed entering R11's room without wearing gloves and a gown to assist R11 to the bathroom. During an interview on 3/24/26 at 9:44 a.m., NA-A stated a gown and gloves must be worn when entering a contact isolation room to prevent spreading an illness. NA-A stated they thought R11 was no longer on contact isolation. They confirmed the contact isolation signage on R11's door and stated they should have worn a gown and gloves when entering R11's room.	F0880		04/16/2026

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F0880 SS = D	Continued from page 7 During an interview on 3/25/26 at 9:48 a.m., the infection preventionist stated gown and gloves needed to be worn any time a staff member was in a contact isolation room, if there was any risk of coming into contact with anything in the resident room, which meant pretty well every time the gown and gloves needed to be worn. During an interview on 3/26/26 at 9:16 a.m., the director of nursing (DON) expected staff to gown and glove when entering a contact isolation room. They stated a concern for spreading the infection if gown and gloves were not worn in a contact isolation room. The DON confirmed that R11 was on contact isolation. The facility process Contact Precautions dated 9/21/23, indicated staff were required to put on an isolation gown and gloves prior to entering a contact isolation room.	F0880		04/16/2026

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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 3/23/26 to 3/26/26, a standard licensing 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 Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed: H54588882C (iQIES #1135936). NO licensing orders were issued.	20000		04/09/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/26/2026**
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20000	Continued from page 1 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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.	20000		04/09/2026
21100	Food Supplies; Storage of Perishable food CFR(s): MN Rule 4658.0650 Subp. 5 Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	21100	Corrected	04/16/2026

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21100	Continued from page 2 Based on observation and interview, the facility failed to date opened products, dispose of expired products, and failed to have a process to ensure stored food was labeled with an expiration date that staff could understand. This deficient practice had the potential to affect all 15 residents who received food from facility kitchen. Findings include: During the initial kitchen tour on 3/23/26 at 1:27 p.m., nutrition services manager (NSM) stated products were dated when opened. The following was observed during the tour: Dry storage: 6 cans of pasta sauce had no discernible expiration date. 6 cans of tomato paste had no discernible expiration date. 5 cans of carrots had an expiration date of 12/28/25. Cold storage: In cooler 3, there was an open, undated half gallon of heavy cream. In freezer 1, beef stew tray had no expiration date. Kitchen cooking line: Small fridge on kitchen line had an open, undated liquid egg carton. 7 open, undated spices. In addition, there were no discernable expiration dates on the spices. Resident dining room on 3rd floor: Open, undated ketchup bottles on 9 tables. In addition, there were no discernable expiration dates on the bottles. During an interview on 3/24/26 at 1:26 p.m., cook (C)-A stated they discard canned goods when beyond the expiration date. C-A was unable to locate the pasta sauce and tomato cans and stated they would need to ask their supervisor to determine the expiration date. During an interview on 3/24/26 at 1:39 p.m., NSM stated the canned goods in dry storage had Julian dates on them and stated they had to look them up	21100		04/16/2026

Minnesota Department of Health

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21100	Continued from page 3 on computer. NSM's expectation was that staff would discard expired products but confirmed that the products had not been dated in a way that staff could identify the expiration date. They stated there was no facility process to identify an expiration date (in Gregorian calendar format) for products that were delivered with a Julian calendar expiration date. NSM stated the concern with not discarding expired food was the potential for residents to become sick if it was served. During an interview on 3/25/26 at 2:07 p.m., the facility administrator stated the kitchen monitors expiration dates until it comes to the dining room or nursing kitchenette. They expect foods would be discarded when expired. Facility Food Storage Chart – Food Storage Guidelines, revised 4/7/25, identifies the following product discard after opening guidelines: cream – refrigerate 3 – 4 days catsup – open 1 month ground spices – 6 months Facility food storage policy requested but not received. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could review policy's regarding food storage, revise as needed, set up a system to ensure expired food is discarded timely, educate staff and perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		04/16/2026
21385	Infection Control; Staff assistance CFR(s): MN Rule 4658.0800 Subp. 3 Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	21385	Corrected	04/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER **ESSENTIA HEALTH VIRGINIA CARE CENT**		STREET ADDRESS, CITY, STATE, ZIP CODE **901 9TH STREET NORTH , VIRGINIA, Minnesota, 55792**	

(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
21385	Continued from page 4 Based on observation, interview, and record review the facility failed to wear appropiriate personnal protective equipment (PPE) for a resident on contact precautions. This affected 1 of 1 resident (R11) reviewed for infection control. Findings include: R11's quarterly Minimum Data Set (MDS) dated 2/10/26, identified R11 as cognitively intact. R11’s diagnoses included ataxia following cerebral infarction, diabetes mellitus type 2, paroxysmal atrial fibrillation, hypertension, and legal blindness. R11's care plan revised 2/24/26, identified left eye blepharoconjunctivitis infection: will resolve infection incurred and not spread same to others. It instructed to implement contact precautions. R11’s provider orders dated 3/25/26 identified contact precautions through duration of eye drops and duration of left eye symptoms. During dining observations on 3/23/26 at 5:10 p.m., R11’s door had an isolation sign on it which indicated R11 was on contact precautions. The sign indicated gown, and gloves had to always be worn when staff entered the room. Registered nurse (RN)-B was observed taking R11 the dinner tray in. RN-B placed gloves on but did not put a gown on and entered R11’s room. During a second observation on 3/23/26 at 5:39 p.m., RN-B again entered R11’s room with gloves on but without a gown on. During an interview on 3/23/26 at 5:39 p.m., RN-B stated gown and gloves needed to be worn while in a contact isolation room when staff would come in contact with the resident or the items in the resident’s room. If contact was not made, like taking in a food tray, then staff only had to wear gloves in the isolation room. During an observation on 3/24/26 at 9:31 a.m., R11’s door had an isolation sign on it which indicated R11 was on contact precautions. The sign instructed that gown and gloves always had to be worn when staff entered the room. Nursing assistant (NA)-A was observed entering R11’s room without wearing gloves and a gown to assist R11 to the bathroom. During an interview on 3/24/26 at 9:44 a.m., NA-A	21385		04/16/2026

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21385	Continued from page 5 stated a gown and gloves must be worn when entering a contact isolation room to prevent spreading an illness. NA-A stated they thought R11 was no longer on contact isolation. They confirmed the contact isolation signage on R11's door and stated they should have worn a gown and gloves when entering R11's room. During an interview on 3/25/26 at 9:48 a.m., the infection preventionist stated gown and gloves needed to be worn any time a staff member was in a contact isolation room, if there was any risk of coming into contact with anything in the resident room, which meant pretty well every time the gown and gloves needed to be worn. During an interview on 3/26/26 at 9:16 a.m., the director of nursing (DON) expected staff to gown and glove when entering a contact isolation room. They stated a concern for spreading the infection if gown and gloves were not worn in a contact isolation room. The DON confirmed that R11 was on contact isolation. The facility process Contact Precautions dated 9/21/23, indicated staff were required to put on an isolation gown and gloves prior to entering a contact isolation room. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure infection control procedures and standards are maintained by all staff as appropriate. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21385		04/16/2026
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document	21565	Corrected	04/16/2026

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21565	Continued from page 6 review the facility failed to only leave medications at bedside when there was order to and the resident wanted to self adminster medications. This affected 1 of 1 residents (R5) reviewed for self administration of medication. Findings include: R5's quarterly Minimum Data Set (MDS) dated 3/20/26, indicated R5 was cognitively intact. Diagnoses included diabetes and cerebral vascular accident (CVA)(stroke). R5's Assessment for Resident Self-Administration of Medications/Treatments dated 3/16/26, indicated R5 did not want to self-administer medications and/or treatments (SAM). R5's Physician Order Report (POR) dated 3/26/26 indicated R5 received acetaminophen 500 milligrams (mg), 2 tablets three times a day by mouth. The POR lacked orders for Tums antacids. No staff were in the room. R5's care plan undated, lacked a care plan related to self-administration of medication. During an observation on 3/23/26 at 2:13 p.m., two tylenol were observed in a medicine cup sitting on R5's bedside table along with a second medicine cup which held four tums, and a bottle of tums. During a second observation on 3/25/26 at 2:09 p.m., 4 tums were again observed in a medicine cup, along with the bottle of tums on R5's bedside table. No staff were present. During an interview on 3/25/26 at 2:10 p.m., licensed practical nurse (LPN)-A stated if medications were left at bedside there needed to be an order to leave them at bedside, an order for the medication that is left at beside, and the SAM needed to be fill out and would indicate the resident wanted to self-administer medication and the resident was safe to self-administer medications along with leaving them at bedside. During an interview on 3/26/26 at 8:11a.m., the director of nursing stated an expectation of orders in place and the SAM filled out prior to medications being left at resident bedside. Facility policy Medication Self-Administration last reviewed 9/4/25, indicated medication would never be left unattended with a resident without appropirate assessment and order for	21565		04/16/2026

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21565	Continued from page 7 self-administration. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review with staff current policies to ensure residents who are self administering medication had been assessed and were appropriate to administer their own medication, along with a physicians order for administration. The DON could audit resident to ensure assessment, and physician orders for self administration were in place. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		04/16/2026