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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5BIT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00603

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245458**
2.STATE VENDOR OR MEDICAID NO.
(L2) **936325400**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH VIRGINIA CARE CENT**
(L4) **901 9TH STREET NORTH**
(L5) **VIRGINIA, MN** (L6) **55792**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2013**

6. DATE OF SURVEY **10/01/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **90** (L18)

13.Total Certified Beds **90** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Susan Frericks HPR SWS 10/26/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/24/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/13/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

CMS Certification Number (CCN): 245458

November 25, 2015

Ms. Linda Bump, Administrator
Essentia Health Virginia Care Cent
901 9th Street North
Virginia, Minnesota 55792

Dear Ms. Bump:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 1, 2015 the above facility is certified for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 26, 2015

Ms. Linda Bump, Administrator
Essentia Health Virginia Care Cent
901 9th Street North
Virginia, Minnesota 55792

RE: Project Number S5458024

Dear Ms. Bump:

On August 28, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 14, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On October 1, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 28, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 14, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 23, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 14, 2015, effective September 23, 2015 and therefore remedies outlined in our letter to you dated August 28, 2015, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245458	A. Building B. Wing	10/1/2015

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA HEALTH VIRGINIA CARE CENT	901 9TH STREET NORTH VIRGINIA, MN 55792

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **09/23/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **09/23/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **09/23/2015**
ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **09/23/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **09/23/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/23/2015**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **09/23/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/23/2015**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **09/23/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/23/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **09/23/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	CC/mm	10/26/2015	34983	10/01/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/14/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245458	A. Building B. Wing 01 - MAIN BUILDING 01	9/28/2015

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA HEALTH VIRGINIA CARE CENT	901 9TH STREET NORTH VIRGINIA, MN 55792

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	09/23/2015	ID Prefix Reg. # NFPA 101 LSC K0074	09/23/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/mm	10/26/2015	19251	09/28/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
8/18/2015	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 5BIT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00603

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245458**

2.STATE VENDOR OR MEDICAID NO.
(L2) **936325400**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH VIRGINIA CARE CENT**
(L4) **901 9TH STREET NORTH**
(L5) **VIRGINIA, MN** (L6) **55792**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2013**

6. DATE OF SURVEY **08/14/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **90** (L18)

13.Total Certified Beds **90** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Susan Frericks, HPR SWS — 10/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 10/13/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 28, 2015

Ms. Linda Bump, Administrator
Essentia Health Virginia Care Center
901 9th Street North
Virginia, Minnesota 55792

RE: Project Number S5458024

Dear Ms. Bump:

On August 14, 2015, a standard survey was completed at your facility by the Minnesota Departments 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: chris.campbell@state.mn.us

Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 23, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 23, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 November 14, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 14, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

Mr. Gary Schroeder, Interim Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: gary.schroeder@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245458	A. BUILDING _____ B. WING _____	08/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH VIRGINIA CARE CENT	901 9TH STREET NORTH VIRGINIA, MN 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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Census = 72	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law	F 225		9/23/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/04/2015

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.

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	245458	A. BUILDING _____ B. WING _____	08/14/2015

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

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F 225	Continued From page 1 through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report and comprehensively investigate potential abuse/neglect/mistreatment to the State Agency (SA), for 4 of 4 residents (R13, R4, R41, R61) reviewed for abuse prohibition. Findings include: R13 sustained a hip fracture of unknown origin on 1/19/15, which was not reported to the SA immediately. Progress notes indicated R13 was found on the floor of her room on 1/19/15, at 12:05 a.m. R13 was sent to the hospital, and determined to have a femur fracture, which required surgical repair. The facility did not immediately report the incident to the SA, but reported the incident on 1/21/15.	F 225	1. Resident #13 sustained a hip fracture on 1/19/15 after falling out of bed. It is care planned that one of her risk factors of falls is sleeping right on the edge of her bed. The RN who reported this incident is no longer working here. Res #13's careplan was followed so it was not felt to be reportable until concerns about the type of fracture were brought up. Due to concerns about the type of fracture this incident was discussed with the EH Patient Relations Officer, the VCC Medical Director and the CMO. At that point it was reported to the SA but was late being reported. This was investigated per facility policy and was proved to have been caused by the fall from the bed with no suspicious activity. The investigation and the 5 day report were completed and	

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F 225	Continued From page 2 R13's Physician Order Report identified diagnoses including dementia, depression and osteoporosis. According to R13's 12/10/14 Quarterly MDS, she had severely impaired cognition, exhibited behaviors of physical , verbal and reject of care from 1 to 3 days in the assessment period and, range of motion impairments on both sides and her upper and lower extremities. The MDS also indicated that R13 required total assistance with bed mobility, activities of daily living, and did not transfer or ambulate. A copy of the investigative report and evidence of the 5 day report to the SA was requested and not received from the facility. R13's family reported bruises at a care conference held on 3/17/15 according to progress notes. The facility did not have documentation indicating awareness of the bruises prior to the 3/17/15 care conference note. According to the facility's SA report, a 2.3 centimeter (cm) x 1.6 cm bruise of unknown origin was discovered on R13's posterior upper left arm. This bruise of unknown origin was not immediately reported to the SA, but was reported on 3/19/15. In addition, the multiple other bruises of unknown origin were not reported to the SA or comprehensively investigated. A 3/17/15 facility progress note indicated a "head to toe" was initiated and the following additional bruises were reported at that time: 2.8 cm x 1.8 cm to lower aspect of left posterior arm; all over bruising to posterior surface of left hand; 1 cm x 1 cm grey purple bruise to anterior forearm; 5 cm x 7 cm fading purple grey bruise inferior to right posterior elbow; multiple grey, fading bruises to lower aspect of right posterior forearm; right middle digit was slightly swollen and red with a 1	F 225	were available at the time of survey. An RCA was completed due to frequent falls. Resident was evaluated for a Restorative Nursing Program. The care plan was reviewed and revised as necessary. Resident #13's family reported bruises at her care conference on 3/17/15. The incident was not reported to the SA until 3/19/15. Staff did not report immediately because resident is frequently physically aggressive and combative with cares. Progress notes clearly show residents behavior pattern during this time and the bruises were not determined to be from suspicious activity. An incident investigation was completed and sent to the SA on 3/23/15. Upon interview with reporting RN the nurse stated she did not feel it was reportable because when she interviewed staff involved she found out resident had been combative with cares and has several risk factors for bruising. There is documentation in resident's record regarding combative behavior during this period of time. A comprehensive skin assessment was completed which includes risk factors for bruising. Her care plan was reviewed and updated, along with the resident profile and NA group list. Her history of bruising was comprehensively investigated. Resident #4 initiated a resident to resident incident unintentionally which resulted in physical abuse between the two residents on 4/9/15 at 2018. Resident #4 has a dx of Bipolar Disorder, Depression, Anxiety, Dementia with Behavior Disorder, OCD	

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F 225	Continued From page 3 cm scab. The progress note continued, "Bruising d/t [due to]combativeness during cares, catheter implemented to reduce behaviors." R4 backed another resident (R94) against the TV in the bird lounge and was striking her on the arms according to progress notes dated 4/9/15. R4 was redirected away from the area and away from R94. The facility did not immediately report this incident to the SA, but reported this incident on 4/10/15 (time unknown). An investigation was requested and not received from the facility. A SA report of investigation was not completed within 5 days. R4's Admission Record identified diagnoses that included pain, dementia, and bipolar disorder. Her quarterly Minimum Data Set (MDS) dated 3/29/15, indicated that R4 had periods of delirium, rejection of care, and verbal and physical behaviors. R4's Cognitive Loss/Dementia Care Plan, stated 12/16/14, indicated that she had short and long term memory loss and limitations in decision making. R41 called a friend on 6/7/15, at 8:45 p.m., because a nursing assistant (NA) told R41 she was going to go get help and the NA never returned; this was according to an internal email describing the event. According to the email, R41 also reported that the NA was rude, telling R41 she could do cares by herself. This incident was not immediately report to the SA, but was reported on 6/8/15 (time unknown). Although the facility provided a standard response identifying a 5 day investigative report was submitted, there was not a comprehensive investigation provided upon request.	F 225	and Chronic Pain. She had multiple psychotropic medications when she was admitted to this facility and her primary care providers have been decreasing her medications. The other resident involved was a wanderer who got in front of other residents while they were watching TV, sitting at tables, or in activities. The other resident is no longer in the facility. The incident was reported to the SA at the beginning of the RN's shift on the next day at approximately 1600 which was within 24 hours. The incident was not felt to be reportable immediately due to no physical harm, pain or mental anguish per the " Resident to Resident Altercation Algorithym". The investigation was completed and sent to the SA. Resident #41 reported rude behavior by a NA. The incident report and investigation were completed and reported to the SA two days later. An interview was done with the NA on the date/shift of the incident. The N/A confirmed that she "forgot to go back and boost up resident" She stated she " was not trying to be rude but may have been and that she didn't wash up resident because resident didn't ask" The N/A was put on administrative leave pending an investigation and her employment was ultimately terminated. When questioned, the staff member (RN) stated she did not the incident immediately because she thought putting the employee on administrative leave handled the problem at the time. The incident was reported to the SA within 24 hours. A comprehensive investigation was	

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F 225	Continued From page 4 Complete information regarding the incident including documentation of the investigation was requested, but not received from the facility. The facility provided emails identifying a report had been made to the SA however had no evidence of a comprehensive investigation. R41's Admission Record identified diagnoses for rehabilitation after a procedure (surgical repair of a hip fracture), weakness, pain, congestive heart failure and hypertension. Her ADL Assistance Care Plan directed staff that R41 required assist of 2 to boost up in bed , limited assist of one for dressing, extensive assist of 1 with walker for transfers, and limited assistance with toileting needs. R41's Admission MDS, with a target date of 5/26/15, indicated that she is cognitively intact. R61 was noted to have four bruises on her upper right arm on 10/8/14. These bruises of unknown origin were not immediately reported to the SA, but were reported on 10/9/15 (time unknown). A facility progress note dated 10/8/15, at 9:18 p.m., indicated "4-5 bruises that are reddish/marron [maroon] in color measuring, 3.2 cm x 4.5, 2 cm x 2 cm, 2 cm x 3.5 cm, 1 cm x 2 cm, 1 cm x 1 cm." The facility's investigative report to the SA concluded the bruising was a result of "staff assisting resident with changing her brief, turning resident by holding her shoulder and upper arm. Staff were reminded to be 'more gentle' with resident and to move her more slowly as she has fragile skin." R61's Admission Record identified diagnoses including dementia, generalized pain, incontinence and failure to thrive. R61's quarterly MDS, with a target date of 4/10/15 indicated she was severely cognitively impaired and required	F 225	completed and NA was terminated. Resident #61 was noted to have bruises on her right upper arm on 10/8/14. The incident was discovered at 2118 on 10/8/14. The bruises were reported to SA on 10/9/14 at 1812 within 24 hours. The incident investigation was provided to the surveyor prior to the exit. There was an investigation of the bruising by the RN Manager who has since retired and it was determined to be caused by staff turning resident by holding her shoulder and upper arm when changing resident's brief. Resident had a fall on 9/20/14 which resulted in an ER visit to r/o hip fx. Her transfer assistance had changed due to injury on her left side from the fall. This incident was determined to not have a suspicious cause. A comprehensive skin assessment was completed which includes risk factors for bruising. Her careplan was reviewed and updated, along with the resident profile and NA group list. 2. All residents have the potential to be impacted by the deficient practice. Staff will follow the revised Abuse Prevention Plan should an alleged violation occur involving mistreatment, neglect or abuse including bruises or injuries of unknown orign to a resident. The RN Supervisor will be responsible to review and report incidents on weekends, holidays and after regular work hours. The Administrator will be notified immediately of any alleged violatons(VA reports).If staff have questions about reporting incidents they	

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F 225	Continued From page 5 extensive assistance with ADL's including toileting, transferring and bed mobility. R61's Skin Care Plan, dated 6/26/14, indicated that R41 bruised easily related to medications used and directed staff to provide extensive assist of 1 to turn and reposition every 2-3 hours. It also directed an extensive assist of 2 to boost up in bed. During an interview on 8/12/15, at 2:01 p.m., the director of nursing (DON) stated that she and the administrator "usually" get all the SA reports, but not always. The DON stated that the nurse who made the initial report was responsible for completing the investigation and the reporting. The DON stated that she did not keep track of the progress of each incident. When asked why the events were not reported in a timely manner, the DON answered "I do not know." In an interview on 8/12/15, at 3:59 p.m., the administrator stated staff is supposed to call her immediately, but she did not always get called. In an interview on 8/13/15 at 9:55 a.m., with the Administrator and the DON, the administrator stated that immediate reporting to the DON or administrator is required. Immediate is considered within one to two hours. The staff was responsible for reporting to the SA within 24 hours and to then begin the investigation. The administrator indicated the facility may be failing to document if the DON or Administrator was notified. The administrator, when asked to clarify expectations, stated that external reporting to the SA was to be done within 24 hours.	F 225	are instructed to call their RN Manager or DON after hours or on weekends. 3. The Abuse Prevention Policy was reviewed and revised to include identification of suspicious events that require reporting and investigation. An Incident Tracking Log was created to include all reportable and non -reportable resident incidents. This log is on a shared drive which is available to all registered nursing staff to update and keep current with all incidents. There is also a nursing reference book on each nursing unit with all the information on how to report incidents, including the Policy, algorithms, telephone numbers, etc. for reporting incidents of unknown orign or suspected abuse.VCC staff were re-educated on the incident reporting procedure, the Abuse Prevention Plan and the need to complete the investigation process. 4. Occurence/Accident Form reports will be reviewed daily Monday through Friday with the IDT team. Audits of incident report completion will be completed weekly by the DON or designee for a minimum of three months.Staff will be re-educated or counseled as needed based on the results of the audits. The audit results will be reported to the quarterly QI team and the QI team will make recommendations for ongoing monitoring based on results. 5. Completion date for F225 is September 23rd. 2015 6. Persons responsible: Administrator,	

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F 225	Continued From page 6	F 225	DON, RN Managers.	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an abuse prohibition policy that directed staff to immediately report to the State Agency (SA). In addition, the facility failed to develop and implement a system for: identifying abuse; immediately reporting potential abuse to the SA; thoroughly investigating each incident; and responding to occurrences to prevent further incidents. Further, the facility failed to report and consistently investigate potential abuse/neglect/mistreatment to the state agency for 4 of 4 residents (R13, R61, R4, and R41) reviewed for abuse prohibition. Findings include: The facility policy and procedure "Abuse Prevention Plan", dated 11/13, directed staff to notify the facility administrator "immediately (within 24 hours) if alleged allegation of mistreatment, abuse, neglect, or injuries of unknown source regardless if the report was submitted to the MDH/CEP [Minnesota Department of Health/Common Entry Point]." The policy also directed staff to promptly (within 24	F 226	1. Resident #13 sustained a hip fracture on 1/19/15 after falling out of bed. It is care planned that one of her risk factors of falls is sleeping right on the edge of her bed. Her care plan was followed so it was not felt to be reportable. Due to concerns about the type of fracture this incident was discussed with the EH Patient Relations Officer, the VCC Medical Director and the CMO. At that point it was reported to the SA but was late being reported. This was investigated per facility policy and was determined to have been caused by the fall from the bed with no suspicious activity. The investigation and the 5 day report were completed. An RCA was was completed due to frequent falls. Resident was evaluated for a Restorative Nursing Program. The care plan was reviewed and revised as necessary. Resident #13's family reported bruises at her care conference on 3/17/15. A comprehensive skin assessment was completed which includes risk factors for	9/23/15

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F 226	Continued From page 7 hours) review, investigate and report all suspected cases of maltreatment. The facility policy directed staff to make an electronic report within 24 hours "of the time of initial knowledge that the incident occurred" to the MDH. The policy contained a section titled for identifying abuse/neglect that addressed an approach for identifying individual resident risk factors. However, the policy did not address the identification of suspicious events that required reporting and investigation. On 8/12/15, at 2:01 p.m., the director of nursing (DON) was interviewed. The DON stated the facility did not have a system to track allegations of abuse/neglect/mistreatment, including reports to the SA. The DON stated staff nurses go to the website and report allegations to the SA. The DON stated either the registered nurses (RN) or licensed practical nurses (LPN) were responsible to make reports of potential abuse, neglect or mistreatment. The DON stated the evening or night shift they "usually" leave the reporting for the nurse manager to do the next day. Staff nurses print off the report, leave it in a mailbox and leave it for the next shift. The reports get reviewed at the team "huddle" on Monday or Thursday. There is a "Fall Meeting" on Mondays; the report might get reviewed there, too. During the interview on 8/12/15, at 2:01 p.m., the DON stated that she and the Administrator "usually" received the allegations reported to the SA, but not always. The DON also stated that she "usually" got the final word from the SA which indicated no further investigation is needed, but not always. The DON stated the nurse making the initial report is responsible for completing the	F 226	bruising. Her care plan was reviewed and updated, along with the resident profile and NA group list. Her history of bruising was comprehensively investigated. Resident #4 initiated a resident to resident incident unintentionally which resulted in physical abuse between the two residents The investigation was completed. Resident #41 reported rude behavior by a NA. The incident was reported to the SA within 24 hours. A comprehensive investigation was completed, NA was terminated. Resident #61 was noted to have bruising on 10/8/14. A comprehensive skin assessment was completed which includes risk factors for bruising. Her careplan was reviewed and updated, along with the resident profile and NA group list. 2. All residents have the potential to be impacted by the deficient practice. Staff will follow the revised Abuse Prevention Plan should an alleged violation occur involving mistreatment, neglect or abuse including bruises or injuries of unknown orign to a resident. The RN Supervisor will be responsible to review and report incidents on weekends and holidays. The Administrator will be notified immediately of any alleged violations(VA reports). 3. The Abuse Prevention Policy was reviewed and revised to include identification of suspicious events that	

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F 226	Continued From page 8 investigation and the reporting. The DON stated she did not keep track of the progress of each incident. When asked why the 4 events were not reported timely, the DON answered "I do not know." In an interview on 8/12/15, at 3:59 p.m., the administrator stated staff is supposed to call her immediately, but she guesses that she does not always get called. She also indicated sometimes incidents get reported to the campus-wide (includes hospital and clinic) Risk Management, Patient Relations Officer system first and she found out about them the next day. In an interview on 8/12/15, at 4:28 p.m., LPN-B stated that reporting to the SA should happen "the sooner, the better", but should be done with-in 24 hours. In an interview on 8/12/15, at 4:32 p.m., LPN-A stated that incidents are to be reported to the State immediately, which means within 24 hours. In an interview on 8/12/15, at 4:38 p.m., RN-C stated that she reported immediately, but thought they had 24 hours. On 8/12/15, at 4:46 p.m., RN-D stated that they had 2 hours to report to the administrator and 24 hours to report to the SA. In an interview on 8/13/15, at 9:34 a.m., the Patient Relations Officer stated he got calls and email reports from families, patients or staff. The email reports went to an in-box and are not immediate notifications. If he gets an incident report from the nursing home, he will notify the	F 226	require reporting and investigation.The policy was updated to clarify the incident reporting procedure which includes immediate notification to Administrator and SA. An Incident Tracking Log was created to include all reportable and non -reportable resident incidents. Administrator or DON or designee will track and monitor all incidents. VCC staff were re-educated on the incident reporting procedure, the Abuse Prevention Plan and the investigative process. 4. Occurence/Accident Form reports will be reviewed daily Mon-Fri with the IDT team, the RN Supervisor will review them on weekends and holidays. Audits of incident report completion will be completed weekly by the DON or designee. Staff will be re-educated or counseled as needed based on the results of the audits. The audit results will be reported to the quarterly QI team and the QI team will make recommendations for ongoing monitoring based on results. 5. Completion date for F226 is September 23rd. 2015 6. Persons responsible: Administrator, DON or designee	

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F 226	Continued From page 9 supervisor, DON and administrator. The Patient Relations Officer stated he talked to the Administrator daily, but did not report to the SA and did not work with nursing home regulations. In an interview with the DON on 8/13/15, at 9:28 a.m., she stated the investigation had to start right away with demographics, then notification and reporting; a complete investigation was completed after that. The Supervisor who had the incident occur on their unit is in charge of the whole process from reporting to investigation. The DON stated she is not involved with reporting and investigations unless needing to answer questions. The DON stated she suspected the inconsistencies in timeliness of reporting was related to staff being uncertain what to report, so they wait to talk with someone else. She stated they discussed incidents in the morning meetings, which occur three times a week. She again stated there is no system for monitoring and tracking allegations. In an interview on 8/13/15 at 9:55 a.m., with the administrator and the DON, the administrator stated that immediate reporting to the DON or administrator is required. Immediate is considered within one to two hours. The staff was responsible for filing to the SA within 24 hours and to then begin the external investigation. The administrator indicated the facility may be failing to document if the DON or Administrator was notified. The administrator, when asked to clarify expectations, stated that external reporting to the State Agency is to be done within 24 hours. The Administrator also stated that the DON is actively involved in resolution. The DON stated that the facility is not able to track and trend with the computer system they currently use. She stated	F 226		

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(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
F 226	Continued From page 10	F 226		

the residents with the most bruises have more combative behaviors. The DON verified that without a comprehensive investigation, they were unable to rule out abuse and that agreed the behavioral residents were more vulnerable.

R13 sustained a hip fracture of unknown origin on 1/19/15 according to a progress note of same date at 12:39 a.m.. Progress notes identified R13 was found on the floor of her room on 1/19/15, at 12:05 a.m. R13 was sent to the hospital, and determined to have a femur fracture, which required surgical repair. The facility did not immediately report the incident to the SA, but according to the Investigative Report Submission for the SA the incident was reported on 1/21/15.

R13's family reported multiple bruises at a care conference held on 3/17/15. The facility did not have documentation indicating awareness of the bruises prior to the 3/17/15 care conference note. Although multiple bruises of unknown origin were identified and documented on 3/17/15, at 4:22 p.m. only one bruise was reported. According to the facility's SA incident report, a 2.3 centimeter (cm) x 1.6 cm bruise of unknown origin was discovered on R13's posterior upper left arm. This bruise of unknown origin was not immediately reported to the state agency, but was reported on 3/19/15.

R4 backed another resident (R94) against the TV in the bird lounge and was striking her on the arms according to progress notes dated 4/9/15. R4 was redirected away from the area and R94. The facility did not immediately report this incident to the SA, but reported this incident on 4/10/15 (time unknown). An investigation was requested and not received from the facility. A SA report of

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F 226	Continued From page 11 investigation was not completed within 5 days. R41 called a friend on 6/7/15, at 8:45 p.m., because a nursing assistant (NA) told R41 she was going to go get help and the NA never returned; this was according to an internal email describing the event. According to the email, R41 also reported that the NA was rude, telling R41 she could do cares by herself. This incident was not immediately report to the SA, but was reported on 6/8/15 (time unknown). Although the facility provided a standard response identifying a 5 day investigative report was submitted, there was not a comprehensive investigation provided upon request. R61 was noted to have four bruises on her upper right arm on 10/8/14 according to progress notes. The multiple bruises of unknown origin were not immediately reported to the SA, but were reported on 10/9/15 (time unknown). During an interview on 8/12/15, at 2:01 p.m., when asked why the events were not reported timely, the DON answered "I do not know."	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a lift sling was	F 241	1. Resident #6 expired on8/15/15	9/23/15

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F 241	Continued From page 12 placed in a dignified manner for a resident while in the wheelchair for 1 of 2 residents (R6) reviewed utilizing lift slings. Findings include: R6's quarterly Minimum Data Set (MDS) dated 7/3/15, indicated R6 had moderate impairment in cognition, extensive assistance with two persons to transfer with upper and lower physical impairments to both sides. The MDS indicated R6 had a diagnosis of a stroke. R6's care plan dated 4/8/15, identified R6 was to be transferred with an EZ lift and two staff. The care plan did not identify R6 refused to allow the tucking of the lift sling. On 8/10/15, at approximately 1:00 p.m. R6 was observed with lift sling under R6 while in the wheelchair. The sling straps were drawn up between the resident's legs and then over the legs over the hip area to R6's side. On 8/10/15, at 6:30 p.m. R6 was again observed during resident interview to have the lift sling under the resident in the wheelchair. The sling straps were drawn up between the resident's legs and then over the legs in the hip area to R6's side. On 8/14/15, at 10:48 a.m. nursing assistant (NA)-J verified the lift slings should be tucked in so others can not see the lift sling On 8/14/15, at 10:46 a.m. registered nurse (RN)-A reported that lift slings should be safely tucked in and not be visible to others. RN-A also reported that if a resident does not allow the tucking of the lift sling it should be on the care	F 241	2. All residents have the potential to be treated in an undignified manner, especially those with cognitive or physical impairments. The care plans of all residents who use lift slings will be reviewed and revised by 9/23/15. 3. The Policy on Dignity was reviewed and revised to include lift sling placement. All staff were re-educated on resident dignity, especially focused on lift sling placement and comfort.Staff were reminded to immediately report any potential concerns related to resident dignity to their supervisor or any other member of the facility management staff. 4. Observational monitoring will be completed a minimum of four times a week at random times for a period of three months. Results will be reviewed during the quarterly QI committee meeting. The QI team will make recommendations for ongoing monitoring. 5. Completion date for F241 is Sept 23,2015 6.Persons responsible: RN Managers and Social Workers.	

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F 241	Continued From page 13 plan. On 8/14/15, at 11:47 a.m. the director of nursing (DON) confirmed it is not a dignified experience for the residents to have a lift sling visible. She stated the expectation was the lift slings would not be visible while residents were in their wheelchairs. The DON reported that the facility does not have a policy on the placement of lift slings.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to offer bathing frequency preferences for 1 of 3 residents (R77) reviewed for choices. Findings include: R77's quarterly Minimum Data Set (MDS) dated 7/14/15, indicated R77 was cognitively intact, had no mood or behavior symptoms and choices regarding the type of bath received was somewhat important. The MDS indicated R77 required physical help with bathing and supervision with personal hygiene.	F 242	1. Resident #77 has been interviewed for her preference for bathing. The plan of care, profile and NA group list for #77 was revised based on her preferences. 2. All residents have the potential to be affected by this deficient practice. All residents will be interviewed for their choice of bathing by 9/23/15 and care plans will be updated. 3. The policy for Residents Rights, Refusal of Care or Treatment was reviewed and revised as necessary. All staff were re-educated on residents rights	9/23/15

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F 242	Continued From page 14 R77's face sheet printed 8/12/15, identified diagnoses that included generalized pain, congestive heart failure, anxiety, and osteoarthrosis (arthritis). R77's care plan dated 5/25/14, directed staff to provide extensive assist of one staff with weekly shower and shampoo. The care plan indicated R77 had no bathing preference. The nursing assistant (NA) group sheets (care information sheets) indicated R77 was scheduled for one bath/shower a week. During an interview on 8/11/15, at 9:09 a.m. R77 stated she received one shower a week, but preferred at least 3 showers a week. R77 stated she did not have a choice in how many showers she received. During an interview on 8/12/15, at 1:07 p.m. nursing assistant (NA)-D stated if residents want another shower, she just gives them one. On 8/12/15, at 1:42 p.m. NA-D stated the registered nurse (RN) asks the residents on admission how many baths they prefer. During an interview on 8/14/15, at 10:14 a.m. RN-A stated they ask about bathing preferences on admission and if they bring it up at their quarterly assessments/care conferences. RN-A stated the residents are not specifically asked after admission. During an interview on 8/14/15, at 11:37 a.m. NA-D stated R77 has never asked her for another bath.	F 242	to make choices about their cares, including bathing preferences. 4. Resident audits on preferences for bathing will be completed a minimum of four times a week on day and pm shift for a period of three months. Results will be reviewed during the quarterly QI committee meeting. The QI Team will make recommendations for ongoing monitoring. 5. Completion date for F242 is September 23rd, 2015. 6. Responsibility for corrections is: RN Managers.	

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F 242	Continued From page 15 The facility policy for Resident Rights, Refusal of Care or Treatment dated 6/07, indicated each resident had the right to control their own plan of care and treatment and the right to choose activities, schedules, and health care; and make choices about aspects of their life in the facility that would be significant to them.	F 242		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess and re-evaluate fall interventions for 2 of 3 residents (R35, R19) reviewed for accidents.	F 280	1. Resident #35 had a comprehensive fall assessment completed including interventions and a RCA. The care plan, profile and NA group list were revised to	9/23/15

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F 280	Continued From page 16 Findings include: R35's comprehensive admission Minimum Data Set (MDS) dated 7/15/15, indicated R35 had moderate cognitive impairment, no behaviors, and minimal symptoms of depression. The MDS identified R35 required extensive assist of 2 staff for bed mobility and toilet use, and extensive assist of one staff with transfers and wheelchair locomotion, and assist of two staff with ambulation. R35 had a balance impairment and required assistance to stabilize, had range of motion impairment of the upper and lower extremities on one side of the body, and had falls prior to and since admission. The Care Area Assessments (CAA) dated 7/5/15, indicated R35 was alert and oriented, able to make needs known and use the call light to ask for assistance. The CAA indicated R35 was aware of his limitations and did not attempt to get up unattended, was more weak lately and had several falls prior to admission. The CAA directed R35 was to wear non-skid footwear at all times and have a clutter-free environment. Facility incident reports and progress notes indicated R35 had falls on 7/5/15, at 6:50 a.m. and 7/13/15, at 7:50 a.m. No assessments were completed for the falls to assist with developing appropriate interventions and evaluate the efficacy of the current interventions. During an interview on 8/12/15, at 1:30 a.m., registered nurse (RN)-A stated they do an assessment of a resident's condition following a fall, and assess and treat according to the injury and situation. RN-A stated they do a root cause	F 280	include the interventions. The IDT fall team participated in the process. Resident #35 was assessed for a Restorative program. Resident # 19 had a comprehensive fall assessment completed including interventions and a RCA. The care plan, profile and NA group list were revised to include the interventions. The IDT fall team participated in the process. 2. All residents could be affected by the deficient practice. All residents with falls will have their care plans reviewed and/or revised to be individualized by 9/23/15. 3. The Care Planning Policy was reviewed and revised as appropriate. The Acident/injury Policy was reviewed and revised as neccessary. Nursing staff were re-educated on the Policies and process for accident/incident assignments. 4. The DON or designee will review all events to ensure that a RCA is completed. A minimum of three audits will be done weekly for three months to ensure compliance. Staff will be re-educated on an ongoing basis as needed based on the results of the audits.The monitoring results will be reported to the quarterly QI team. The QI team will make recommendations for ongoing monitoring. 5. Completion date for F225 is September 23. 2015. 6. Persons responsible: DON RN Managers.	

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F 280	Continued From page 17	F 280		

analysis which was recorded in the events in the electronic chart and they had a falling stars committee that was supposed to meet weekly.

During an interview on 8/14/15, at 10:35 a.m. the DON stated she was not involved with the falls meetings anymore. The DON stated the days for the meetings had been moved for various reasons, but they were to be meeting weekly and were to do a root-cause analysis.

R19's Admission Record specified she was admitted for rehabilitation following a fall with arm fracture, and had chronic pain. R19's Minimum Data Set (MDS) assessment, with a target date of 6/10/15, indicated she was cognitively intact. The MDS identified R19 as needing extensive assistance with toileting, personal hygiene and dressing. The MDS also indicated that R19 was frequently incontinent of bladder, but was always continent of bowel.

R19's Care Area Assessment (CAA) for falls identified balance problems during transitions and two falls in early June (6/6/15 and 6/8/15). Risk factors were listed as use of antipsychotic medications, diuretics, narcotic pain medication, diagnosis of anemia, schizophrenia, depression, neuropathy, incontinence, point pain due to degenerative joint disease (DJD), and diabetes with poorly controlled blood sugars. The CAA directed staff to continue to monitor for safety, assist with cares, ensure call light was within reach and encourage use, and keep nonslip footwear on. The identified goal was no injury.

A progress note dated 6/6/15, at 7:34 a.m. indicated R19 was found on the floor at 6:45 a.m. According to the note R19 stated that she slid out of bed because of the "green pad, that thing is slippery! " R19 denied hitting her head and denied any pain. R19 was noted to not be wearing

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F 280	Continued From page 18 "grippy socks". Subsequent progress notes indicated that R19 was monitored for adverse effects from the fall. A progress note dated 6/8/15, at 2:20 p.m., indicated R19 was found on the floor in front of her door. According to the progress note, R19 slipped off her wheel chair while coming out of her room. R19 denied hitting her head. The note stated to place dye in R19's wheelchair. This was not added to R19's care plan. Event reports were provided for each of R19's falls. The event reports categorized the falls, linked related progress notes and provided a checklist of pain and body observation, neurological checks, mental status and possible contributing factors. The reports did not provide detail for analysis nor did they provide interventions. Although requested, the facility did not provide documentation of further assessment of R19's falls.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide assistance with eating as directed by the plan of care for 1	F 282	1. Resident #58 has been re-evaluated for assistance with eating. She has also been evaluated for an OT eating program	9/23/15

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F 282	Continued From page 19 (R58) of 4 residents reviewed for nutrition. In addition, the facility failed to follow care plan interventions for appropriate bed height for 1 of 2 residents (R14) reviewed for bed height. Findings include R58 was observed on 8/10/15, 8/11/15, and 8/12/15. R58 was observed not to receive assistance with eating during meal service. R58's quarterly minimum data set (MDS) dated 5/26/15, indicated severe cognitive impairment and required physical assistance of one for eating. R58's current resident profile indicated diagnosis of Alzheimer's disease, esophageal reflux, and vitamin D deficiency. R58's Nutritional progress note date 4/17/15, indicated res has had a 6.3 pound weight loss in the past month appetite fluctuates, will eat a little more with staff assistance. R58's care plan dated 5/19/15, indicated poor nutritional intake, encourage good nutrition and adequate fluid intake and "please assist me with feeding at the current time. On 8/10/15, at 5:30 p.m. during the supper meal R58 was observed not to receive staff assistance with feeding during the meal. Documented meal intake was 1-25%. On 8/11/15 at 11:55 a.m. during the lunch meal R58 was observed not to receive staff assistance with feeding during the meal. Documented meal intake was 1-25%.	F 282	and need for adaptive equipment which were both deemed not appropriate due to impaired cognition. She is now seated at a table with other residents who need either staff supervision or assistance with eating. Her care plan, profile and NA group list were revised as neccessary. Dietician and Dietary Tech reassessed and monitored for nutrition risk and reaffirmed appropriatness of care. Resident #14 was re-assessed for proper bed height and her care plan, profile and NA group lists were updated as necessary, including fall interventions. 2.All residents have plans of care which must be followed by staff caring for the resident. All resident with specific bed heights and those who need staff assist with eating will be reviewed. Their care plans, profiles and NA group lists will be updated as needed. All residents are reviewed by nursing during their MDS assessment period to ensure care plans, profiles and NA group lists are updated with any changes. 3. The Care Plan Implimentation policy was reviewed and revised as necessary. Care Plans remain readily available for all staff providing direct care to the residents. Staff were re-educated on the Care Plan Policy, the eating assistance care plan for resident #58 and safety interventions including appropriate bed heights for all residents. 4. Observational audits will be completed to ensure the plans of care are being followed. A minimum of three audits will	

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F 282	Continued From page 20 On 08/12/2015, at 7:50 a.m. during the breakfast meal R58 was observed not to receive staff assistance with feeding during the meal. Documented meal intake was 51-75%. On 8/12/15, at 12:05 p.m. during the lunch meal R58 was observed not to receive staff assistance with feeding during the meal. Documented meal intake 25-50%. On 08/12/2015, at 8:09 a.m. nursing assistant (NA)-F stated, R58 had dementia, and will wander off from the dining table. Staff tried to redirect her back to the table but did not sit and feed [R58]. On 08/12/2015, at 12:33 p.m. dietary aide (DA)-A verified R58's care plan indicated, "I need help with feeding." DA-A further stated she thought R58 needed feeding assistance. On 08/12/2015, at 12:39 p.m. the administrator acknowledged staff should have been following the care plan. It would be expected to have someone feeding her. She lost some weight several months ago and then balanced off; with her prognosis that is anticipated. However, we did fail to follow the care plan. On 08/12/2015, at 1:08 p.m. the director of nursing (DON) verified her expectation would be the staff should be following R58's plan of care. The facility policy titled "CARE PLAN IMPLEMENTATION" effective 7/06, indicated the facility will implement the resident's identified plan of care. R14's annual Minimum Data Set (MDS) dated 7/17/15 included a severe cognitive impairment,	F 282	be done weekly at various times to ensure on-going compliance for three months. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The moniitoring results will be reported to the Quartery QI team. The QI team will make recommendations for ongoing monitoring. 5. Completion date is September 23rd, 2015. 6. Persons responsible: DON, RN Managers.	

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F 282	Continued From page 21 requiring full assistance with bed mobility, total dependence on staff to transfer, with a diagnosis of dementia. The MDS also indicated R14 was at a risk for falls. R14's care plan dated 4/15/15, instructed staff to keep the bed at regular height. The undated nursing assistant task sheet did not identify fall interventions. On 8/12/15, starting at 7:11 a.m. to 8:24 a.m. R14 was observed in bed. The bed was observed to be in a high position. The top of the mattress was approximately 3 1/2 feet (ft) from the ground. On 8/12/15, at 11:50 a.m. R14 was observed to be lying in bed with the bed in a high position The top of the mattress was approximately 3 1/2 ft from the ground. On 8/14/15, at 10:24 a.m. R14 was again observed to be lying in bed with the bed in a high position The top of the mattress was approximately 3 1/2 ft from the ground. On 8/14/15, at 10:25 a.m. nursing assistant (NA-)H verified the bed is high and is not at a regular bed height. NA-H then lowered the bed. On 8/14/15, at 10:30 a.m. registered nurse (RN)-A reported the bed should be at regular height unless care planned differently. On 8/14/15, at 11:44 a.m. director of nursing (DON) verified all beds should be at regular height unless care planned differently. Regular height meant the average sized person could rise from the bed with their feet on the floor.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities	F 311		9/23/15

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F 311	Continued From page 22 specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide assistance with eating for 1 (R58) of 4 residents reviewed for nutrition. Findings include R58 was observed on 8/10/15, 8/11/15, and 8/12/15. R58 was observed not to receive assistance with eating during meal service. R58's quarterly minimum data set (MDS) dated 5/26/15, indicated severe cognitive impairment and required physical assistance of one for eating. R58's current resident profile indicated diagnosis of Alzheimer's disease, esophageal reflux, and vitamin D deficiency. R58's Nutritional progress note dated 4/17/15, indicated R58 had a 6.3 pound weight loss in the past month, appetite fluctuated, would eat a little more with staff assistance. R58's care plan dated 5/19/15, indicated poor nutritional intake, encourage good nutrition and adequate fluid intake and "please assist me with feeding at the current time. On 8/10/15, at 5:30 p.m. during the supper meal R58 was observed not to receive staff assistance with feeding during the meal. Documented meal intake was 1-25%. On 8/11/15 at 11:55 a.m. during the lunch meal	F 311	1. Resident #58 has been re-evaluated for assistance with eating. She has also been evaluated for an OT eating program and need for adaptive equipment, which was not deemed appropriate. Her care plan, profile and NA group list were revised as neccessary. Dietary re-evaluated her and made no changes.She is assisted at mealtimes and is seated at a table with other residents who need assist or supervision with eating. 2.All residents have plans of care which must be followed by staff caring for the resident. All residents will be assessed by OT or RN for need with assist with eating. If identified as needing assist their care plans, profiles and NA groups lists are updated and assist will be provided by staff. They will be screened for potential restorative eating programs. They will be observed at mealtimes. All residents care plans will be reviewed by nursing during their MDS assessment period and ensure their care plans, profiles and NA group lists are updated with any changes. 3. The Care Plan Implimentation policy was reviewed and revised as necessary. Care Plans remain readily available for all staff providing direct care to the residents. Staff were re-educated on the	

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F 311	Continued From page 23 R58 was observed not to receive staff assistance with feeding during the meal. Documented meal intake was 1-25%. On 08/12/2015, at 7:50 a.m. during the breakfast meal R58 was observed not to receive staff assistance with feeding during the meal. Documented meal intake was 51-75%. On 8/12/15, at 12:05 p.m. during the lunch meal R58 was observed not to receive staff assistance with feeding during the meal. Documented meal intake 25-50%. On 8/12/15, at 8:09 a.m. nursing assistant (NA)-F stated, R58 had dementia, and would wander off from the dining table. Staff tried to redirect her back to the table but they did not sit and feed [R58]. On 8/12/15, at 12:33 p.m. dietary aide (DA)-A verified R58's care plan indicated, "I need help with feeding." DA-A further stated she thought R58 needed feeding assistance. On 8/12/15, at 12:39 p.m. the administrator acknowledged it would be expected to have someone feeding [R58]. She lost some weight several months ago and then balanced off; with her prognosis that is anticipated. On 8/12/15, at 1:08 p.m. the director of nursing (DON) verified her expectation would be the staff should be following R58's plan of care. The facility policy titled "CARE PLAN IMPLEMENTATION" effective 7/06, indicated the facility will implement the resident's identified plan of care.	F 311	documenting of I&O's, the Care Plan policy and the eating assistance care plan for resident #58. Staff were trained as necessary on feeding assistance to residents.Nursing staff will be assigned to monitor the dining rooms at mealtimes. 4. Observational audits will be completed to ensure residents are recieving assistance with eating per the plans of care. A minimum of three audits will be done weekly at various times to ensure on-going compliance for three months. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The moniitoring results will be reported to the Quartery QI team. The QI team will make recommendations for ongoing monitoring. 5. Completion date is September 23rd, 2015. 6. Persons responsible: DON, RN Managers	

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F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assessment, intervention development, and implementation of safety interventions to prevent accidents for 5 of 6 residents (R35, R19, R14, R59, R56) reviewed for accident hazards. Findings include: R35's comprehensive admission Minimum Data Set (MDS) dated 7/15/15, indicated R35 had moderate cognitive impairment, no behaviors, and minimal symptoms of depression. The MDS identified R35 required extensive assist of 2 staff for bed mobility and toilet use, and extensive assist of one staff with transfers and wheelchair locomotion, and assist of two staff with ambulation. R35 had a balance impairment and required assistance to stabilize, had range of motion impairment of the upper and lower extremities on one side of the body, and had falls prior to and since admission. R35's signed physician orders identified diagnoses that included gait abnormality, history of falls, cerebrovascular disease and cerebral	F 323	Resident #35 had a comprehensive fall assessment completed including interventions and a RCA. The care plan, profile and NA group list were revised to include the intervention of Dycem on wheelchair. The IDT fall team participated in the process. Resident # 35 was assessed for a restorative program and evaluated for safety of propelling himself in the wheelchair by pulling himself along the railings in the halls. During the Stars meeting on 8/10/15 a summary of the meeting was documented and a conclusion was written with the following interventions put in place: OT and PT were started for 10 treatment sessions and he was placed on a Restorative Ambulation Program. Resident #19 had a comprehensive fall assessment completed including interventions and a RCA. The care plan, profile and NA group list were revised, including intervention of Dycem on wheelchair. The IDT team fall team participated in the process. A Restorative	9/23/15

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F 323	Continued From page 25 embolism (stroke) with hemiplegia (weakness on one side of the body), convulsions, altered mental status, anemia, depressive disorder, and malaise. The physician orders also indicated R35 received an antidepressant, blood pressure, and anti-seizure medications (all of which may increase fall risk). The Care Area Assessments (CAA) dated 7/5/15, indicated R35 was alert and oriented, able to make needs known and use the call light to ask for assistance. The CAA indicated R35 was aware of his limitations and did not attempt to get up unattended, was more weak lately and had several falls prior to admission. The CAA directed R35 was to wear non-skid footwear at all times and have a clutter-free environment. R35's care plan dated 6/23/15, indicated R35 had the potential for falls due to history of falls at home, weakness, history of stroke with one-sided weakness, and use of medications that could contribute to falls. The care plan directed staff to walk R35 with a hemi-walker (a walker used when there is weakness on one side of the body) and limited assist of one staff daily, 3 to 5 days a week, place the call light within reach at all times, and place the resident on the falling star program (program to monitor high risk fall residents). The care plan further directed to keep frequently used items within reach, resident to wear non-skid footwear, keep room free from clutter with a clear path to the bathroom and closet, and remind to ask for assistance with activities of daily living (ADLs) as needed. The care plan further indicated R35 required extensive assist of two for transfers and extensive assist of one for wheelchair mobility on and off the unit.	F 323	Services evaluation was also completed. Staff re-educated resident and male friend of risks for safety. Resident #14 expired on 9/10/15. Resident # 59 was reassessed for proper bed height and care plan, profile and NA group lists were updated as necessary, including fall interventions. Her toileting plan was re-evaluated with the current use of EZ-lift while on the commode. Resident # 56's bed with trapeze and mattress was re evaluated. After assessment of the bed and interview with the resident, resident #56 decided he did not want the trapeze any longer, as he did not use it. His bed has been replaced. Res#56 is the only resident who was currently using a trapeze. 2. All residents require comprehensive fall risk assessments to be completed on admission, quarterly, annually and with significant changes in condition. Assessments, RCA, investigations, interventions and implimentation of safety interventions, which includes specific bed heights, are required to prevent accidents for those residents at risk. Any resident with a need for a trapeze will be evaluated by therapy.We will utilize a specific bed (Stryker) which has a trapeze attatched and does not require adjustments to the mattress length. 3. The policies and procedures were reviewed and revised as appropriate. Staff	

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F 323	Continued From page 26 The nursing assistant (NA) care guide sheets indicated R35 was on the falling star program and was to be transferred with extensive assist of 2 staff and a transfer belt. R35's fall risk assessment dated 6/22/15, at the time of admission, indicated R35 was at risk for falls due to falls at home prior to admit, weakness, history of a stroke with left-sided weakness, medication use and required extensive assist of 2 with transfers. Facility incident reports indicated R35 had a fall on 7/5/15, at 6:50 a.m. when he fell out of bed while reaching too far and attempting to get up on the wrong side of the bed. During the root cause analysis on 7/6/15, the factors to be considered included R35's mood/behavior, mental status, vital signs, medications, last toilet use, environmental issues, circumstances of the fall, and was the care plan followed. Root cause analysis was not determined, evaluation was not completed, and no changes were made to the care plan. Resident progress notes and fall event dated 7/13/15, at 7:50 a.m. indicated R35 was found on the floor next to his wheelchair, bleeding from a laceration and a bump on his forehead. R35 stated he was reaching for something and slid out of the chair. He was sent to the emergency room for a scan of his head, which was negative, and steri-strips to the laceration. A fall scene investigation was done. No new interventions were implemented at that time. The fall team meeting notes and root cause analysis were empty and a conclusion was not documented. A safety event dated 7/13/15, at 5:45 p.m.	F 323	were re-educated on the policies and procedures, including following and implementing the care plan interventions related for bed height, trapeze placement.All staff were educated to not make adjustments to any bed related to a trapeze without a maintanence work order. 4. Three observational audits will be completed by DON or designee for a minimum of three months to ensure comprehensive fall assessments are completed and appropriate interventions are in place and implemented, including bed heights and trapeze usage. Occurrance/Accident reports will continue to be reviewed with the IDT and Stars committee to assure that appropriate interventions are developed. RCA, tracking and trending, fall rates will be reviewed at the Stars meetings. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The DON will report monitoring results to the quarterly QI committee. The QI team will make recommemdations for ongoing monitoring. 5.Completion dates is September 23rd, 2015 6. Persons responsible: DON, Managers and RN Supervisors.	

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F 323	Continued From page 27 indicated R35 had another fall and was found sitting on the floor in the hallway next to the wheelchair, gripping the hand rail with his right hand. R35 stated he was pulling himself along with the railing and pulled himself right off the wheelchair onto the floor. dye (non-skid material) was applied to the wheelchair seat as an intervention. The dye was not entered on the care plan, the NA care guide sheets, or on the computer resident profile. The fall description details and contributing factors were documented on the facility form, however the root cause of the fall and nurse reviewing the fall were not filled out. The Falls Team Meeting notes conclusion identified R35 had been moved to a room closer to the nurse's station and had Crohn's disease, so focus on bowel movements. There was no documentation of a root cause analysis of the fall or evaluation of the effectiveness of current interventions including the dye on the wheelchair. The nurse practitioner (NP) nursing home note dated 7/20/15, indicated R35 had a recent fall and bumped his head, for which he was sent to the emergency room and had a scan of the head. The CT scan was negative for brain injury. The NP ordered physical therapy and occupational therapy to improve his strength and ability to walk. The physical therapy (PT) discharge summary dated 8/4/15, indicated R35 was treated for ambulation and strengthening and had improved walking to minimum assistance for 100 feet with the hemi-walker. A safety event dated 8/8/15, at 9:00 p.m. indicated R35 was found sitting on the floor in the hallway by his wheelchair and had been pulling	F 323		

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himself in his wheelchair using the handrail. R35 stated he pulled so hard he slipped off his wheelchair and landed on his buttocks. The progress note indicated the dye was on the seat of the wheelchair, but R35 scooted to the edge of the seat in his wheelchair. The root cause analysis was documented on 8/8/15, at 9:15 p.m. by the licensed practical nurse (LPN) completing the form, and noted the same information identified in the progress note. The falls team meeting notes were blank, but the form was signed by several RNs and a social worker on 8/10/15. There was no documentation of assessment, evaluation of interventions, and no new interventions initiated.

During an interview on 8/12/15, at 7:09 a.m. R35 stated he never gets up by himself and knows that he can't get himself up. R35 stated he falls mostly in the hallway when he pulls himself along the railing as he pulls too hard.

During observation on 8/12/15 at 12:46 p.m. the call light was on the bottom of the bed. R35 was observed coming down the hall independently in his wheelchair, using his right leg to propel the wheelchair. There was a white cloth quilted pad over the cushion of the wheelchair with straps on the corners that hooked around the corners of the cushion. The dye was not visible on the chair. At 12:58, R35 turned on the call light on. NA-D answered the call light and during an interview at 1:07 p.m., stated the fall prevention interventions for R35 included having the call light within reach, the bed was lowered to the floor, the recliner chair that he sits in is all the way down and the remote is kept on the left side so he cannot reach it, and dye was on the wheelchair. NA-C then located the dye on the chair underneath R35. The

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dye was approximately 4 inch x 14 inch strip of blue non-skid material. NA-D stated R35 was much stronger after working with PT than he was when he was admitted. NA-D stated the kiosk resident profile would have the information about the dye. NA-D had the NA group sheet that indicated how R35 transferred and that he was on the falling star program.

During an interview on 8/12/15, at 1:30 a.m., registered nurse (RN)-A stated they do an assessment of a resident's condition following a fall, and assess and treat according to the injury and situation. An incident/events report was done. RN-A stated they do a root cause analysis which was recorded in the events in the electronic chart and they had a falling stars committee that was supposed to meet weekly.

During an interview on 8/13/15, at 9:55 a.m. the administrator stated an internal falls investigation form was filled out and the falls committee meeting was held. The RN manager in each area got the report and it was investigated there. The director of nursing (DON) stated they had quality assurance with falls and discussed the root cause there.

During an interview on 8/14/15, at 10:35 a.m. the DON stated she was not involved with the falls meetings anymore. The DON stated the days for the meetings had been moved for various reasons, but they were to be meeting weekly and were to do a root-cause analysis.

The facility policy and procedure for Incident/Accident revised 9/09, directed the incident report to be completed, investigated as needed, with implementation of interventions to

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prevent a recurrence of the incident. The interventions were to be communicated to staff by updating the care plan and NA group sheet, place on 24 hours report and place resident on clinical monitoring. Completed incident reports were given to the DON or administrator for review.

The facility policy and procedure for Fall Risk Assessment Protocol revised 7/28/15, directed restorative services, occupational and physical therapy, an RN and IDT to meet weekly at the Falls meeting to do a root-cause analysis and discuss issues regarding fall prevention and interventions. New falls were to be reviewed at the IDT morning meetings.

R19's Admission Record specified she was admitted for rehabilitation following a fall with arm fracture, and had chronic pain. R19's Minimum Data Set (MDS) assessment, with a target date of 6/10/15, indicated she was cognitively intact. The MDS identified R19 as needing extensive assistance with toileting, personal hygiene and dressing. The MDS also indicated that R19 was frequently incontinent of bladder, but was always continent of bowel.

R19's Care Area Assessment (CAA) for falls identified balance problems during transitions and two falls in early June (6/6/15 and 6/8/15). Risk factors were listed as use of antipsychotic medications, diuretics, narcotic pain medication, diagnosis of anemia, schizophrenia, depression, neuropathy, incontinence, point pain due to degenerative joint disease (DJD), and diabetes with poorly controlled blood sugars. The CAA directed staff to continue to monitor for safety, assist with cares, ensure call light was within reach and encourage use, and keep nonslip footwear on. The identified goal was no injury.

R19's Safety Care Plan, with a start date of

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F 323	Continued From page 31 6/5/14 indicated she had a potential for falls, a history of falls, weakness and poor safety awareness. The goal was that R19 would not be injured by a fall. Approaches, with start dates were: -self locking wheelchair (7/24/15) -call light within reach at all times. (6/5/15) -Resident placed on Falling STARS program (7/22/15) -Keep frequently used items within reach (6/5/15) -Nonskid footwear (6/5/15) -Please keep my room free from clutter, make sure I have a clear path to the bathroom and to my closet (6/5/15) -Remind me to ask for assistance with ADLs as needed (6/5/15) A progress note dated 6/6/15, at 7:34 a.m. indicated R19 was found on the floor at 6:45 a.m. According to the note R19 stated that she slid out of bed because of the "green pad, that thing is slippery! " R19 denied hitting her head and denied any pain. R19 was noted to not be wearing "grippy socks". Subsequent progress notes indicated that R19 was monitored for adverse effects from the fall. A progress note dated 6/8/15, at 2:20 p.m., indicated R19 was found on the floor in front of her door. According to the progress note, R19 slipped off her wheel chair while coming out of her room. R19 denied hitting her head. The note stated to place dycem in R19's wheelchair. This was not added to R19's care plan. According to a 6/28/15, 11:45 p.m. progress note, R19 was found on the floor in her room. In the note, she told staff she was going to the bathroom. R19 stated she did not hit her head,	F 323		

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F 323	Continued From page 32	F 323		

but did fall on her right knee. Subsequent progress notes indicated right knee ad rib pain requiring PRN Tylenol. A 7/3/15 note two areas on R19's ribcage sustained bruising and pain from the 6/28/15 fall.

A progress note dated 7/21/15, at 8:57 a.m. stated resident and male friend were leaving facility per usual. R19 was in the emergency room, as when she was getting into the car, she fell backwards and her head hit the tar and was bleeding. R19 returned to the facility from the ER on 7/21/15, at 10:44 a.m. with 4 staples to the back of her head. Subsequent progress notes indicated that monitoring and neuro checks were in place to ensure that the resident and the site were healing.

A progress note dated 7/22/15, at 6:50 a.m. identified R19 was found sitting on the floor by her bed. R19 stated that she was trying to get into her wheelchair. The note stated that R19 was "Wearing fuzzy socks and they appeared to have bunched up on her feet". R19 denied pain and denied hitting her head. Subsequent notes indicated that R19's vital signs and condition were being monitored.

Event reports were provided for each of R19's five falls. The event reports categorized the falls, linked related progress notes and provided a checklist of pain and body observation, neurological checks, mental status and possible contributing factors. The reports did not provide detail for analysis nor did they provide inteventions.

Review of progress notes revealed a restorative note on 7/23/15 stated R19 would not be picked

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F 323	Continued From page 33 up by skilled therapy and had refused Restorative programs "in the past". Althoguh requested, the facility did not provide documentation of root cause analysis, falling stars meeting notes or tracking/trending information regarding R19's five falls. This was verified by interview on 8/12/15, at 8:59 a.m., by RN-A, who stated she could not find documentation of changes in interventions, studies of R19's falls or root cause analysis. RN-A stated the restorative aide was in charge of the "Falling Star Program". The restorative aide did not respond to calls by RN-A for interview. RN-A stated that being on in the Falling Stars program meant that those residents are discussed at the weekly fall meeting. R14's annual Minimum Data Set (MDS) dated 7/17/15 included a severe cognition impairment, full assistance with bed mobility, total dependence on staff to transfer, and a diagnosis of dementia. The MDS also indicated R14 was at risk for falls. R14's care plan dated 4/15/15, instructed staff to keep the bed at regular height. On 8/12/15, from 7:11 a.m. to 8:24 a.m. R14 was observed in bed. The bed was observed to be in high position. The top of the mattress was approximately 3 1/2 feet (ft) from the ground. On 8/12/15, at 11:50 a.m. R14 was observed to be lying in bed with the bed in high position. The top of the mattress was approximately 3 1/2 ft from the ground. On 8/14/15, at 10:24 a.m. R14 was again observed to be lying in bed with the bed in a high position The top of the mattress was	F 323		

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F 323	Continued From page 34 approximately 3 1/2 ft from the ground. On 8/14/15, at 10:25 a.m. nursing assistant (NA)-H verified the bed was high and not at a regular bed height. NA-H then lowered the bed. R59's quarterly MDS dated 7/8/15, included a severe cognition impairment, extensive assistance with bed mobility and transfer assistance, with a diagnosis of psychotic disorder. The MDS included the resident was a high risk for falls with a previous fall the last quarter. The care plan dated 4/6/15 directed staff to utilize an EZ lift with one person for transfers. On 8/11/15, at 8:20 a.m. and at 10:22 a.m. R59 was observed in bed with the bed in a high position. The top of the mattress was approximately 3 1/2 ft from the ground. On 8/12/15, at 7:21 a.m. R59 was observed to be on the commode in R59's room with the harness and leg straps connected to an EZ stand. The brakes were locked. The resident was alone in the room. On 8/12/15, at 7:26 a.m. NA-I came into the room and handed R59 a washcloth and instructed the resident to wash their face and that they would be back shortly. R59 remained in the EZ stand on the commode. On 8/12/15, at 7:27 a.m. NA-I reported it is the normal routine of R59 to be left hooked to the EZ stand while using the bathroom, as R59 likes to sit for quite a while. On 8/12/15, at 7:46 a.m. NA-I returned to R59's room to finish morning cares.	F 323		

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F 323	Continued From page 35 On 8/14/15, at 10:30 a.m. registered nurse (RN)-A reported the bed should be at regular height unless care planned differently. RN-A further stated that she believed it was okay for the residents to be left hooked to the EZ stand and left alone as long as the aids checked on them several times. On 8/14/15, at 11:44 a.m. director of nursing (DON) verified all beds should be at regular height unless care planned differently. Regular height means the average person can rise from the bed with their feet on the floor. The DON also confirmed that a resident should never be left alone in a room attached to any lift and the aids were taught that in training. The policies titled Safety- Infection Prevention Manual dated 6/13 and Nursing Service Policy and Procedure Manual Lifting and /or Transferring did not address leaving residents attached to the lifts. R56's quarterly MDS dated 5/14/15, indicated R56 was cognitively intact requiring extensive assistance to transfer and total dependence for bed mobility with two persons. The MDS included a diagnosis of seizure disorder or epilepsy. On 8/10/15, at 2:35 p.m. R56's bed was observed to have a mattress that was too short for the bed. The end of the bed had two foam cushions between the mattress and the bottom bracket that held the mattress in place. During an environmental tour on 8/13/15, at 2:35 p.m. with the environmental services director (ESD), the ESD confirmed the mattress was too	F 323		

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F 323	Continued From page 36 short and there were two foam cushions between the mattress and the bottom bracket that held the mattress in place. The ESD stated the nursing department ordered the mattresses. On 8/13/15, at 3:40 p.m. RN-A verified the mattress was too short, but stated she thought it had something to do with the trapeze on the bed. She stated restorative takes care of the mattresses. On 8/13/15, at 3:48 p.m. NA-E who worked in the rehab department, stated it had to do with the trapeze per resident's request. She stated she had not seen spacers to insert when the mattress does not fit the bed. 08/14/15, at 12:20 p.m. the administrator stated the facility should have a mattress spacer or long mattress to properly fit the bed frame. Using foam cushions was not only a safety issue but an infection control issue as well .	F 323		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal	F 334		9/23/15

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F 334	Continued From page 37 representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical	F 334		

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F 334	Continued From page 38 contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to document provision of immunization information and receipt of consent for immunizations for 5 of 5 residents (R25, R9, R85, R77, R27) reviewed for influenza and pneumococcal immunizations. Findings include: R25's face sheet printed 8/12/15, indicated R25 resided in the facility during the previous influenza season and received the influenza vaccine on 10/2/14. The face sheet further indicated R25 received the pneumococcal vaccine in 2008, which was after her initial admission to the facility. Review of progress notes indicated R25 received the 2014 Flu vaccine. R25's medical record did not indicate whether R25 gave consent or was provided the influenza or pneumococcal information, including the risks and benefits of the vaccines. R9's face sheet printed 8/12/15, indicated R9 resided in the facility during the previous influenza season, had an allergy to the influenza vaccine	F 334	1 Residents # 25, 9, 85 and 27 or representatives were interviewed and asked for consent for influenza and/or pneumococcal vaccinations. They were provided information about the benefts and potential risks of the vaccine. Immunizations were given per resident wishes and documented in the record. 2. All residents have the potential to be impacted by a deficient practice in this area.Resident or representatives will be asked for consent for immunizations prior to administration. Consent or refusals will be documented in the residents record. 3. The Influenza and Pneumoccal vaccination policy was reviewed and revised as necessary. All nursing staff were re-educated on the process of offering the Pneumococcal and Influenza vaccines and providing information about the benefits and potential risks of the vaccine. Information flyers are part of the admission packet for each resident.The	

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F 334	Continued From page 39 and was offered and declined the pneumococcal vaccine. R9's medical record did not indicate whether R9 gave consent or was provided the influenza or pneumococcal information, including the risks and benefits of the vaccines. R85's face sheet printed 8/12/15, indicated R85 resided in the facility during the previous influenza season and refused the influenza vaccine. The face sheet indicated R85 received the pneumococcal vaccine on 3/17/14. The progress note indicated R85 refused the influenza vaccine on 10/2/14. R85's medical record did not indicate whether R85 gave consent or received the influenza or pneumococcal information, including the risks and benefits of the vaccines. R77's face sheet printed 8/12/15, indicated R77 resided in the facility during the previous influenza season, received the influenza vaccine on 10/2/14 and received the pneumococcal vaccine on 11/5/1992, which was after the age of 65. The progress note indicated R77 received the 2014 Flu vaccine on 10/2/14. R77's medical record did not indicate whether R77 gave consent or was provided the influenza information, including the risks and benefits of the vaccine. R27's face sheet printed 8/12/15, indicated R27 resided in the facility during the previous influenza season and received the influenza vaccine on 10/2/14, and the pneumococcal vaccine on 11/2/06. The progress note indicated R27 received the 2014 Flu vaccine on 10/2/14. R27's medical record did not indicate whether R27 gave consent or was provided the influenza information, including the risks and benefits of the vaccine.	F 334	letter that is sent out related to vaccines has been reviewed and revised. 4. Audits will be completed within one week after admission to this facility to ensure ongoing compliance with education about Influenza and Pneumococcal vaccines risks and benefits, and to ensure that consent is recieved and documented in the resident's record. Random chart audits will be completed each week to ensure on going compliance throught the influenza season of 2015 - 2016. The monitoring results will be reported to the Quarterly QI team. The QI team will make recommendations for ongoing monitoring. 5. Completion date is September 23rd, 2015. 6. Persons responsible: DON RN Managers	

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F 334	Continued From page 40 On 8/14/15, at 10:44 a.m. the director of nursing (DON)/infection control practitioner (ICP) provided a letter dated 9/22/14, that was sent to each resident, family member, or representative to inform them of the influenza vaccine and notify them the vaccine would be given on 10/2/14. Attached to the letter was an informational sheet on the influenza and pneumococcal vaccines. The letter directed if the recipient did not wish to receive the vaccine, they were provided a number to call and notify staff. The letter was silent about providing consent for the vaccines. The medical records did not indicate who the information was provided to, if the letter and vaccine information was received, or if consent was provided. The DON/ICCP verified documentation in the residents' medical records was not complete regarding the vaccine information provided, who it was provided to, or the consent received. The facility policy and procedure for Influenza & Pneumococcal Immunizations revised 6/2014, indicated each resident, family or representative is informed and provided with education about the influenza and pneumococcal vaccinations upon admission. The policy and procedure further indicated a letter was to be sent to current resident, family member, or representative regarding the influenza vaccination with the educational handout that explains risks and benfits. Prior to administration of the influenza vaccine record, each resident's would be reviewed for contraindication, and refusals or contraindications would be documented in the chart. There was no policy or procedure for ensuring consent was obtained prior to administration of the immunization.	F 334		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		9/23/15

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F 441 SS=F	Continued From page 41 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive infection control program that included complete tracking and trending of infections. This had the potential to affect all 72 residents residing in the facility. In addition, the facility failed to ensure proper hand hygiene was completed during services for 2 of 2 residents (R14, R19) observed during cares. Findings include: During an interview on 8/14/15, at 10:44 a.m. with the director of nursing (DON)/Infection Control practitioner (ICP) regarding the infection control program, the infection log was reviewed. The DON/ICP stated they audit symptoms and look for the 3 symptoms of a UTI before testing/treating it. The DON/ICP stated they look at patterns for certain units/halls. The DON/ICP stated they log room numbers, type of infection, and whether it is positive or negative for UTI's, but not specific organisms. The DON/ICP further stated Clostridium Difficile (c-diff) and Methicillin-resistant Staphylococcus aureus (MRSA) (antibiotic resistive micro-organisms) are tracked and isolation was initiated. Infections were addressed in Quality Assurance. The Line Listing of Resident Infections were to be used to log the type of infection, symptoms, cultures, treatment and other actions. A review of the resident infections logged from 5/15, through 7/15, indicated there were 8 urinary tract infections (UTI's) recorded. Of those recorded, 2 did not have organisms recorded, and 2 negative	F 441	1. A comprehensive infection control program has been developed which includes complete tracking and trending of infections. 2. All residents have the potential to be affected by the deficient infection control practices. 3. VCC Infection Control Nurses or designee will track and trend resident infections from infection reports for data analysis. VCC will do infection surveillance of staff for breaches in infection control practices. The VCC ICP will continue to perform antibiotic review to monitor the appropriate use of antibiotics. The VCC infection control policy has been reviewed and revised. Nursing staff were educated on the revison of policies and procedures and documentation in the EMR for infection reports. 4. monitoring will be completed by doing infection control surveys and infection and exposure control audits weekly times 1 month, then monthly until the quarterly QI meeting. DON or designee will complete weekly audits to determine ongoing compliance. The monitoring results will be reported to the Quarterly QI team. The QI team will make recommendations for ongoing monitoring. 5. Completion date is September 23rd. 2015.	

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F 441	Continued From page 43 cultures continued with antibiotic treatment. None of those recorded include the colony count, urinalysis results, or results of treatment. The 3 appropriate symptoms were not consistently logged. There was no documentation of tracking and trending, or identifying and using the patterns to identify the potential cause of infections and prevent the spread of infections. The facility was unable to provide a policy and procedure for the development and implementation of a comprehensive infection control program. R19's Admission Record specified she was admitted for rehabilitation following a fall. R19's Minimum Data Set (MDS) assessment, with a target date of 6/10/15, indicated that she was cognitively intact. The MDS identified R19 as needing extensive assistance with toileting, personal hygiene and dressing. The MDS also indicated that R19 was frequently incontinent of bladder, but was always continent of bowel. On 8/12/15, at 8:07 a.m., nursing assistant (NA)-B, entered R19's room to assist her out of bed and to breakfast. NA-B did not wash her hands or use hand sanitizer after entering R19's room. NA-B asked R19 what she would like to wear for the day and donned a pair of gloves. With gloves on, NA-B took a blue pair of pants and a black sweatshirt from R19's closet. NA-B then assisted R19 to take off her hospital gown, and remove her incontinence product. NA-B assisted R19 with getting an incontinence brief and her pants on over her feet to her ankles, then assisted R19 to stand and pull up the brief and pants. With the same gloves on, NA-B assisted R19 to stand, pivot and sit in her wheelchair. NA-B then removed the gloves and put them in the garbage can. Without washing/sanitizing her	F 441	6. Persons responsible: DON RN Managers 7. The direct caregivers responsible for resident # 19 and #59's cares were re-educated on proper infection control technique related to washing hands and changing gloves when providing cares. 8. All residents have the potential to be affected by a break in infection control practices. 9. The infection control policy for handwashing and glove use was reviewed. All staff were re-educated on proper handwashing and gloving. 10. Observational monitoring will be completed to ensure ongoing compliance with infection control techniques. A minimum of four observational audits will be completed weekly at various times for three months to ensure ongoing compliance. Staff will be re-educated as needed basis on the results of the audits. The monitoring results will be reported to the quarterly QI team. The QI team will make recommendations for ongoing compliance. 11. Completion date is September 23rd, 2015. 12. Persons responsible: DON, RN Managers, RN Supervisors.	

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F 441	Continued From page 44 hands, NA-B donned another pair of gloves. NA-B took a cloth to the bathroom, wet it, and provided it to R19 to dab at something dried on her lips. NA-B then took the gloves off, put them in the garbage, tied up the garbage and without washing her hands, used both hands to push R19 to the nurse's cart while holding the garbage in her left hand. On 8/12/15, at 7:46 a.m. nursing assistant (NA)-I was observed during cares with R59. NA-I donned gloves and assisted R59 off of the commode. NA-I provided perineal care, applied cream, pulled up pants and utilizing the lift, transferred R59 into the wheelchair. NA-I then put the foot pedals on the wheelchair, and put a blanket and sweater on R59. NA-I then removed the gloves and performed hand hygiene. On 8/12/15, at 7:52 a.m. NA-I verified that the gloves were not removed and hand hygiene was not completed after providing perineal cares for R59. On 8/14/15, at 10:42 a.m. registered nurse (RN)-A verified that gloves should be removed and hand hygiene completed immediately after perineal cares were completed. On 8/14/15, at 11:42 a.m. the director of nursing (DON) stated it was her expectation that hand hygiene was completed after personal cares. The Safety- Infection Prevention Policy and Procedure dated 12/12 directed staff to perform routine hand hygiene before and after touching a patient, before and after glove use and before and after body fluid exposure.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245458	A. BUILDING _____ B. WING _____	08/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH VIRGINIA CARE CENT	901 9TH STREET NORTH VIRGINIA, MN 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
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure clean and well-maintained rooms and common areas. This had the potential to affect all 72 residents residing in the facility. Findings include: During the environmental tour on 8/13/15, at 2:35 p.m. the environmental services manager (ESM) verified the following findings: -Carpet in all hallways was badly stained, dirty and worn. -Wall paper was peeling up near the bedside table on the right side of the bed in room 308 -Dusty bathroom vents in rooms 313, 316, 321, 323, 325 -Cracks in paint and caulking around top of the sink in rooms 315, 321 -Walls: paint chipping, scratched, and marred in rooms 315, 316, 331, 321 -Wood handrails on 3rd floor across from TV room were badly scratched and marred with blue-colored markings -Walls in hallway across from elevators in entry to nursing home on third and fourth floors had several holes in them from previous wall hangings	F 465	1. Rooms 308,313,316, 321,323,325,315,331 were cleaned, repaired and painted. Work orders were completed on common areas that needed repairs. Contractors have been hired to paint the railings, radiator and walls in common areas. Carpeting has been shampooed. 2 All residents have the potential to be affected by the deficient practice.The Houskeeping Supervisor will do a walk through of each resident room and common areas to audit other areas for cleanliness and repair prior to September 23rd, 2015.Work orders will be completed on all areas with the need of cleaning or repair. 3. Maintenance does a daily walk through of the facility Monday through Friday. When areas are noted to need repair an online work order is placed. The Maintenance Deptartment gets the work order and completes the repair based on priorities. They also have a schedule for routine maintenance. All staff are to report if there is a maintenance concern. Staff were educated on the online process for completing work orders. 4. Observational audits will be completed	9/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245458	A. BUILDING _____ B. WING _____	08/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH VIRGINIA CARE CENT	901 9TH STREET NORTH VIRGINIA, MN 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
F 465	Continued From page 46 -Wall to left of center elevators (when facing the elevator) had a hole in it approximately 4 centimeters in diameter. -Radiator on 3rd floor, between Govie's Diner and the elevators was scraped and badly marred. The ESM stated there was a preventative maintenance program they utilized. They go through every room at least once a year. In addition, the staff send maintenance requests on line to the department, and the requests go into one of two areas; patient care equipment or general maintenance. The maintenance logs were reviewed and several requests had been received from the staff. They were logged and prioritized. Specific areas were scheduled for painting during one or two months of the year. The Procedure Detail Report indicated all walls and bathrooms would be painted, patched and repaired as necessary. The facility was unable to provide a policy and procedure for maintenance and cleaning of the resident rooms and common areas.	F 465	weekly on 3 random rooms by EVS Supervisor or designee to ensure rooms and common areas are clean and well maintained.Results of audits will be reported to quarterly QI team.The QI team will make recommendatoins for ongoing monitoring. Policy and Procedure for maintanence and cleaning of rooms is in place. 5 Completion date is September 23rd 2015. 6. Persons responsible: EVS Supervisor, Maintenance Supervisor, ES Manager	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245458	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/18/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH VIRGINIA CARE CENT	**901 9TH STREET NORTH** **VIRGINIA, MN 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
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on August 18, 2015. At the time of this survey, Virginia Regional Medical Center C & NC was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000	EPOC	

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

Electronically Signed | 09/04/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245458	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/18/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH VIRGINIA CARE CENT	**901 9TH STREET NORTH** **VIRGINIA, MN 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
K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us, and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 and 4th floors. 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 licensed capacity of 90 beds and had a census of 73 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245458	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/18/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH VIRGINIA CARE CENT	**901 9TH STREET NORTH** **VIRGINIA, MN 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
K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of records and interview, it was determined that the facility failed to vary the times in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 73 residents. Findings include: On facility tour between 12:30 PM and 3:30 PM on 8/18/2015, a review of the available fire drill reports in 2014 and 2015 revealed that the facility had conducted Evening-Shift fire drills between the hours of 10:01 PM, 6:45 PM, 3:01 PM, 3:00 PM, 3:50 PM not varied times in accordance with Section 19.7.1.2. This deficient practice was confirmed by the Secretary of Facility/Environmental Services.	K 050	1. An allotted time frame was given to the conducters of the fire drills by EV Manager and provided DON a copy of the varied times. 2. All residents have the potential to be affected by the deficient practice. 3.Monthly audits will be completed by EV Manager or designee to ensure compliance. These audits will be reviewed at the quarterly QI meeting. The QI team will make recommendations for ongoing monitoring. 4. Completion date is September 23rd 2015 5. Persons responsible: EV Manager or designee	9/23/15
K 074	NFPA 101 LIFE SAFETY CODE STANDARD	K 074		9/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245458	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/18/2015**

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

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K 074 SS=E	Continued From page 3 Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has cubicle curtains that does not meet the requirements in accordance with NFPA 25 (98) and NFPA 701 (99). This deficient practice could affect 6 patients, staff and visitors by hampering proper sprinkler coverage. Findings include: On facility tour between 12:30 PM and 3:30 PM on 8/18/2015, it was found that the cubicle curtain in patient rooms 344,346, and 348 did not meet the 1/2 inch diagonal mesh requirement in accordance with NFPA 25 (98) and NFPA 701.	K 074	1. Cubicle curtains in rooms 344,346,348 were replaced by housekeeping. All rooms on the 3rd and 4th floors were checked by housekeeping and all cubicle curtains that were not in compliance were removed and replaced. 2. All residents, staff and visitors have the potential to be affected by the deficient practice. 3. Housekeeping will do random audits of 3 rooms once a week to ensure Cubicle Curtains are in compliance.Results of audit will be reviewed at quarterly QI meeting. The QI team will make	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245458	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/18/2015**

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

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K 074	Continued From page 4 This was confirmed by the Secretary of Facility/Environmental Services.	K 074	recommendations for ongoing audits. 4.Completion date is September 23rd, 2015 5. Persons responsible: EVS Supervisor or designee.	

Minnesota Department of Health
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MDH

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If you have comments please send to:
monica.larson@health.state.mn.us

Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-671 form for data entry?	Go to CMS-671
I'm finished and would like to exit the application.	Exit

ESSENTIA HEALTH VIRGINIA CARE				
Provider No. **245458**	Medicare F75 7	Medicaid F76 **37**	Other F77 **28**	Total Residents F78 **72**

ADL	Independent	Assist of One Two Staff	Dependent
Bathing	F79 **1**	F80 **59**	F81 **12**
Dressing	F82 **16**	F83 **55**	F84 **1**
Transferring	F85 **17**	F86 **46**	F87 **9**
Toilet Use	F88 **17**	F89 **49**	F90 **6**
Eating	F91 **42**	F92 **27**	F93 **3**

A. Bowel/Bladder Status	**B. Mobility**
F94 **6** With indwelling or external catheter.	F100 **0** Bedfast all or most of time..
F95 Of total number of residents with catheters, **5** were present on admission.	F101 **57** In chair all or most of time.
F96 **51** Occasionally or frequently incontinent of bladder.	F102 **4** Independently ambulatory.
F97 **34** Occasionally or frequently incontinent of bowel.	F103 **20** Ambulation with assistance or assistive device.
F98 **0** On individually written bladder training program.	F104 **0** Physically restrained.

F99 **0** On individually written bowel training program.	F105 Of total number of residents with restrained, **0** were admitted with orders for restraints. F106 **6** With contractures. F107 Of total number of residents with contractures, **6** had contractures on admission.

C. Mental Status	**D. Skin Integrity**
F108 **0** With mental retardation.	F115 **7** With pressure sores (exclude stage I).
F109 **49** With documentation signs and symptoms of depression.	F116 **5** Of the total number of residents with pressure sores excluding stage I, how many residents had pressure sores on admission?
F110 **22** With documentation psychiatric diagnosis (excluding dementias and depression).	F117 **64** Receiving preventive skin care.
F111 **15** Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type.	F118 **1** With rashes.
F112 **9** With behavioral symptoms.	
F113 **9** Of the total number of residents with behavioral symptoms, the total number receiving a behavior management prpgram.	
F114 **0** Receiving health rehabilitative services for MI/MR.	

E. Special Care	
F119 **1** Receiving hospice care benefit.	F127 **0** Receiving suction.
F120 **0** Receiving radiation therapy.	F128 **12** Receiving injections (exclude vitamin B12 injections)
F121 **0** Receiving chemotherapy.	F129 **2** Receiving tube feedings.
F122 **0** Receiving dialysis.	F130 **22** Receiving mechanically altered diets including pureed and all chopped food (not only meat).
F123 **2** Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion.	F131 **7** Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy).
F124 **8** Receiving respiratory treatment.	F132 **0** Assistive devices while eating.
F125 **0** Receiving tracheostomy care.	

F126 **3** Receiving ostomy care.	

F. Medication	**G. Other**
F133 **42** Receiving any psychoactive medication.	F140 **9** With unplanned significant weight loss/gain.
F134 **12** Receiving antipsychotic medications.	F141 **0** Who do not communicate in the dominant language of the facility (includes those who use sign language).
F135 **17** Receiving antianxiety medications.	F142 **2** Who use non-oral communicationdevices.
F136 **36** Receiving antidepressant medications.	F143 **21** With advance directives.
F137 **0** Receiving hypnotic medication.	F144 **44** Received influenza immunization.
F138 **13** Receiving antibiotics.	F145 **52** Received pneumococcal vaccine.
F139 **58** On pain management program.	

I certify that this Information is accurate to the best of my knowledge.		
Name of Person Completing	Title	Date
Deborah Morell	**MDS/RS Coordinator**	**08/21/2015**

To be completed by MDH survey team.
F146 Was ombudsman office notified prior to survey? **Yes**
F147 Was ombudsman present during any portion of the survey? **No**
F148 Medication error rate **0%**

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Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-672 form for data entry?	Go to CMS-672
I'm finished and would like to exit the application.	Exit

Standard Survey Date Format: mm/dd/yy From F1: **08/10/15** To F2: **08/14/15**	Extended Survey Date Format: mm/dd/yy From F3: To F4:	
Name of Facility: **ESSENTIA HEALTH VIRGINIA CARE**	Provider Number: **245458**	Fiscal Year ending:
Address: **901 9TH STREET NORTH, VIRGINIA, SAINT LOUIS, MN 55792**		
Telephone Number: F6 **218-749-9400**	State/County Code: **MN / SAINT LOUIS**	State/Region Code: **MN / 05**
A. F9 **03 - SNF/NF - Medicare/Medicaid** B. Is this facility hospital based? F10 **Yes** If yes, indicate Hopsital Provider Number: F11 ~~**24-5458**~~ 240084		
Ownership: F12 **05 - Non Profit - Nonprofit Corporation**		
Owned or leased by Multi-Facility Organization: F13 **Yes** Name of Multi-Facility Organization: F14 **Essentia Health**		
Dedicated Special Care Units (show number of beds for all that apply)		
AIDS F15 **0** Dialysis F17 **0** Head Trama F19 **0** Huntington's Disease F21 **0** Other Spec Rehab. F23 **0**	Alzheimer's Disease F16 **0** Disabled Child Young Adult F18 **0** Hospice F20 **0** Ventilator/Respiratory Care F22 **0**	
Does the facility currently have an organized resident group? F24		**Yes**
Does the facility currently have an organized group of family members of residents? F25		**No**

Does the facility conduct experimental research? F26	**No**
Is the facility part of a continuing care retirement community (CCRC)? F27	**No**

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of the last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement.	Date: mm/dd/yy F28 **NA**	Hours waived per week: F29 **NA**
Waiver of 24 hr licensed nursing requirement.	Date: mm/dd/yy F30 **NA**	Hours waived per week: F31 **NA**

Does the facility currently have an approved nurse aide training and competency program? F32	**No**

The following three questions are to be completed by the survey team.

1) Was this a staggered Survey?	**No - Not Staggered**
2) If staggered, day of the week starting?	**Surveyor to Complete**
3) If staggered, starting time?	**Surveyor to complete AM**

FACILITY STAFFING

		A	B	C	D
	Tag #	Services Provided 1 2 3	Full-Time Staff (hours)	Part-Time Staff (hours)	Contract (hours)
Administration	F33		**240**	**112**	**0**
Physician Services	F34	**Yes No No**			
Medical Director	F35		**0**	**0**	**4**
Other Physician	F36		**0**	**0**	**0**
Physician Extender	F37	**Yes No No**	**0**	**0**	**80**
Nursing Services	F38	**Yes No No**			
RN Director of Nursing	F39		**80**	**0**	**0**
Nurses with Admin Duties	F40		**80**	**0**	**0**
Registered Nurses	F41		**474**	**72**	**0**
Licensed Practical/ Vocational Nurses	F42		**536**	**496**	**0**

Certified Nurse Aides	F43		1680	488	0
Nurse Aides in Training	F44		0	0	0
Medication	F45		0	0	0
Pharmacists	F46	Yes No No	0	0	10
Dietary Services	F47	Yes No No			
Dietitian	F48		0	80	0
Food Service Workers	F49		0	873	0
Therapeutic Services	F50				
Occupational Therapist	F51	Yes No No	0	0	80
Occupational Therapy Assistant	F52		0	0	80
Occupational Therapy Aides	F53		0	0	0
Physical Therapist	F54	Yes No No	0	0	80
Physical Therapy Assist	F55		0	0	80
Physical Therapy Aides	F56		80	0	0
Speech/Language	F57	Yes No No	0	0	5
Therapeutic Recreation Spec.	F58	Yes No No	48	0	0
Qualified Activities Prof.	F59	No No No	0	0	0
Other Activities Staff	F60	Yes No No	80	184	0
Qualified Social Workers	F61	Yes No Yes	152	0	0
Other Social Services Staff	F62	No No No	0	0	0
Dentists	F63	No No Yes	0	0	0
Podiatrists	F64	No No Yes	0	0	0
Mental Health Services	F65	No No Yes	0	0	0
Vocational Services	F66	No No No			
Clinical Laboratory Services	F67	Yes No No			

Diagnostic X-ray Services	F68	No No Yes			
Administration Storage of Blood	F69	No No No			
Housekeeping Services	F70	Yes No No	476	0	0
Other	F71		0	80	0
Name of Person Completing Form: **Sheryl Leoni**					Date: **08/21/15**

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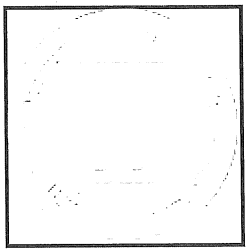

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245458	ESSENTIA HEALTH VIRGINIA

Type of Survey (select all that apply):

I					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 32981	08-10-2015	08-14-2015	0.25	1.00	34.75	2.00	5.75	1.50
2. 34089	08-10-2015	08-14-2015	0.00	1.00	36.25	2.00	2.50	8.00
3. Team Leader 34983	08-10-2015	08-14-2015	2.00	1.00	36.25	2.00	2.50	15.00
4. 35575	08-10-2015	08-14-2015	0.00	1.00	28.00	10.00	2.25	3.50
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours	17.50
Total Clerical/Data Entry Hours.....	3.25
Was Statement of Deficiencies given to the provider on-site at completion of the survey?	Y

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245458	ESSENTIA HEALTH VIRGINIA

Type of Survey (select all that apply):

H	I				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 19251	08-18-2015	08-18-2015	1.00	0.00	3.00	0.00	1.50	1.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.75

Total Clerical/Data Entry Hours..... 0.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245458	**ESSENTIA HEALTH VIRGINIA CARE CENT**	*K4 **08/18/2015**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING 01

[A]
A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2000 EXISTING
13	2786 R	2000 NEW

ASC Form		
14	2786 U	2000 EXISTING
15	2786 U	2000 NEW

ICF/MR Form		
16	2786 V, W, X	2000 EXISTING
17	2786 V, W, X	2000 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K29: [ ] K56: [ ]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]
1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]
4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]
7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1	A2	A3	A4	A5
[ ]	[X]	[ ]	[ ]	[ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

A.	B.	C.
[X]	[ ]	[ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY

F5458024

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

2000 CODE

Form Approved
OMB Exempt

FIRE SAFETY SURVEY REPORT 2000 CODE - HEALTH CARE
Medicare – Medicaid

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
K1 245458	K2

PART I — Life Safety Code, New and Existing
PART IV — Waiver Recommendation Form

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
ESSENTIA HEALTH VIRGINIA CARE CENTER	A. BUILDING _____ B. WING _____ C. FLOOR 3RD, 4TH Fl K3	901 9TH STREET NORTH VIRGINIA, MN 55792	A. (●) Fully Sprinklered (All required areas are sprinklered) B. ( ) Partially Sprinklered (Not all required areas are sprinklered) C. ( ) None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
[✔] MEDICARE [✔] MEDICAID	8/18/2015 K4	K6	5. [✔] 2000 EXISTING 6. [ ] 2000 NEW K7

5. SURVEY FOR CERTIFICATION OF

1. ( ) HOSPITAL 2. (●) SKILLED/NURSING FACILITY 4. ( ) ICF/MR UNDER HEALTH CARE 5. ( ) HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW

1. ( ) ENTIRE FACILITY 2. (●) DISTINCT PART OF (SPECIFY) 3rd and 4th floor

3. [ ] IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED?
a. ( ) YES b. (●) NO

6. BED COMPOSITION a. TOTAL NO. OF BEDS IN THE FACILITY	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID	e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID
90	____	90	90	_____

7. A. (●) THE FACILITY MEETS, BASED UPON (CHECK ALL APPROPRIATE BOXES)

1. ( ) COMPLIANCE WITH ALL PROVISIONS 2. (●) ACCEPTANCE OF A PLAN OF CORRECTION 3. ( ) RECOMMENDED WAIVERS 4. ( ) EQUIVALENCIES 5. ( ) PERFORMANCE BASED DESIGN

B. ( ) THE FACILITY DOES NOT MEET THE STANDARD

K9

SURVEYOR *(Signature)*	TITLE	OFFICE	DATE
SURVEYOR ID 19251 K10	DEPUTY FIRE MARSHAL	FIRE MARSHAL DIVISION	8/18/2015
FIRE AUTHORITY OFFICIAL *(Signature)*	TITLE	OFFICE	DATE
	INTERIM FIRE SAFETY SUPERVISOR	FIRE MARSHAL DIVISION	O8/24/2015

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART I - LSC REQUIREMENTS - Items in italics relate to the FSES				K-12 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 and 4th floors. 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.
	BUILDING CONSTRUCTION				
K11	If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1½ hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2	◉	○	○	
K12	2000 EXISTING Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1	◉	○	○	
	1 ◉ I (443), I (332), II (222) — Any Height				
	2 ○ II (111) — One story only (non-sprinklered).				
	3 ○ II (111) — Not over three stories with complete automatic sprinkler system.				
	4 ○ III (211) — Not over two stories with complete automatic sprinkler system.				
	5 ○ V (111) — Not over two stories with complete automatic sprinkler system.				
	6 ○ IV (2HH) — Not over two stories with complete automatic sprinkler system.				
	7 ○ II (000) — Not over two stories with complete automatic sprinkler system.				
	8 ○ III (200) — Not over one story with complete automatic sprinkler system.				
	9 ○ V (000) — Not over one story with complete automatic sprinkler system.				
	☐ Building contains fire treated wood. *Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.*				

ID PREFIX					MET	NOT MET	N/A	REMARKS
K12	2000 NEW Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.3.5.1.							
	1		I (443), I (332), II (222)	Any height with complete automatic sprinkler system				
	2		II (111)	Not over three stories with complete automatic sprinkler system				
	3		III (211)	Not over one story with complete automatic sprinkler system.				
	4		V (111)					
	5		IV (2HH)					
	6		II (000)					
	7		III (200)	Not Permitted				
	8		V (000)					
	☐ Building contains fire treated wood. *Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.*							
K103	Interior walls and partitions in buildings of Type I or Type II construction shall be noncombustible or limited-combustible materials. 18.1.6.3, 19.1.6.3 (Indicate N/A for existing buildings using listed fire retardant treated wood studs within non-load bearing one-hour rated partitions.)				◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	INTERIOR FINISH				
K14	2000 EXISTING Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than 1/28 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 *Indicate flame spread rating/s* A	◉	○		
	2000 NEW Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Lower half of corridor walls, not exceeding 4ft in height, may have a Class C flame spread rating. 10.2, 18.3.3.1, 18.3.3.2, NFPA TIA 00-2 *Indicate flame spread rating/s*_____				
K15	2000 EXISTING Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2 *Indicate flame spread rating/s* A	◉	○		
	2000 NEW Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (Rooms not over 4 persons in capacity may have a flame spread rating of Class A, Class B, or Class C). 18.3.3.1, 18.3.3.2. *Indicate flame spread rating/s*_____				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K16	2000 EXISTING Newly installed interior floor finish complying with 10.2.7 shall be permitted in corridors and exits if Class I. 19.3.3.3 In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, no interior floor finish requirements shall apply.	◉	○	○	
	CORRIDOR WALLS AND DOORS				
K17	2000 EXISTING Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 *If the walls have a fire resistance rating, give rating _____ if the walls terminate at the underside of a ceiling, give a brief description in REMARKS, of the ceiling, describing the ceiling throughout the floor area.*	◉	○		
	2000 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.4, 18.3.6.5				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K18	2000 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3	◉	○		
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
	2000 NEW Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3				
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
K19	Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) In other than smoke compartments containing patient bedrooms, miscellaneous opening are permitted in vision panels or doors provided the aggregate area of the opening per room does not exceed 20 in.^{2} and the opening is installed in bottom half of the wall (80 in.^{2} in fully sprinklered buildings). 18.3.6.5, 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	VERTICAL OPENINGS				
K20	2000 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 *If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.* ☐	◉	○	○	
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	2000 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.2.5.6, 8.2.5, 18.3.1.1.				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K21	Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: ☑ (a) The required manual fire alarm system and ☑ (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and ☑ (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	Describe method used in REMARKS				
	SMOKE COMPARTMENTATION AND CONTROL				
K23	2000 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2	◉	○	○	
	2000 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Smoke barriers shall also be provided on floors that are usable, but unoccupied. 18.3.7.1, 18.3.7.2				
K24	The smoke compartments shall not exceed 22,500 square feet and the travel distance to and from any point to reach a door in the required smoke barrier shall not exceed 200 feet. 18.3.7.1, 19.3.7.1	○	○	◉	
	Detail in REMARKS zone dimensions including length of zones and dead end corridors.				
K25	2000 EXISTING Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5	◉	○	○	
	2000 NEW Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5				
K26	Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.4, 19.3.7.4	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K27	2000 EXISTING Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	◉	○	○	
	2000 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8				
K28	2000 EXISTING Door openings in smoke barriers shall provide a minimum clear width of 32 inches (81 cm) for swinging or horizontal doors. 19.3.7.7	◉	○	○	
	2000 NEW Door openings in smoke barriers are installed as swinging or horizontal doors shall provide a minimum clear width as follows: Provider Type / Swinging Doors / Horizontal Sliding Doors Hospitals and Nursing Facilities: 41.5 inches (105 cm) / 83 inches (211 cm) Psychiatric Hospitals and Limited Care Facilities: 32 inches (81 cm) / 64 inches (163 cm) 18.3.7.7				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K104	Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5	◉	○	○	
	Describe any mechanical smoke control system in REMARKS.				
	HAZARDOUS AREAS				
K29	2000 EXISTING One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	◉	○	○	

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms	☐	☐	✔
c. Laundries (greater than 100 sq feet)	☐	☐	✔
d. Repair Shops and Paint Shops	☐	☐	✔
e. Laboratories (if classified a Severe Hazard - see K31)	☐	☐	✔
f. Combustible Storage Rooms/Spaces (over 50 sq feet)	✔	✔	☐
g. Trash Collection Rooms	☐	☐	✔
i. Soiled Linen Rooms	✔	✔	☐

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a ¾ hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1.				

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms			
c. Laundries (greater than 100 sq feet)			
d. Repair, Maintenance and Paint Shops			
e. Laboratories (if classified a Severe Hazard - see K31)			
f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq feet)			
g. Trash Collection Rooms			
i. Soiled Linen Rooms			
m. Combustible Storage Rooms/Spaces (over 100 sq feet)			

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

K30	Gift shops shall be protected as hazardous areas when used for storage or display of combustibles in quantities considered hazardous. Non-rated walls may separate gift shops that are not considered hazardous, have separate protected storage and that are completely sprinkled. Gift shops may be open to the corridor if they are not considered hazardous, have separate protected storage, are completely sprinklered and do not exceed 500 square feet. 18.3.2.5, 19.3.2.5	○	○	◉	

Area	Automatic Sprinkler	Separation	N/A
L. Gift Shop storing hazardous quantities of combustibles	☐	☐	☐

ID PREFIX		MET	NOT MET	N/A	REMARKS
K211	Where Alcohol Based Hand Rub (ABHR) dispensers are installed: ☑ The corridor is at least 6 feet wide ☑ The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) ☑ The dispensers shall have a minimum spacing of 4 ft from each other ☑ Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. ☑ Dispensers are not installed over or adjacent to an ignition source. ☑ If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623	◉	○	○	
	EXITS AND EGRESS				
K22	Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating “No Exit”. 7.10, 18.2.10.1, 19.2.10.1	◉	○	○	
K32	Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2	◉	○		
K33	2000 EXISTING Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1 *If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.* ☐	◉	○	○	
	If enclosures are less than required, give a brief description and specific location in REMARKS.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Exit enclosures (such as stairways) in buildings four stories or more are enclosed with construction having a fire resistance rating of at least two hours, are arranged to provide a continuous path of escape, and provide a protection against fire and smoke from other parts of the building. In all buildings less than four stories, the enclosure is at least one hour. 7.1.3.2, 8.2.5.2, 8.2.5.4, 18.3.1.1, 18.2.2.3				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K34	Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4	◉	○	○	
K35	The capacity of required mean of egress is based on its width, in accordance with 7.3.	◉	○		
K36	Travel distance (exit access) to exits are measured in accordance with 7.6. • Room door to exit ≤ 100 ft (≤ 150 ft sprinklered) • Point in room or suite to exit ≤ 150 ft (≤ 200 ft sprinklered) • Point in room to room door ≤ 50 ft • Point in suite to suite door ≤ 100 ft 18.2.6, 19.2.6	◉	○		
K37	2000 EXISTING Existing dead-end corridors shall be permitted to be continued to be used if it is impractical and unfeasible to alter them so that exists are accessible in not less than two different directions from all points in aisles, passageways, and corridors. 19.2.5.10	○	○	◉	
	2000 NEW Every exit and exit access shall be arranged so that no corridor, aisle or passageway has a pocket or dead-end exceeding 30 feet. 18.2.5.10				
K38	Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1	◉	○		
K39	2000 EXISTING Width of aisles or corridors (clear and unobstructed) serving as exit access shall be at least 4 feet. 19.2.3.3	◉	○		

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet. 18.2.3.3, 18.2.3.4				
K40	2000 EXISTING Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. An exception is provided for existing 34-inch doors in existing occupancies. 19.2.3.5	◉	○		
	2000 NEW Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 41.5 inches in clear width. Doors in exit stairway enclosures shall be no less than 32 inches in clear width. In psychiatric hospitals or limited care facilities (e.g.,ICF/MD providing medical treatment) doors are at least 32 inches wide. 18.2.3.5				
K41	All sleeping rooms have a door leading to a corridor providing access to an exit or have a door leading directly to grade. One room may intervene in accordance with 18.2.5.1, 19.2.5.1 *If doors lead directly to grade from each room, check this box.* ☐	◉	○		
K42	Any patient sleeping room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 18.2.5.2, 19.2.5.2	◉	○		
K43	Patient room doors are arranged such that the patients can open the door from inside without using a key. Special door locking arrangements are permitted in facilities. 18.2.2.2.4, 18.2.2.2.5, 19.2.2.2.4, 19.2.2.2.5	◉	○	○	
	If door locking arrangement without delay egress is used indicate in REMARKS 18.2.2.2.2, 19.2.2.2.2	○	○	○	
K44	Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5, 19.2.2.5	◉	○	○	
K47	Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K72	Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1	◉	○		
	ILLUMINATION				
K45	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8	◉	○		
K46	Emergency lighting of at least 1½ hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.	◉	○		
K105	2000 NEW (INDICATE N/A FOR EXISTING) Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the Life Safety Branch of the electrical system described in NFPA 99. 18.2.9.2., 18.2.10.2 (Indicate N/A if life support equipment is for emergency purposes only).			☑	
	EMERGENCY PLAN AND FIRE DRILLS				
K48	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1	◉	○	○	
K50	Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2	○	◉	○	K50-THE FACILITY CONDUCTED THE EVENING-SHIFT FIRE DRILLS BETWEEN THE HOURS OF 10:01 PM, 6:45 PM, 3:01 PM,3:00 PM, 3:50PM NOT VARIED TIMES AS REQUIRED.

ID PREFIX		MET	NOT MET	N/A	REMARKS
	FIRE ALARM SYSTEMS				
K51	A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6	◉	○		
K52	A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,	◉	○		
K155	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8	◉	○	○	
K53	2000 EXISTING (INDICATE N/A FOR HOSPITAL AND FULLY SPRINKLERED NURSING HOMES) In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. CFR 483.70	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW (NURSING HOME AND EXISTING LIMITED CARE FACILITIES) An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridor.) Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.3				
K109	2000 EXISTING LIMITED CARE FACILITIES (INDICATE N/A FOR HOSPITALS OR NURSING HOMES) An automatic smoke detection system is installed in all corridors with detector spacing no further apart than 30 ft on center in accordance with NFPA 72. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridors.) Such detectors are electrically interconnected to the fire alarm system. 19.3.4.5.1 Smoke Detection System ☐ Corridors ☐ Rooms ☐ Bath	○	○	◉	
K54	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3	◉	○		
	Give a brief description, in REMARKS of any smoke detection system which may be installed.				
K55	2000 EXISTING Every patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8	◉	○		
	2000 NEW Every patient sleeping room shall have an outside window or outside door. The allowable sill height shall not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	intended for occupancy for less than 24 hours. Window sill height for limited care facilities shall not exceed 44 inches (112 cm) above the floor. 18.3.8				
K60	Initiation of the required fire alarm systems shall be by manual fire alarm initiation, automatic detection, or extinguishing system operation. 18.3.4.2, 19.3.4.2, 9.6.2.1	◉	○		
	AUTOMATIC SPRINKLER SYSTEMS				
K56	2000 EXISTING Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13	◉	○	○	
	2000 NEW There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1.				
K154	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1.	◉	○	○	
	A. Date sprinkler system last checked and necessary maintenance provided. 6/29/15				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	B. Show who provided the service. VIKING				
	C. Note the source of water supply for the automatic sprinkler system. city				
	(Provide, in REMARKS, information on coverage for any non-required or partial automatic sprinkler system.)				
K61	Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72	◉	○	○	
K62	Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	◉	○	○	
K63	Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13	◉	○	○	
K64	Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6	◉	○		
	SMOKING REGULATIONS				
K66	Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4, 8-6.4.2 (NFPA 99) (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in use areas are not required. (Note: This exception is not applicable to medical gas storage areas.) 8-3.1.11.3 (NFPA 99)	◉	○	○	K66-SMOKE FREE FACILITY

ID PREFIX		MET	NOT MET	N/A	REMARKS
	(2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	○	○	○	
	BUILDING SERVICE EQUIPMENT				
K67	Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2	◉	○	○	
K68	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2, 19.5.2.2.	◉	○	○	
K69	Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96	○	○	◉	
K70	Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). 18.7.8, 19.7.8	◉	○	○	
K71	Rubbish Chutes, Incinerators and Laundry Chutes. 18.5.4, 19.5.4, 9.5, 8.4, NFPA 82 (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4.	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	(4) Existing flue-fed incinerators shall be sealed by fire resistive construction to prevent further use.	○	○	○	
K160	2000 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, *Safety Code for Existing Elevators & Escalators*. All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. 9.4.2, 9.4.3, 19.5.3 (Includes firefighters service **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)	◉	○	○	
	2000 NEW Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, Safety Code for Elevators and Escalators, including Fire Fighter's Service Requirements. 9.4.2, 9.4.3, 18.5.3 (Includes firefighters service **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
K161	2000 EXISTING Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* 19.5.3, 9.4.2.2	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	(Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.)	○	○	○	
	2000 NEW Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All escalators and conveyors comply with ASME/ANSI A17.1, *Safety Code for Elevators and Escalators.* 18.5.3, 9.4.2.1				
	FURNISHINGS AND DECORATIONS				
K73	Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4	◉	○	○	
K74	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13 ☐ Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2. ☐ Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 ☐ Newly introduced upholstered furniture and mattresses means purchased since March, 2003.	○	◉	○	K74-THE FACILITY HAS SEVERAL RESIDENT ROOM 344, 346, 348 THAT CURTAINS DID NOT MEET THE REQUIREMENTS FOR PROPER SPRINKLER COVERAGE.
K75	Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed .5 gal/ft^2 (20.4 L/m^2). A	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	capacity of 32 gal (121 L) shall not be exceeded within any 64-ft^2 (5.9-m^2) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. 18.7.5.5, 19.7.5.5	◉	○	○	
	LABORATORIES				
K31	Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard shall be protected in accordance with NFPA 99. (Laboratories that are not considered to be severe hazard shall meet the provision of K29.) 18.3.2.2, 19.3.2.2, Chapter 10 (NFPA 99)	○	○	◉	
K136	Procedures for laboratory emergencies shall be developed. Such procedures shall include alarm actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department in accordance with 10-2.1.3.1 (NFPA 99), 18.3.2.2., 19.3.2.1	○	○	◉	
K131	Emergency procedures shall be established for controlling chemical spills in accordance with 10-2.1.3.2 (NFPA 99)	○	○	◉	
K132	Continuing safety education and supervision shall be provided, incidents shall be reviewed monthly, and procedures reviewed annually shall be in accordance with 10-2.1.4.2 (NFPA 99).	○	○	◉	
K133	Fume hoods shall be in accordance with 5-4.3, 5-6.2 (NFPA 99).	○	○	◉	
K134	Where the eyes or body of any person can be exposed to injurious corrosive materials, suitable fixed facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. Fixed eye baths designed and installed to avoid injurious water pressure shall be in accordance with 10-6 (NFPA 99).	○	○	◉	
K135	Flammable and combustible liquids shall be used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals.	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	Storage cabinets for flammable and combustible liquids shall be constructed in accordance with NFPA 30, Flammable and Combustible liquids Code, 4-3 (NFPA 99), 10-7.2.1 (NFPA 99)	○	○	◉	
	MEDICAL GASES AND ANESTHETIZING AREAS				
K76	Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4	◉	○	○	
K77	Piped in medical gas, vacuum and waste anesthetic gas disposal systems comply with NFPA 99, Chapter 4.	○	○	◉	
K78	Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others. (b) Relative humidity is maintained equal to or great than 35% 4-3.1.2.3(n) and 5-4.1.1 (NFPA 99), 18.3.2.3, 19.3.2.3	○	○	◉	
K140	Medical gas warning systems shall be in accordance with NFPA 99, Standard for Health Care Facilities. (a) Master alarm panels are in two separate locations and have audible and visible signals. (b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4-3.1.2.2 (c) Where a level 2 gas system is used, one alarm panel that complies with 4-3.1.2.2(b)3a,b,c,d and with 4-3.1.2.2(c)2,5 shall be permitted. 4-4.1 (NFPA 99) exception No. 4. 4-3.1.2.2 (NFPA 99)	○	○	◉	
K141	Medical gas storage areas shall have a precautionary sign, readable from a distance of 5 ft, that is conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUSION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K142	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.	○	○	◉	
K143	Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8-6.2.5.2 (NFPA 99)	○	○	◉	
	ELECTRICAL AND EMERGENCY POWER				
K106	Hospitals and inpatient hospices with life support equipment have an Type I Essential Electric System, and nursing homes have a Type II ESS that are powered by a generator with a transfer switch and separate power supply in accordance with NFPA 99. 12-3.3.2, 13-3.3.2.1, 16-3.3.2 (NFPA 99)	◉	○	○	
K107	Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1.4, 18.3.4.1, 19.3.4.1	◉	○		
K108	2000 NEW (INDICATE N/A FOR EXISTING) Power for Alarms, emergency communication systems, and illumination of generator set locations are in accordance with essential electrical system of NFPA 99. 18.5.1.2			☑	
K144	Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)	◉	○	○	
K145	The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.2, 3-5.2.2 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K146	The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source 3-6. (NFPA 99)	◉	○	○	
K147	Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1	◉	○		
K130	Miscellaneous List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84	

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1		* K4

K6 DATE OF PLAN APPROVAL

K3 MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS _____

NUMBER OF THIS BUILDING _____

☐

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786R	2000 EXISTING
13	2786R	2000 NEW

ASC Form		
14	2786U	2000 EXISTING
15	2786U	2000 NEW

ICF/MR Form		
16	2786V, W, X	2000 EXISTING
17	2786V, W, X	2000 NEW

* K7 ☐ SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: ☐ 1 PROMPT 2 SLOW 3 IMPRACTICAL

LARGE

K8: ☐ 4 PROMPT 5 SLOW 6 IMPRACTICAL

APARTMENT HOUSE

K8: ☐ 7 PROMPT 8 SLOW 9 IMPRACTICAL

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)

K29: ☐ K56: ☐

ENTER E – SCORE HERE

K5: ☐ e.g. 2.5

*K9: FACILITY MEETS LSC BASED ON *(Check all that apply)*

A1. ☐ (COMP. WITH ALL PROVISIONS)

A2. ☐ (ACCEPTABLE POC)

A3. ☐ (WAIVERS)

A4. ☐ (FSES)

A5. ☐ (PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. ☐

K0180

A. ☐ FULLY SPRINKLERED (All required areas are sprinklered)

B. ☐ PARTIALLY SPRINKLERED (Not all required areas are sprinklered)

C. ☐ NONE (No sprinkler system)

* MANDATORY

PROJECT NUMBER:	PROVIDER NAME	SURVEY DATE
F5458024	ESSENTIA HEALTH VIRGINIA CARE CENTER	8/18/2015

Administrator: F5458024 Phone Number: 245458

Email address: linda.bump@essentiahealth.org

State Fire Inspector: KERRY QUEEN 651-769-7780

These are preliminary findings only. A complete and final Statement of Deficiencies 2567 report will be provided by US Mail.

☐ **At the time of this inspection, this facility was found to comply with the requirements of the 2000 Life Safety Code applicable to: ☑ SNF/NF ☐ Hospital ☐ ICFMR ☐ ASC Facilities participating in the Medicare/Medicaid programs.**

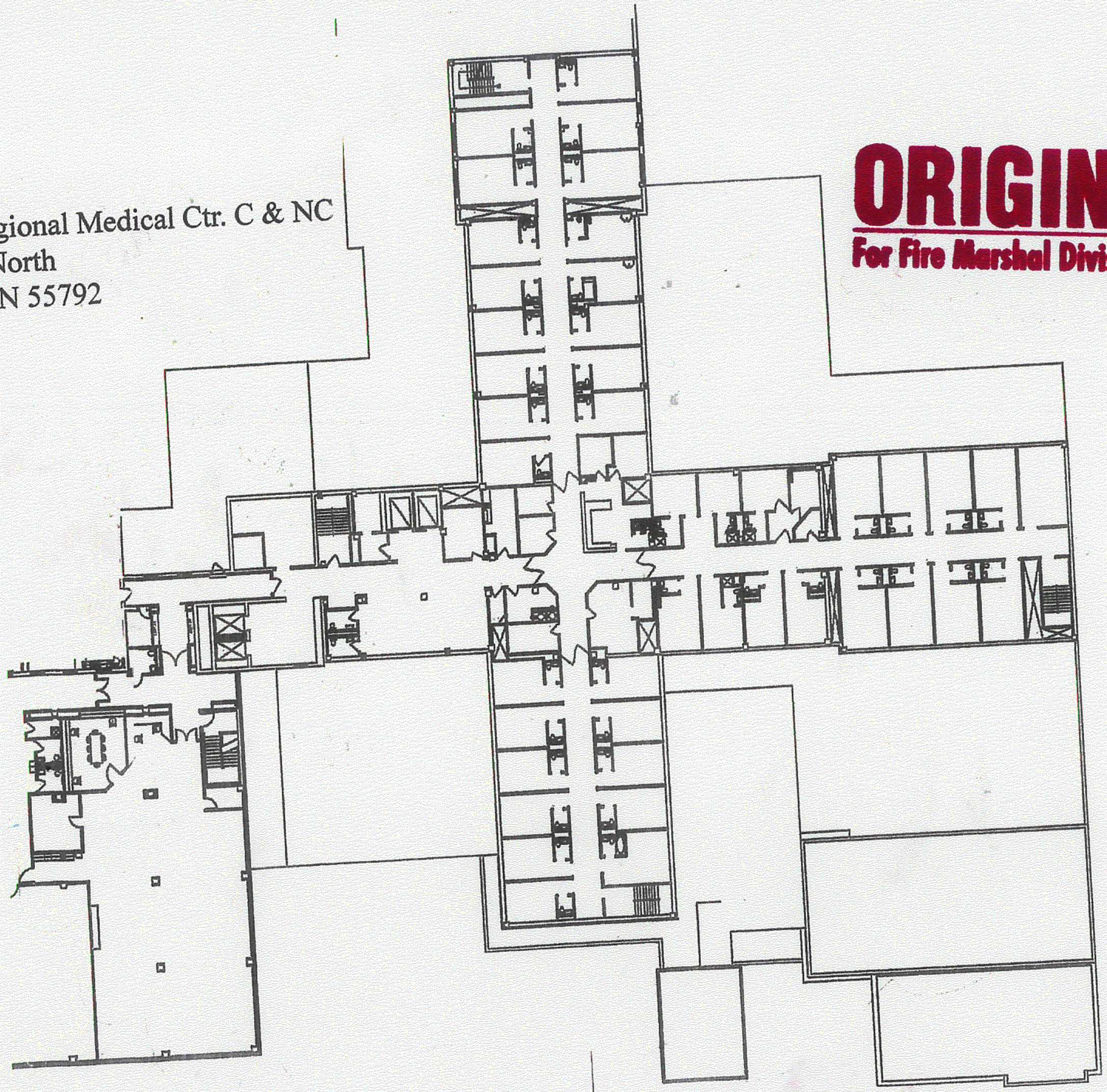
☑ **The following fire/life safety deficiencies were found during this inspection:**

K TAG S& S	☑ **Draft Summary of Deficiency(ies)** ☐ **Revisit** ☐ **Clearance**
K-50 S&S= F	THE FACILITY CONDUCTED THE EVENING-SHIFT FIRE DRILLS BETWEEN THE HOURS OF 10:01 PM, 6:45 PM, 3:01 PM,3:00 PM, 3:50 PM NOT VARIED TIMES AS REQUIRED.
K-74 S&S= E	THE FACILITY HAS SEVERAL RESIDENT ROOM 344, 346, 348 THAT CURTAINS DID NOT MEET THE REQUIREMENTS FOR PROPER SPRINKLER COVERAGE.

File HC 00141008

Virginia Regional Medical Ctr. C & NC
901 9th St. North
Virginia, MN 55792

ORIGINAL
For Fire Marshal Division File

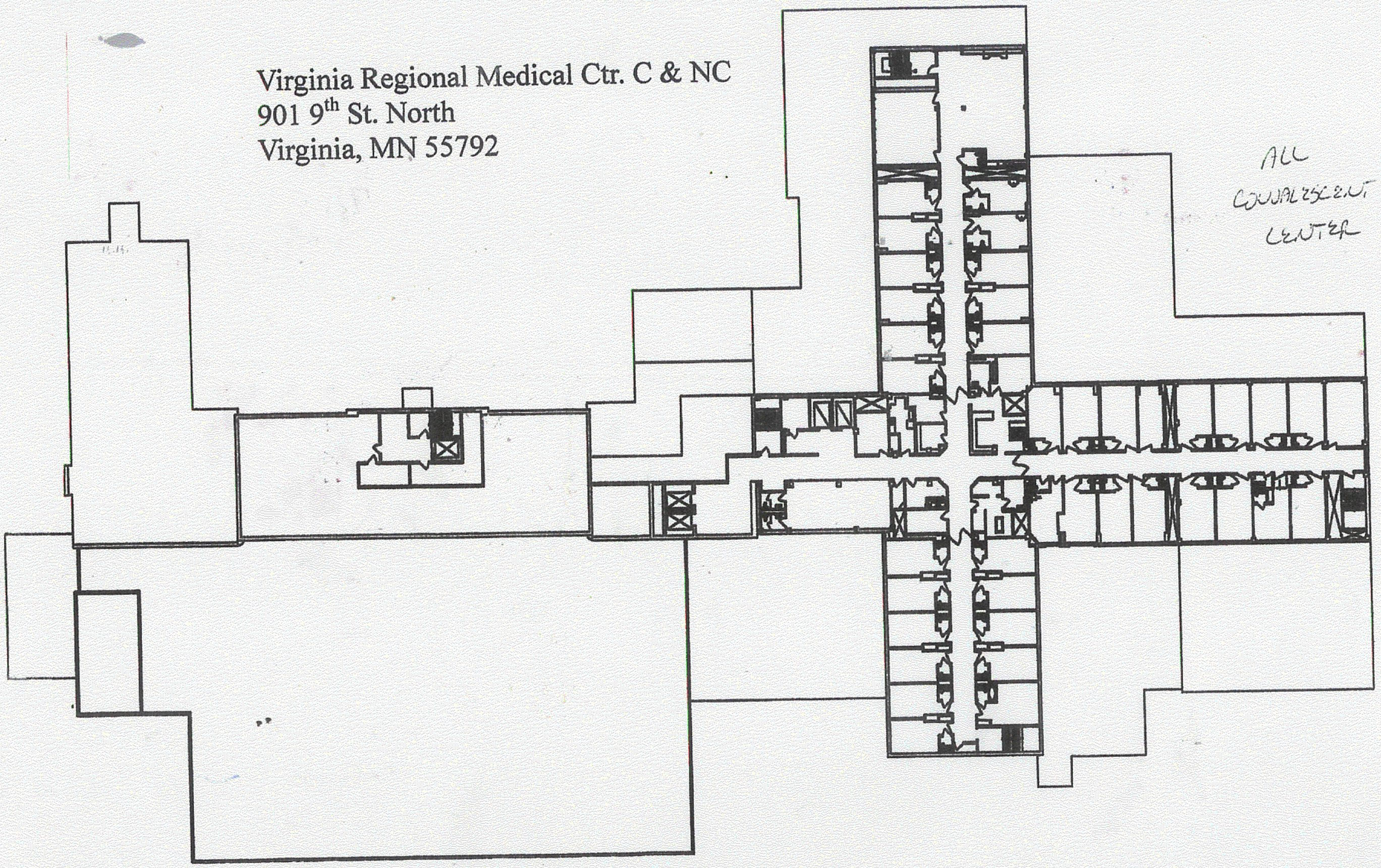


3rd Floor

File HC 00141008

Virginia Regional Medical Ctr. C & NC
901 9th St. North
Virginia, MN 55792

ALL
COGNALESCENT
CENTER



NORTH

Virginia Regional Medical Center

4th Floor

SCALE 1/32"=1'-0"

ORIGINAL
For Fire Marshal Division File

S5458024

MINNESOTA DEPARTMENT OF HEALTH
Division of Health Policy, Information and Compliance Monitoring
85 East Seventh Place, Suite 300, P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email for ADMINISTRATOR: linda.bump@essentiahealth.org
National Provider Identifier (NPI) Number: 1396748034
One facility may have multiple NPI Numbers. Please verify the NPI number associated with the provider type for this survey, i.e. for a nursing home survey, the NPI Number will be associated with the Nursing Home.

OWNERSHIP INFORMATION AT THE TIME OF SURVEY

Name of Facility: ESSENTIA HEALTH VIRGINIA CARE CENTER City: VIRGINIA

Name of Legal Entity Operating Provider: ESSENTIA HEALTH VIRGINIA LLC

Name and Address of Governing Board President:

Name: DANIEL NIKCEVICH, M.D.
Address: 502 EAST 2ND ST

City/State/Zip: DULUTH, MN 55805

If legal entity or president of the governing board is different than what is noted above, please provide the information below.

Name of Facility: _____ City: _____

Name of Legal Entity Operating Provider: _____

Name and Address of Governing Board President:

Name: _____
Address: _____

City/State/Zip: _____

SIGNATURE

Completed by: [signature]
Title: CFO
Date: 8/11/15