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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 7KLQ

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 CENTER**
(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 **12/20/2013** (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:

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

* Code: **A** (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):
On December 20, 2013 this department completed a health Post Certificatoin Revisit by review of the plan of correction and on and on December 9, 2013 the Departmetnnt of Public Safety completed a PCR to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective December 20, 2013, the facility is certified for 89 skilled nursing facility beds.

17. SURVEYOR SIGNATURE — Date :
Pat Halverson, Unit Supervisor — 2/3/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate Johnston, Enforcement Specialist — 3/9/2014 (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: **00** (L30)

VOLUNTARY
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
12/12/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245458

February 25, 2014

Mr. Jeffrey Brown, Administrator
Essentia Health Virginia Care Cent
901 9th Street North
Virginia, MN 55792

Dear Mr. Brown:

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 December 20, 2013, the above facility is certified for:

89 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 89 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.

Please contact me if you have any questions.

Sincerely,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 3, 2014

Mr. Jeffrey Brown, Administrator
Essentia Health Virginia Care Cent
901 9th Street North
Virginia, MN 55792

RE: Project Number S5458022

Dear Mr. Brown:

On November 14, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 20, 2013 that included an investigation of complaint number H5458012. 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 December 20, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 9, 2013 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 September 20, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 20, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 20, 2013, effective December 20, 2013 and therefore remedies outlined in our letter to you dated November 14, 2013, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson /bz

Pat Halverson , Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 218-723-2359 Fax: 218-302-6151

Enclosure
cc: Licensing and Certification File

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	12/20/2013

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 F0226 Reg. # 483.13(c) LSC	Correction Completed 12/20/2013	ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 12/20/2013	ID Prefix F0253 Reg. # 483.15(h)(2) LSC	Correction Completed 12/20/2013
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 12/20/2013	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 12/20/2013	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 12/20/2013
ID Prefix F0318 Reg. # 483.25(e)(2) LSC	Correction Completed 12/20/2013	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 12/20/2013	ID Prefix F0334 Reg. # 483.25(n) LSC	Correction Completed 12/20/2013
ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 12/20/2013	ID Prefix F0428 Reg. # 483.60(c) LSC	Correction Completed 12/20/2013	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 12/20/2013
ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 12/20/2013	ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 12/20/2013	ID Prefix Reg. # LSC	Correction Completed

Reviewed By ✓ State Agency	Reviewed By 10562	Date: 2-3-14	Signature of Surveyor: 10562	Date: 2-3-14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/20/2013		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 A. Building B. Wing	(Y3) Date of Revisit
245458	01 - MAIN BUILDING 01	12/9/2013

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	10/28/2013	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		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By ✓ State Agency	10562	2/3/14	10562	2-3-14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/18/2013

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	12/20/2013

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 **F0226** Reg. # **483.13(c)** LSC	Correction Completed **12/20/2013**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **12/20/2013**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **12/20/2013**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **12/20/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/20/2013**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **12/20/2013**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **12/20/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **12/20/2013**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **12/20/2013**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **12/20/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **12/20/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **12/20/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/20/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **12/20/2013**	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/PH	02/03/2014	12835	12/20/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/20/2013

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

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**	12/9/2013

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	**10/28/2013**	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		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** MM/PS	**Date:** 02/03/2014	**Signature of Surveyor:** 03005	**Date:** 12/09/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 9/18/2013		**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**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 7KLQ

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 **09/20/2013** (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):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Ann Hyrkas, HFE NE II 12/09/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 12/12/2013 (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

24-5458

At the time of the standard survey completed September 20, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

An investigation of complaint H5458012 was completed. The complaint was found unsubstantiated.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7517

November 8, 2013

Mr. Jeffrey Brown, Administrator
Essentia Health Virginia Care Center
901 9th Street North
Virginia, MN 55792

RE: Project Number S5458022, Complaint Number H5458012

Dear Mr. Brown:

On September 20, 2013, 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. In addition, at the time of the September 20, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5458012.

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. In addition, at the time of the September 20, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5458012 that was found to be unsubstantiated.

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>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;

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

<u>Informal Dispute Resolution</u> - 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:

Pat Halverson
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, Minnesota 55802

Telephone: (218) 723-4637
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 October 30, 2013, 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 October 30, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 December 20, 2013 (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 March 20, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

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 _____ B. WING _____	09/20/2013

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

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F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. An investigation of complaint H5458012 was completed. The complaint was found unsubstantiated. CENSUS = 78	F 000	OK 12-9-13 BLH	
F 226 SS=C	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	F 226	F 226 Develop/Implement Abuse/Neglect, etc Policies 1. The definition for Resident to Resident Maltreatment has been written into the EH- VCC Abuse Prevention Policy dated November 2013, on page 10. 2. All residents have potential to be affected by this deficient practice 3. Each initial and/or quarterly resident care conferences will include a brief mention of the definition of Resident to Resident Maltreatment as it pertains to the Abuse Reporting Policy. The recorder for the care conference will include a notation in the resident medical record to verify the review of Resident to Resident Maltreatment definition. All Staff will be educated relative to the definition. 4. Designated Quality Team Representatives (Social Workers)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/27/13

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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F 226	Continued From page 1 facility failed to ensure the abuse prohibition policy included a definition regarding resident to resident mistreatment. Findings include: The administrator was interviewed on 9/18/13, at 2:32 p.m. and verified the facility abuse prevention plan, dated 1/13, lacked a definition of resident to resident mistreatment.	F 226	will audit resident medical records to ensure definition was included in care conference for those residents covered each month. Monthly audits will occur X 6 months. 5. Completion date for F226 is December 20, 2013. 6. Persons Responsible: Administrator, Social Services, ID Team.	
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 interview, and document review, the facility failed to ensure staff spoke to residents in a dignified manner for 2 of 2 residents (R19, R73) reviewed for dignity. Findings include: R19's diagnoses included congestive heart failure (CHF), shortness of breath, osteoarthritis and dementia. The admission minimum data set (MDS) dated 4/30/13, indicated R19 had moderate cognitive impairment, and required extensive assistance of one staff for dressing, personal hygiene, bathing and toileting. The MDS also indicated R19 required limited assistance of one staff for bed mobility and transfers. The care plan dated 5/8/13, indicated R19 had vision and	F 241	F 241 Dignity and Respect of Individuality 1. R19 and R73 have been interviewed regarding complaint of undignified and/or dis-respectful treatment by staff. Alleged staff involve were also interviewed. Complete investigations have taken place regarding both R19 and R73.To the extent possible the Abuse Prevention Policy and Resident Bill of Rights was reviewed with R19 and R73. Corrective action	

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F 241	Continued From page 2 hearing impairments, and required limited assistance with bathing, dressing, grooming and was independent with toileting. When interviewed on 9/17/13, at 9:17 a.m. R19 stated some of the employees have been very "snotty" when they talk to her. R19 further stated when she asks for help staff tell her she can do it herself. R19 stated she is legally blind and needs their assistance, but staff becomes "snotty" towards her. R19 stated she had reported this, but could not remember who she reported it to. R73's diagnoses included cerebral vascular accident (CVA), recent fall with left tibia fracture, osteoarthritis, chronic back pain, and generalized pain. The annual minimum data set (MDS) dated 3/18/13 indicated R73 was cognitively intact, and required extensive assistance of one staff for bathing, transfers, dressing, toileting and personal hygiene. When interviewed on 9/16/13, at 2:26 p.m. R73 indicated a staff member had been rude to him about three weeks ago. R73 stated he was using the bathroom, and told the staff member he was in pain. R73 stated the staff member told him she was sick of him complaining about being in pain all of the time, and he was just looking for attention. R73 said the staff member had said the same thing to him a few days later when his daughter was visiting. R73 stated he had reported this to the social workers. During interview on 9/19/13, at 9:04 a.m. the social worker (SW)-B stated that R73 had reported a staff member had been "mouthy" to him, but he did not want this reported to the nurse, he would discuss it at care conference.	F 241	has taken place with regard to alleged staff involved. 2. All residents have the potential to be affected by this deficient practice. 3. All staff will honor and obey Resident Bill of Rights, and the Abuse Prevention Policy. All complaints of violations to the Resident Bill of Rights will be investigated by ID Team designees to ensure proper reporting, education and corrective actions are taken promptly. All staff will be re-educated to the Resident Bill of Rights and Abuse Reporting Policy. This training will include, specific emphasis regarding resident dignity and respect, and our obligation to promote and care for residents in a manner and environment that maintains and enhances resident dignity and respect in full recognition of resident individuality. 4. All incidences alleging failure to obey Resident Bill of Rights will be reviewed by the Quality Team Designees monthly. The Quality Team Designees will determine corrective actions to ensure compliance. A minimum of 10	

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F 241	Continued From page 3 During his care conference, SW-B stated he did not want to discuss it. SW-B stated R73 saw it as a "personality clash." The resident bill of rights dated 7/1/07, directed the, "Facility must with courtesy promote and care for you in a manner and environment that maintains or enhances your dignity and respect in full recognition of your individuality."	F 241	structured audits per month will be conducted to observe staff interactions with residents to ensure dignity and respect are maintained and enhanced. Each structured audits will also include monitoring of resident grooming to include combing of hair, removal of facial hair, cleanliness and clipping of nails, per individual resident preference. 5. Completion date for F241 is December 20, 2013	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure clean and sanitary conditions were maintained in 7 of 34 resident bathrooms (R9, R21, R24, R42, R65, R102, R121) and in 4 of 35 resident rooms (R24, R105 ,R121, R140) and 1 of 2 shower rooms. In addition, the facility did not ensure 12 of 12 mechanical lifts were clean and in good repair. Findings include: An environmental tour was conducted with the facilities and environmental services manager (ESM) on 9/19/13, at 12:15 p.m. The following was observed:	F 253	F 253 Housekeeping and Maintenance Services 1. Resident Bathrooms for R21,R24,R42,R64,R102,R121, and Resident Rooms for R24,R105,R121 and R140 and One of Two Shower Rooms have been repaired including cracked ceilings, gouged walls, scrapes, wall patching and painting, paint chip repair, replacement of missing baseboards, removal of staining and rust streaks behind	

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F 253	Continued From page 4 In R9's bathroom ceiling was cracked at the corner by the vent. The corner wall near the toilet was discolored with brown streaks running down the wall approximately four feet. There were rust stains on the outside edges of the toilet and floor. The front of the toilet at the base had a black area. In R21's bathroom had a missing baseboard behind the toilet. There was a rust stain on the floor and along the edge of the toilet. In R24's bathroom were several scrapes along wall with multiple paint chips on floor. A piece of molding was missing on a corner near the bathroom in bedroom area. In R42's bathroom the wall behind the toilet was water mark discolored, there was toilet tissue stuck to the floor and the wall near the door had long scraped areas near the floor. In R65's bathroom the floor and the seal around the toilet was discolored and the walls were scraped. In R102's bathroom there was green foam taped to the back of a commode over the toilet and on the back of a second commode in the bathroom. The foam was uncleanable. In R105's room the protective panel on the heat register was pulled away and falling off from the	F 253	toilets. As well, green foam was removed from commode and protective panel on heat register was replaced. Ceiling vents were cleaned and repaired as appropriate. Exposed light bulbs in Shower area were repaired. 12 of 12 resident lift devices have been cleaned completely and the identified repairs have been made and parts have been installed to proper working order. 2. All residents have the potential to be affected by this deficient practice. 3. Each of the identified resident bathrooms, resident rooms, shower rooms and lift devices have been inspected to ensure clean and sanitary conditions. Each of the identified maintenance service repairs have been reviewed and inspected. 12 of 12 lift devices have been inspected, cleaned and are in service. Employee educations will occur with regard to work order system, reporting conditions needing correction regarding orderly, sanitary and safe environments. As well education will take place regarding cleaning of resident lift devices after each resident contact, and weekly deep cleaning of each lift device. 4. Structured audits identifying (wall and ceiling damage, chipped paint, gouges, scrapes, staining, lights vents	

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F 253	Continued From page 5 register. In R121's bathroom, the ceiling had a crack in the center approximately 12 inches long. The bathroom ceiling vent had brown spots on it and the ceiling around the fan was lifting up. There was approximately an eight inch circular stain on two ceiling tiles in the door way of R121's room. In R140's room were scraped areas on the wall above the head of the bed and the paint was chipped and scraped behind the recliner. In the fourth floor shower room the ceiling vent had a thick layer of dust. There were two overhead lights in the shower room and one was an exposed light bulb. On the third floor the covering on the extended legs of the EZ lifts (mechanical lifts) was cracked and or broken with pieces missing on three of the four lifts. All four of the EZ stands (mechanical stand aid) were soiled a black/gray color and had food debris on the foot platform. On the fourth floor there were two EZ lifts and two EZ stands. On both lifts the legs and base were soiled a black/gray color. Both EZ stands were soiled a black/gray color and had food debris on the foot platform. The ESM indicated maintenance requests were done on the computer. The staff making the	F 253	leaks or any condition deemed unsanitary or needing repair) will be conducted on ten resident rooms including bathrooms, shower/bathing areas will be completed and findings documented monthly for six months. Resident Lift Devices will be audited for cleanliness and need of repair weekly times 6 months. Appropriate electronic work order requests will be generated that same day. Monthly audit results will be reviewed at Quality Team Meetings at least quarterly. The Quality Team will determine corrective action to be taken. 5. Completions date: December 20, 2013 6. Responsible Persons: Administrator, Manager of Facilities and Environmental Services, Housekeeping Supervisor, Nursing Managers, Nursing Assistants, Restorative Nursing.	

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F 253	Continued From page 6 request would get a return email when maintenance got the request and when the work was completed. Some of the housekeeping staff were reluctant or refused to use the computer. The EZ stands and lifts were gone over yearly. Maintenance and repairs were made and the batteries were checked. Nursing was responsible for the cleaning. The ESM indicated the nursing assistants (NA) put the foam on the commodes. At 1:30 p.m. the director of nursing (DON) indicated there was not a cleaning schedule for the EZ stands and lifts. The NAs were responsible to make sure they were clean when using. The facility's Maintenance Work Orders policy effective 2/27/12, indicated if a problem was found with a piece of equipment or any part of the facility was in need of repair, an intranet work order or a written work order must be filled out and sent to the maintenance department. A written request could be also be put in the department's mailbox and would be picked up on daily rounds.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279	F 279 Develop Comprehensive Care Plans 1. An individualized care plan related to Coumadin use was developed for resident #105 based on the results of her comprehensive assessment. 2. All residents require comprehensive, individualized plans of care based on needs identified during the assessment process. Comprehensive care	

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F 279	Continued From page 7 needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a care plan was developed for the use of Coumadin (anticoagulant medication) for 1 of 3 residents (R105) reviewed for unnecessary medications and the use of Coumadin. Findings include: R105's diagnoses included intra-cerebral hemorrhage, hemiplegia, dysphasia, bipolar disease, hypothyroidism, osteoporosis, diabetes mellitus, hyperlipidemia, hypertension, esophageal reflux, depression, anxiety, pneumonia, anemia, and seizure disorder. The quarterly minimum data set (MDS) dated 9/4/13, indicated R105 had moderate cognitive impairment, required extensive assistance with transfers, toileting, and personal hygiene, and	F 279	plans will be developed for all residents in a timely manner. 3. Policies and procedures were reviewed and revised as appropriate. All staff involved in the process of developing comprehensive plans of care were re-educated on the process. All residents who receive Coumadin were reviewed for accuracy of their care plans. 4. Care plans will be monitored to ensure they are comprehensive and address Coumadin use. A minimum of four records will be reviewed weekly 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: December 20, 2013 6. Responsible Persons: Administrator, DON, RN Unit Managers, ID Team	

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F 279	Continued From page 8 needed physical help with bathing. The 9/4/13, review further indicated R105 was frequently incontinent of urine and continent of bowel, and was receiving an anticoagulant medication. Physician's orders dated 9/12/13, directed R105 was to receive Coumadin (an anticoagulant medication) 4 mg daily. The medication administration records (MAR) dated from 6/2013, to 9/2013, indicated R105 was receiving Coumadin with the dose based on blood levels. The care plan dated 8/28/12, lacked a problem statement, goal, or any approaches related to the risks of Coumadin therapy. There is a risk of bleeding with anticoagulant therapy. On 9/19/13, at 11:00 a.m. registered nurse (RN)-E stated R105's care plan lacked the information identifying Coumadin therapy. RN-E confirmed R105's care plan should have contained a problem statement and interventions related to R105 receiving an anticoagulant medication.	F 279		
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.	F 282	F 282 Services by Qualified Persons/Per Care Plan 1. Resident # 19 is deceased. Resident #27's care plan for ROM was reviewed and updated as necessary. The staff caring for resident #27 were re-educated on the plan of care. Resident #4's care plan for ROM was reviewed and updated as necessary. The staff caring for	

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F 282	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure restorative nursing range of motion (ROM) services were provided as directed by the care plan for 2 of 3 residents (R27, R4) reviewed for ROM; and the facility failed to provide assistance with facial hair removal and nail care for 1 of 3 residents (R19) reviewed for activities of daily living (ADLs). Findings include: DEFINITIONS: Active assisted range of motion - (AAROM) - the resident performs the exercise, but requires help from staff to complete. Passive range of motion - (PROM) - staff performs the exercise with no effort from the resident. R27 was not provided restorative AAROM services as directed by the care plan. R27's diagnoses included anemia, cerebrovascular accident (CVA-stroke), expressive aphasia (difficulty speaking), right sided hemiparesis (weakness on one side of the body), and depression. The quarterly Minimum Data Set (MDS) dated 8/30/13, indicated R27 had long term and short term memory problems with moderate cognitive impairment; had no behaviors; required total assistance from staff with all activities of daily	F 282	resident #4 were re-educated on the plan of care. 2. All residents have plans of care which must be followed by staff caring for the resident. 3. All residents in the facility will be reviewed by nursing and restorative services department during their MDS assessment period to ensure their restorative services plan is appropriate. Nursing will request therapy evaluations if indicated by the assessment. Care plans will be updated as needed. Policies and procedures were reviewed and revised as appropriate. Care plans remain readily available for all staff providing direct care to the residents. Staff were re-educated on the restorative programs for resident #27 and #4, and on the policy for resident grooming. 4. Observational audits will be completed to ensure the plans of care are being followed. A minimum of five audits will be done weekly at various times throughout the day to ensure on-going 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: December 20, 2013	

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	245458	A. BUILDING _____ B. WING _____	09/20/2013

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F 282	Continued From page 10 living (ADL's); was non-ambulatory; and had functional limitations in ROM in both upper and lower extremities (UE/LE). The nursing assistant (NA) Care Guide (no date), directed the NA's to complete ROM. The Weekly Documentation Restorative Service sheet for September 2013, directed R27 should receive AAROM to the left upper and lower extremity, 7-10 repetitions, twice a day. The falls care plan dated as reviewed 5/26/13, directed the NA's to complete the ROM program to the left upper and lower extremities once a day to maintain ROM. The care plan was inconsistent with R27's current plan of twice a day. On 9/18/13, at 6:27 p.m. NA-K entered R27's room to provide evening cares. NA-K removed R27's upper clothing and when removing R27's right arm from the sleeve R27 became angry and said, "Ow!" NA-K stated, R27's, "Right arm gets stiff and we have to be careful because it gets sore." NA-K then completed further cares (applied night gown, brushed teeth). NA-K left the room and returned with the mechanical lift and NA-B. R27 was transferred to bed, and p.m. cares were completed appropriately. After cares were completed, both NA-K and NA-B stated they were all done, cleaned up area, and left the room. No ROM was observed to be provided with bedtime care. When questioned regarding R27's ROM program, NA-B stated she didn't usually work on that unit and was unsure. NA-K stated she was not sure if R27 was on a specific ROM program, but they [NA's] do, "Move her arms and legs when removing her clothing."	F 282		

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F 282	Continued From page 11 On 9/18/13, at 7:30 p.m. family member (F)-A arrived to visit R27 and stated she visits R27 almost daily, sometimes more than once a day, and had never seen staff complete ROM services with R27, "They don't do it." On 9/19/13, at 10:43 p.m. NA-A stated she does not provide daytime ROM for R27 because F-A will do it, "She knows we just don't have time." On 9/19/13, at 2:36 p.m. the registered nurse manager (RN)-A was interviewed regarding R27's ROM program not being completed. RN-A confirmed ROM should be completed as directed on the care plan and stated staff had not reported they were unable to complete their resident ROM programs. R4 was not provided restorative PROM services as directed by the care plan. R4 had diagnoses that included anemia, osteoarthrosis, CVA with left sided weakness, macular degeneration, and shoulder joint pain. The quarterly MDS dated 7/2/13, indicated R4 had severe cognitive impairment; had no behaviors; required total assistance of staff with all ADL's; was non-ambulatory; and had functional limitations in range of motion (ROM) to one upper and one lower extremity. The NA care guide dated 3/9/12, directed bilateral	F 282		

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F 282	Continued From page 12 UE/LE PROM 7-10 repetitions twice a day. The self care deficit care plan reviewed 6/26/13, directed PROM to both UE/LE BID. On 9/18/13, at 12:11 p.m. R4 was observed in the w/c in the dining room. R4 received the lunch meal. At 12:19 p.m. NA-E started feeding R4. At 1:30 p.m. R4 was done eating and assisted in the w/c to her room by NA-E. At 2:01 p.m. R4 was still in her room in the w/c. At 3:27 p.m. R4 was observed in bed on the right side. Sleeping. At 4:58 p.m. R4 was observed in the w/c in the dining room waiting for dinner. At 5:12 p.m. R4 received the meal and NA-K started feeding R4. At 6:07 p.m. R4 was done eating and NA-K assisted R4 to her room in the w/c and turned on the TV. No ROM was observed to be completed throughout the observations. On 9/19/13, at 9:18 a.m. NA-A stated she would be completing ROM with R4 and assisted R4 to her room in the w/c. NA-A explained appropriately what UE/LE ROM consisted of and started to perform ROM to R4's left upper arm. NA-A completed approximately seven repetitions in the left wrist, shoulder, and stretched the left elbow and fingers on the left hand a few times. NA-A then explained R4's legs were stiff and it was easier to do ROM when she was in bed. NA-A then stated, "I have to be honest, the majority of the time we're not able to complete ROM like it should be done due to not enough time/short staffing." NA-A stated, "We do lift their arms and legs with cares though." No further ROM was completed during the observation. NA stated, "I try, but there's not enough time in the day."	F 282		

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F 282	Continued From page 13 On 9/19/13, at 2:36 p.m. RN-A was interviewed regarding R4's ROM program not being completed. RN-A confirmed ROM should be completed as directed on the care plan and stated staff had not reported they were unable to complete their resident ROM programs. R19 was not provided nail care or facial hair grooming as directed by the care plan. R19's diagnoses included congestive heart failure (CHF), shortness of breath, osteoarthritis and dementia. The admission minimum data set (MDS) dated 4/30/13, indicated R19 had moderate cognitive impairment, and required extensive assistance of one staff for personal hygiene. The care plan dated 4/17/13, directed staff to check fingernails, cut as needed, and shave as needed. The individual care guide sheet, undated, indicated R19 had poor hearing and vision, and required assistance with facial hair removal. During observation on 9/17/13, at 9:26 a.m., R19 had long fingernails with brown debris underneath them, and facial hair measuring approximately 1/4 inch along the jaw line. During interview at this time, R19 stated that staff usually shaved her, and it bothered her that she had not been shaved.	F 282		

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F 282	Continued From page 14 On 9/20/13, at 9:56 a.m. R19's personal hygiene and grooming was observed. Nursing assistant (NA)-J washed R19's face, hands and periarea, then dressed her. R19 asked if NA-J would cut her fingernails, and NA-J stated she would. At approximately 10:15 a.m., NA-J stated she had completed daily grooming on R19, and would cut her fingernails shortly. NA-J stated she had noticed R19's facial hair, but did not have time to shave her. The DON, interviewed on 9/19/13, at 1:15 p.m, stated she would expect nursing staff to follow the care plan. The facility policy and procedure on care plan revised 5/5/10 8/11, directed nursing staff to be informed of the plan of care and will provide the services in the plan of care.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide nail care and facial hair removal for 1 of 3 residents (R19) who required staff assistance with activities of daily	F 312	F 312 ADL Care Provided for Dependent Residents 1. Resident #19 is deceased. 2. All residents have the potential to be effected by the deficient practice. 3. All residents will be reassessed during their next scheduled MDS assessment period for their preference for shaving. Policies and procedures for grooming (facial hair and nail care) have been reviewed and revised. All staff will be re-educated on the grooming policy and where to find resident preferences in the care plan.	

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F 312	Continued From page 15 living (ADL's). Findings include: R19 had debris underneath her fingernails, and facial hair. R19's diagnoses included congestive heart failure (CHF), shortness of breath, osteoarthritis and dementia. The admission minimum data set (MDS) dated 4/30/13, indicated R19 had moderate cognitive impairment, and required extensive assistance of one staff for personal hygiene. The care plan dated 4/17/13, directed staff to check fingernails, cut as needed, and shave as needed. The individual care guide sheet, undated, indicated R19 had poor hearing and vision, and required assistance with facial hair removal. During observation on 9/17/13, at 9:26 a.m., R19 was noted to have long fingernails with brown debris underneath them, and facial hair measuring approximately 1/4 inch along the jaw line. During interview at this time, R19 stated that staff usually shaved her, and it bothered her that she had not been shaved. On 9/20/13, at 9:56 a.m. R19's personal hygiene and grooming was observed. Nursing assistant (NA)-J washed R19's face, hands and periarea, then dressed her. R19 asked if NA-J would cut her fingernails, and NA-J stated she would. At approximately 10:15 a.m., NA-J stated she had completed daily grooming on R19, and would cut her fingernails shortly. NA-J stated she had noticed R19's facial hair, but did not have time to shave her.	F 312	4. A minimum of five audits will be done weekly at various times throughout the day to ensure on-going 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: December 20, 2013 6. Responsible Persons: Administrator, DON, RN Unit Managers, ID Team	

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F 312	Continued From page 16 The director of nursing (DON) was interviewed on 9/19/13, at 1:15 p.m. The DON stated she would expect residents be groomed, shaved and have nail care done daily. The facility policy and procedure on shaving, facial hair removal dated 8/11, directed nursing staff will shave residents daily and as needed. The facility was unable to provide a policy on nail care.	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure restorative nursing range of motion (ROM) services were provided for 2 of 3 residents (R27, R4) who were reviewed for ROM. Findings include: DEFINITIONS: Active assisted range of motion - (AAROM) - the resident performs the exercise, but requires help from staff to complete. Passive range of motion - (PROM) - staff performs the exercise with no effort from the	F 318	F 318 Increase/Prevent Decrease in Range of Motion 1. Resident #27 received a comprehensive assessment for range of motion services. Nursing received orders for therapy evaluations for resident #27. Appropriate interventions were developed and implemented based on the assessment. Staff were educated on the interventions and the care plan was updated. Resident #4 received a comprehensive assessment for range of motion services. Nursing received orders for therapy evaluations for resident #4. Appropriate interventions were developed and implemented based on the assessment. Staff were educated on the interventions and the care plan was updated. 2. All residents have the potential to need ROM services.	

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F 318	Continued From page 17 resident. R27 was not provided restorative AAROM services based on assessed needs. R27 ' s diagnoses included anemia, cerebrovascular accident (CVA-stroke), expressive aphasia (difficulty speaking), right sided hemiparesis (weakness on one side of the body), and depression. The quarterly Minimum Data Set (MDS) dated 8/30/13, indicated R27 had long term and short term memory problems with moderate cognitive impairment; had no behaviors; required total assistance from staff with all activities of daily living (ADL's); was non-ambulatory; and had functional limitations in ROM in both upper and lower extremities (UE/LE). The ADL Functional/Rehabilitation Care Area Report (CAA) dated 11/29/12, did not identify R27 had ROM services. The Restorative Services Care Conference Review form dated 8/20/13, identified functional ROM impairment in both UE/LE, and directed R27 should receive AAROM to the left upper and lower extremity 7-10 repetitions BID (twice a day) with the nursing assistants (NA ' s) to maintain the current level of mobilty in the lower extremity and maintain strength in the upper extremity to aide in repositioning. The NA Care Guide (no date), directed the NA ' s to complete ROM. The falls care plan dated as reviewed 5/26/13, directed the NA ' s to complete the ROM program to the left upper and lower extremities once a day to maintain ROM. The care plan was inconsistent with R27 ' s current	F 318	3. All residents in the facility will be reviewed by nursing and restorative services department during their MDS assessment period to ensure their restorative services plan is appropriate. Nursing will request therapy evaluations if indicated by the assessment. Care plans will be updated as needed. 4. Residents identified with a need for ROM services will be reviewed to ensure appropriate documentation of the assessment and individualized interventions. A minimum of five observational audits will be completed weekly at various times throughout the day to ensure ongoing 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: December 20, 2013 6. Responsible Persons: Administrator, DON, Restorative Services Manager, ID Team	

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F 318	Continued From page 18 plan of twice a day. On 9/18/13, at 12:06 p.m. R4 was observed in bed resting and at 12:08 p.m. two NA's (NA)-D and (NA)-A entered the room with the mechanical lift and shut the door. At 12:27 p.m. R4 arrived to the dining room assisted in the wheelchair (w/c) by NA-A. At 12:34 p.m. NA-D started feeding R27. At 1:35 p.m. a family member arrived (F)-A and finished feeding R27. At 1:50 p.m. R27 was done with the meal and F-A assisted R27 in the w/c out of dining room. At 3:30 p.m. another nursing assistant (NA)-K entered the room as R27 had been placed in bed and wanted to get out of bed. NA-K obtained the mechanical lift and (NA)-C and NA-K entered the room and shut the door. On 9/18/13, at 4:58 a.m. R27 was observed in the dining room in the wheelchair waiting for dinner. At 5:17 p.m. R27 received the meal and at 5:20 p.m. NA-C started feeding R27. At 5:50 p.m. R27 was done with the meal. At 6:00 p.m. NA-C assisted R27 in the wheelchair down the hall and placed her by the nurse ' s desk. At 6:09 p.m. (NA)-B wheeled R27 to the room and started a movie on the TV. At 6:27 p.m. NA-K entered the room to complete evening cares. NA-K removed R27 ' s upper clothing and when removing R27 ' s right arm from the sleeve R27 became angry and said "owe. " NA-K stated "her right arm gets stiff and we have to be careful because it gets sore." NA-K then completed further cares (applied night gown, brushed teeth). NA-K left the room and returned with the mechanical lift and NA-B. R27 was transferred to bed, and p.m. cares were completed appropriately. After cares were completed, both NA-K and NA-B stated they were all done, cleaned up area, and left the room. No ROM was observed to be provided during any of	F 318		

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F 318	Continued From page 19 the day or evening observations. When questioned regarding R27 ' s ROM program NA-B stated she didn't usually work on that unit and was unsure. NA-K stated she was not sure if R27 was on a specific ROM program, but they [NA ' s] do " move her arms and legs when removing her clothing " at night taking the arms/legs out of the sleeves/pants. NA-C was also questioned regarding R27 ' s ROM program and he stated he was not aware of any special ROM program for R27. On 9/18/13, at 7:30 p.m. F-A arrived to visit R27 and stated she visits R27 almost daily, sometimes more than once a day, and had never seen staff complete ROM services with R27. F-A added, " they don ' t do it. " On 9/19/13, at 10:43 p.m. NA-A stated she does not usually complete ROM on R27 during the day as F-A will do it because she knows "we just don't have time." R27 ' s Weekly Documentation Restorative Service sheets for June, July, August, and September 2013, instructed the NA ' s to complete AAROM to the left UE/LE, 7-10 repetitions twice a day. The record directed to document how many minutes it took to perform the task, initial, and make a weekly note related to progress with the goal. The documentation on the forms indicated most of the boxes including the " minutes " boxes were initialed by staff which indicated the ROM had been completed all but once in June, twice in July, and August, and four times in September (blank spaces). There was one weekly note documented in August which indicated " Resident does continue to aide [sic] in repositioning. " No further weekly notes were documented.	F 318		

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F 318	Continued From page 20 On 9/19/13, at 2:36 p.m. the RN manager (RN)-A was interviewed regarding R27 ' s ROM program not being completed. RN-A confirmed ROM should be completed as directed on the care plan and stated staff had not reported they were unable to complete their resident ROM programs. On 9/19/13, at 2:43 p.m. the restorative assistant (RA)-M stated the restorative documentation was reviewed monthly and the programs were reviewed quarterly. The NA's were interviewed to see if there had been any changes in condition or declines, but they [NA ' s] were not questioned regarding how the ROM programs were going. RA-M stated he was aware the minutes were not being documented on the restorative documentation sheets and confirmed they were inaccurate. RA-M added, the facility had been discussing revamping the restorative program. On 9/20/13, at 10:06 a.m. the Restorative Manager RN-G stated R27 has only the left side ROM as " that's what therapy initially recommended. " R27 had not had any issues and she had no concerns from family. RN-G stated R27 had required total assistance with all ADL ' s since admission to the facility and had not changed. R4 was not provided restorative PROM services based on assessed needs. R4 ' s diagnoses included anemia, osteoarthrosis, CVA with left sided weakness, macular degeneration, and shoulder joint pain.	F 318		

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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 318	Continued From page 21 The ADL Functional/Rehabilitation Potential CAA dated 9/27/12, indicated R4 was totally dependent with ADL ' s and was on a ROM program to keep the joints limber. The quarterly MDS dated 7/2/13, indicated R4 had severe cognitive impairment; had no behaviors; required total assistance of staff with all ADL's; was non-ambulatory; and had functional limitations in range of motion (ROM) to one upper and one lower extremity. The Restorative Services Care Conference Review form dated 9/16/13, identified functional ROM impairment in one UE/LE, and directed R4 should receive PROM to both UE/LE 7-10 repetitions BID with the NA ' s to maintain the current ROM and prevent further contractures due to CVA with left sided effects. The NA care guide dated 3/9/12, directed the NA ' s to complete bilateral UE/LE PROM 7-10 repetitions twice a day. The self care deficit care plan reviewed 6/26/13, directed the NA ' s to complete PROM to both UE/LE BID. On 9/18/13, at 12:11 p.m. R4 was observed in the w/c in the dining room. R4 received the lunch meal. At 12:19 p.m. NA-E started feeding R4. At 1:30 p.m. R4 was done eating and assisted in the w/c to her room by NA-E. At 2:01 p.m. R4 was still in her room in the w/c. At 3:27 p.m. R4 was observed in bed on the right side. Sleeping. At 4:58 p.m. R4 was observed in the w/c in the dining room waiting for dinner. At 5:12 p.m. R4 received the meal and NA-K started feeding R4. At 6:07 p.m. R4 was done eating and NA-K assisted R4 to her room in the w/c and turned on the TV. No ROM was observed to be completed	F 318		

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	245458	A. BUILDING _____ B. WING _____	09/20/2013

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F 318	Continued From page 22 throughout the observations. On 9/19/13, at 9:18 a.m. NA-A stated she would be completing ROM with R4 and assisted R4 to her room in the w/c. NA-A explained appropriately what UE/LE ROM consisted of and started to perform ROM to R4's left upper arm. NA-A completed approximately seven repetititions in the left wrist, shoulder, and stretched the left elbow and fingers on the left hand a few times. NA-A then explained R4's legs were stiff and it was easier to do ROM when she was in bed. NA-A then stated "I have to be honest, the majority of the time we're not able to complete ROM like it should be done due to not enough time/short staffing. " NA-A stated "we do lift their arms and legs with cares though. " No further ROM was completed during the observation. NA stated "I try, but there's not enough time in the day." On 9/18/13, at 9:45 a.m. NA-C stated he was unable to complete ROM appropriately "approximately 30% of the time." NA-C stated " there isn't enough time or staff. People have complained but I don't know what excuse they gave them. " R4 ' s Weekly Documentation Restorative Service sheets for June, July, August, and September 2013, instructed the NA ' s to complete bilateral UE/LE PROM 7-10 repetitions twice a day. The record directed to document how many minutes it took to perform the task, initial, and make a weekly note related to progress with the goal. The documentation on the forms indicated most of the boxes including the " minutes " boxes were initialed by staff which indicated the ROM had been completed all but once in June, three times	F 318		

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F 318	Continued From page 23 in July, and twice in September (blank spaces). There was one weekly note documented in August which indicated " Current ROM maintained. " No further weekly notes were documented. On 9/19/13, at 2:36 p.m. the RN manager (RN)-A was interviewed regarding R4 ' s ROM program not being completed. RN-A confirmed ROM should be completed as directed on the care plan and stated staff had not reported they were unable to complete their resident ROM programs. On 9/19/13, at 2:43 p.m. the restorative assistant (RA)-M stated the restorative documentation was reviewed monthly and the programs were reviewed quarterly. The NA's were interviewed to see if there had been any changes in condition or declines, but they [NA ' s] were not questioned regarding how the ROM programs were going. RA-M stated he was aware the minutes were not being documented on the restorative documentation sheets and confirmed they were inaccurate. RA-M added, the facility had been discussing revamping the restorative program. On 9/20/13, at 10:06 a.m. the Restorative Manager (RN)-G stated R4 has not changed in a few years. R4 would occasionally hold a glass or something, but was usually total care. RN-G stated staff should report when they are unable to complete ROM and the restorative aides could try and assist. RN-G stated the facility had four restorative aides until a couple of years ago, but two left and were not replaced.	F 318		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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F 329	Continued From page 24 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify, assess, and monitor for the effectiveness of interventions related to low blood glucose levels for 1 of 5 residents (R26) whose medications were reviewed. Findings include: R26 had low blood glucose (BG) levels (42-58) with no documentation to indicate if R26 exhibited symptoms, what interventions were provided,	F 329	F 329 Drug Regimen is Free From Unnecessary Drugs 1. Resident #26 had his diabetes management plan reviewed by the attending medical provider. A nursing assessment was completed to identify, assess and monitor for the effectiveness of interventions related to low blood glucose levels. A plan of care was developed for resident #26 with individualized parameters based on his specific needs. 2. All residents receiving medications have the potential to be impacted by a deficient practice in this area. 3. All residents receiving diabetic medications will be reviewed to ensure they have individualized plans of care. Policies and procedures have been reviewed and revised as necessary. The RN will assess resident medication regimens and ensure the plan of care addresses each resident's specific needs. 4. A minimum of three charts will be reviewed weekly for documentation of symptoms, interventions and the effectiveness of interventions for residents who receive insulin. All staff will be educated on the policies and procedures related to hypoglycemia or hyperglycemia. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The	

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F 329	Continued From page 25 and/or if the interventions provided were effective. R26's diagnosis included diabetes mellitus type I (juvenile type) with ophthalmic manifestations. The quarterly Minimum Data Set (MDS) dated 8/27/13, identified R26 had diabetes and received insulin injections (decreases blood sugar) seven out of seven days during the assessment period. The current Physician's orders dated 9/17/13, directed Lantus insulin 18 units every morning (QAM), Novolog insulin 8 units at breakfast and supper, 5 units at lunch, and accuchecks four times a day (QID) with sliding scale insulin (extra insulin based on BG levels). Review of R26's QID accuchecks noted as follows: July 2013 - 7/16/13, 4:30 p.m. BG 58; 7/22/13, 4:30 p.m. BG 58. August 2013 - 8/13/13, 4:30 p.m. BG 44; 8/14/13, 4:30 p.m. BG 52; 8/15/13, at 4:30 p.m. BG 42; 8/19/13, 4:30 p.m. BG 56, and 8/19/13, HS (hour of sleep) BG 58. September 2013 - 9/10/13, 4:30 p.m. BG 56; 9/11/13, HS BG 43; 9/18/13, HS BG 45. The registered nurse manager (RN)-A provided a Hypoglycemia Protocol sheet for residents on insulin. The hypoglycemia protocol provided by the facility directed: BG 45-60 milligrams per deciliter (mg/dL) with or without symptoms - provide 20 grams - 4 glucose tablets (5 grams each); 6 ounces (oz.) of juice or non-diet pop; or 1 ½ packets of jelly. BG less than 45 mg/dL and resident was conscious, cooperative, and able to swallow - provide 30 grams - 6 glucose tablets (5 grams each); 8 oz. of juice or non-diet pop; 2 packets of jelly; or 4 oz. of juice or regular pop with 3 graham cracker squares. BG less than 45 mg/dL and resident unconscious/uncooperative - If no IV access -	F 329	monitoring results will be reported to the quarterly QI team. The QI team will make recommendations for ongoing monitoring. 5. Completion Date: December 20, 2013 6. Responsible Persons: Administrator, DON, RN Unit Managers, ID Team	

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F 329	Continued From page 26 give 1.0 mg Glucagon IM (intramuscular), repeat blood glucose test and retreat every 15 minutes until BG greater than 70 mg/dL without symptoms, or BG greater than 100 mg/dL. Only repeat Glucagon one time. The Medication Administration Record (MAR) for September 2013, indicated on 9/18/13, R26 received IM Glucagon at 9:00 p.m. for a BG of 45. A Nurse's Note dated 9/18/13, at 10:00 p.m. indicated R26's BG was 45 and one hour later was 135. The medical records lacked documentation of any symptoms (such as being unconscious or uncooperative) related to the low BG. In addition, on all of the other days R26's BG was low the medical records lacked evidence of the interventions provided, if R26 was symptomatic, or if the interventions were effective. R26 was observed on 9/18/13, from 12:38 p.m. to 2:17 p.m. and at 5:00 p.m. No signs or symptoms of hypoglycemia were noted. On 9/20/13, at 11:50 a.m. licensed practical nurses (LPN)-I, LPN-G, and the registered nurse manager (RN)-D stated they should follow the facility hypoglycemia protocol when BG are low and provide one item on the list, recheck the BG, and document the information in the nurse's notes. LPN-I, LPN-G, and RN-D all stated they would usually provide juice first. On 9/20/13, at 3:53 p.m. the registered nurse manager (RN)-A stated staff should document any low BG, resident symptoms, the interventions provided, and whether the interventions were effective in the nurse's notes. RN-A added, they would not want to give R26 glucose tablets because, "That would put him over the edge," and confirmed there were no individualized	F 329		

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F 329	Continued From page 27 parameters based on R26's specific needs.	F 329	F 334 Influenza and Pneumococcal Immunizations	
F 334 SS=D	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 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;	F 334	1. Resident #72 and 127 are no longer in this facility. Resident #24's representative was contacted about giving resident#24 the pneumococcal vaccine and provided information about the benefits and potential risks of the vaccine. 2. All residents have the potential to be impacted by this deficient practice. 3. Policies and procedures were reviewed and revised as appropriate. 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 vaccines. Information flyers are part of the admission packet for each resident. 4. Audits will be completed within one week after admission to this facility to ensure ongoing compliance with education about Pneumococcal and Influenza Vaccines risks and benefits. The monitoring results will be reported to the quarterly QI team. The QI team will make recommendations for ongoing monitoring. 5. Completion Date: December 20, 2013	

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F 334	Continued From page 28 (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 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 provide education of the benefits and potential side effects of the Pneumococcal vaccination prior to offering the vaccine for 3 of 3 residents (R24, R72, R127) who were offered and refused the immunization. Findings include: The Influenza and Pneumococcal Vaccines policy	F 334	6. Responsible Persons: Administrator, DON, RN Unit Managers, ID Team	

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F 334	Continued From page 29 effective 11/9/12, indicated the Pneumococcal vaccination would be offered to all residents over the age of 65 who could not provide documentation of previous vaccination, were unsure, or did not know their vaccination status. The policy did not indicate education of the benefits and potential risks of the Pneumococcal vaccination would be provided prior to offering the vaccine. R24 ' s representative, R72, and R127, were not provided education regarding the benefits and potential risks of the Pneumococcal vaccine prior to being offered the vaccine in order to make an informed consent or refusal. R24 was over the age of 65. The Resident Vaccination & Mantoux Record indicated R24 ' s representative refused the vaccine (no date). The medical records lacked evidence education of the benefits and potential risks of the vaccine was provided prior to offering the vaccine. R72 was over the age of 65. The Resident Vaccination & Mantoux Record indicated R72 refused the vaccine (no date). The medical records lacked evidence education of the benefits and potential risks of the vaccine was provided prior to offering the vaccine. R127 was over the age of 65. The Resident Vaccination & Mantoux Record indicated R127 refused the vaccine on 8/16/13. The medical records lacked evidence education of the benefits and potential risks of the vaccine was provided prior to offering the vaccine. On 9/19/13, at approximately 10:00 a.m. the director of nursing (DON) confirmed the facility	F 334		

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F 334	Continued From page 30 did not provide education to residents on the benefits and potential risks of the Pneumococcal vaccine prior to offering the vaccine, and stated there was no further documentation to provide.	F 334		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served in a sanitary manner for 11 of 39 residents who were served cookies in the third floor dining room. Findings include: During the noon meal on 9/18/13, 11 of 39 residents were served cookies by dietary staff with soiled gloves. During continuous observation on 9/18/13, from 12:05 p.m. to 12: 37 p.m. dietary aide (DA)-A was observed pushing a food cart around the dining room, offering residents fruit, bread, jello and cookies. DA-A was wearing gloves, and was observed touching resident wheelchairs and	F 371	F 371 Food Procure, Store/Prepare/Serve-Sanitary 1. Re-educate Dietary Aide (DA)-A to procure food from sources approved or considered satisfactory by Federal, State or local authorizes; and to store, prepare, distribute and serve food under sanitary conditions. Monitor and observe Dietary Aide (DA)-A, to ensure food is served in sanitary manner. Review policy and procedure on gloves, use limitation with (DA)-A. 2. All residents have the potential to be affected by this deficient practice. 3. Re-education of all staff involved in the storage, preparation, distribution and serving of food to proper food handling procedures to ensure food is served under sanitary conditions. Audit and monitor employees involved in food handling at meal times to determine safe food handling practices are in place. 4. Audits and monitors will occur weekly x three months in each	

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F 371	Continued From page 31 tables, opening the refrigerator, and applying a cover up on a resident. DA-A did not remove her gloves and wash her hands after touching these surfaces. DA-A took cookies off of a plate with her soiled gloved hands, and placed them on a smaller plate to give to residents. On 9/18/13, at 12:38 p.m., DA-A was interviewed and stated she usually serves the cookies with her gloved hands, and verified her gloves were soiled. On 9/18/13, at 1:06 p.m. the dietary supervisor was interviewed and verified staff should not be touching food with soiled gloves. The facility policy and procedure on gloves, use limitation, dated 1/15/11, directs employees to use suitable utensils such as deli tissue, spatulas, tongs, single use gloves, or dispensing equipment for ready to eat food. If gloves are used, single use gloves shall be used for only one task including working with ready to eat food, and discarded when damaged, soiled, or when interruptions occur in operation.	F 371	dining area to ensure safe food handling standards are met. Corrective action will occur at time of observation. Audit findings will be reviewed by Quality Team for recommendations and action. 5. Completion Date: December 20, 2013. 6. Responsible Persons: Administrator, DON, Dietary Manager, Dietary Supervisor, Unit Managers.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	F 428 Drug Regimen Review, Report Irregular, Act on 1. Resident #26's Diabetes management plan has been reviewed by the primary care provider and changes have been made to the plan of care. Blood glucose levels have been more	

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F 428	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the consultant pharmacist (CP) failed to identify and report to the facility a lack of monitoring and documentation of the effectiveness of interventions related to low blood glucose levels for 1 of 5 residents (R26) whose medications were reviewed. Findings include: R26 had low blood glucose (BG) levels (42-58) with no documentation to indicate if R26 exhibited symptoms, what interventions were provided, and if the interventions provided were effective. The CP failed to identify and report the irregularities to the Physician and director of nursing (DON). R26's diagnosis included diabetes mellitus type I (juvenile type) with ophthalmic manifestations. The quarterly Minimum Data Set (MDS) dated 8/27/13, identified R26 had diabetes and received insulin injections (decreases blood sugar) seven out of seven days during the assessment period. The current Physician's orders dated 9/17/13, directed Lantus insulin 18 units every morning (QAM), Novolog insulin 8 units at breakfast and supper, 5 units at lunch, and accuchecks four times a day (QID) with sliding scale insulin (extra insulin based on BG levels). Review of R26 ' s QID accuchecks noted as follows: July 2013 - 7/16/13, 4:30 p.m. BG 58; 7/22/13, 4:30 p.m. BG 58. August 2013 - 8/13/13, 4:30 p.m. BG 44; 8/14/13, 4:30 p.m. BG 52; 8/15/13, at 4:30 p.m. BG 42; 8/19/13, 4:30 p.m. BG 56, and 8/19/13, HS (hour of sleep) BG 58. September 2013 - 9/10/13, 4:30 p.m. BG 56;	F 428	stable as a result of the changes to his insulin dose. The consulting pharmacist reviews the resident's MAR monthly. 2. All residents receiving pharmacy services have the potential to be effected. 3. The consultant pharmacist will continue to review all resident MAR's each month and identify, report and make recommendations to the facility regarding any discrepancies in residents' medication management. Nursing staff will fill out a flow sheet for blood glucose levels in the resident's MAR so it is easier for nursing, care provider and pharmacy to read. 4. Flow sheet will have a signature line for the CP to initial that BG levels were reviewed and will report to the attending physician and DON each month during pharmacy reviews. Audits will be done each month by Pharmacy and nursing to ensure that BG flow sheets are initialed. 5. Completion Date: 12/20/13 6. Responsible Persons: Administrator, DON, Pharmacy and ID Team	

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F 428	Continued From page 33 9/11/13, HS BG 43; 9/18/13, HS BG 45. The registered nurse manager (RN)-A provided a Hypoglycemia Protocol sheet for residents on insulin. The hypoglycemia protocol provided by the facility directed: BG 45-60 milligrams per deciliter (mg/dL) with or without symptoms - provide 20 grams - 4 glucose tablets (5 grams each); 6 ounces (oz.) of juice or non-diet pop; or 1 ½ packets of jelly. BG less than 45 mg/dL and resident was conscious, cooperative, and able to swallow - provide 30 grams - 6 glucose tablets (5 grams each); 8 oz. of juice or non-diet pop; 2 packets of jelly; or 4 oz. of juice or regular pop with 3 graham cracker squares. BG less than 45 mg/dL and resident unconscious/uncooperative - If no IV access - give 1.0 mg Glucagon IM (intramuscular), repeat blood glucose test and retreat every 15 minutes until BG greater than 70 mg/dL without symptoms, or BG greater than 100 mg/dL. Only repeat Glucagon one time. The Medication Administration Record (MAR) for September 2013, indicated on 9/18/13, R26 received IM Glucagon at 9:00 p.m. for a BG of 45. A Nurse's Note dated 9/18/13, at 10:00 p.m. indicated R26's BG was 45 and one hour later was 135. The medical records lacked documentation of any symptoms (such as being unconscious or uncooperative) related to the low BG. In addition, on all of the other days R26's BG was low the medical records lacked evidence of the interventions provided, if R26 was symptomatic, or if the interventions were effective. R26 was observed on 9/18/13, from 12:38 p.m. to 2:17 p.m. and at 5:00 p.m. No signs or symptoms of hypoglycemia were noted.	F 428		

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F 428	Continued From page 34 On 9/20/13, at 11:50 a.m. licensed practical nurses (LPN)-I, LPN-G, and the registered nurse manager (RN)-D stated they should follow the facility hypoglycemia protocol when BG are low and provide one item on the list, recheck the BG, and document the information in the nurse ' s notes. LPN-I, LPN-G, and RN-D all stated they would usually provide juice first. On 9/20/13, at 1:53 p.m. the registered nurse manager (RN)-A stated staff should document any low BG, resident symptoms, the interventions provided, and whether the interventions were effective in the nurse's notes. RN-A added, they would not want to give R26 glucose tablets because, "That would put him over the edge," and confirmed there were no individualized parameters based on R26's specific needs. Review of the monthly Consultant Pharmacist's Drug Regimen Review Notes for July 2013, and August 2013, indicated no recommendations were made regarding low BG and the missing documentation. On 9/20/13, at 2:48 p.m. the consultant pharmacist (CP) stated she reviews the MAR's, including insulin doses, but had not checked for documentation when BG were out of range. The CP confirmed she would expect to see documentation in the medical record including resident symptoms, interventions, and effectiveness (BG recheck). The CP verified she had not made a recommendation to the facility.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	F 431 Drug Records, Label/Store Drugs and Biologicals 1. The procedure for disposal of Fentanyl patches has been changed. When a Fentanyl patch is removed and replaced, two staff will witness and sign for disposal of the patch. The Fentanyl patch will be folded	

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F 431	Continued From page 35 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not ensure safe and secure disposal of fentanyl (topical narcotic analgesic medication) patches, and did not supervise all unlicensed staff in medication rooms. This had the potential to affect all residents receiving medications.	F 431	together and flushed down the toilet. Housekeeping staff will not go into the medication room for the purpose of cleaning without nursing supervision. 2. All residents receiving pharmacy services have the potential to be effected. 3. The policy for Fentanyl removal and disposal has been reviewed and revised. The Medication Room Policy was reviewed and revised as necessary. All nursing staff were educated on the policy changes for Fentanyl patch removal and the Medication Room Policy for cleaning by housekeeping staff. A refrigerator lock will be placed on the refrigerators in the medication rooms. 4. A minimum of two audits will be completed each week to monitor the destruction of Fentanyl patches to ensure two staff are witnessing and signing off that the Fentanyl patch is being flushed down the toilet. Any identified concerns will be discussed by the DON with the consulting pharmacy. The monitoring results will be reported to the quarterly QI team who will make recommendations for ongoing monitoring. 5. Completion Date: 12/20/13 6. Responsible Persons: Administrator, DON, Pharmacy, ID Team	

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F 431	Continued From page 36 Findings include: The Food and Drug Administration's (FDA) publication FDA Reminds the Public about the Potential for Life Threatening Harm from Accidental Exposure to Fentanyl Transdermal Systems ("Patches") [4/18/12] The FDA reminded patients, caregivers and physicians about the proper use and disposal of fentanyl patches. The FDA recommended that the adhesive side of the patch be folded together and then the patch should be flushed down the toilet. A fentanyl patch provides continuous delivery of medication over a 72 hour period. The delivery system is not impervious to diversion even after the fentanyl patch has been used, removed or disposed of. Studies show that even after three days of use, 28 - 84 percent of the fentanyl dose could still be present in the patch. The remaining fentanyl in the patch has the potential for for abuse and accidental overdose. On 9/18/13, at 6:09 p.m., licensed practical nurse (LPN)-D, stated that fentanyl patches were placed in the sharps container for disposal and did not require a witness. LPN-d stated that fentanyl patches were signed out or the narcotic book and dated when applied. There was no record of disposal. On 9/18/13, at 6:15 p.m. LPN-C indicated she places the fentanyl patch face down on a glove	F 431		

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F 431	Continued From page 37 and places it in the sharps container. At 6:31 p.m. LPN-A and LPN-B indicated the used fentanyl patches were put in the sharps container. On 9/19/13, at 8:50 a.m. LPN-F, stated that fentanyl patches were placed in the sharps container and there was no record of disposal. The director of nursing (DON), interviewed on 9/19/13, at 1:30 p.m., stated that facility policy directed staff to fold the fentanyl patch in half, put it in a bag and place the bag in the "black box" in the medication room for disposal by the pharmacist. The DON stated that staff, Are suppose to have two nurses sign when destroying the fentanyl patches." The pharmacist came to ensure that fentanyl patches were folded and placed inside the black box. The fourth floor medication room contained a black box with a white cover labeled labeled "RCRA Hazardous Waste" The opening in the top of the black box was large enough to allow access to the hazardous materials inside. The DON asked LPN-H about the procedure for disposal of fentanyl patches, and LPN-H stated that fentanyl patches were to be wrapped up and put in the black box and did not require documentation of disposal. LPN-H stated the black box was pretty much, "A big black sharps container." LPN-H stated that housekeeping staff remove the black box when it's full. On 9/19/13, at 2:12 p.m. the consultant pharmacist was interviewed regarding the disposal of fentanyl patches. The pharmacist stated staff should cut, fold or place fentanyl patches in a baggies and put them in the black box labeled hazardous waste. The pharmacist did	F 431		

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F 431	Continued From page 38 not think there was a separate protocol for fentanyl patches and a disposal company collects the black boxes for permanent disposal. The pharmacist stated that two staff are required to sigh for disposal or waste or narcotics. Housekeeper-B was interviewed on 9/19/13, at 2:35 p.m., and stated that nursing staff place the black box in the soiled utility room and the janitor takes it to be disposed. On 9/19/13, at 2:40 p.m. janitor-H stated that nursing staff either call for removal of full black boxes or place them into the soiled utility room. The janitor took the full black boxes to a locked room in the adjoining hospital. The facility's Hazardous/Regulated Waste, Handling and Disposal policy reviewed/revised last in 3/10, indicated pharmaceutical waste must be properly disposed of in a designated pharmaceutical waste container labeled hazardous waste container. User areas are responsible to place full containers in a secure locked location. Environmental services will pick up the full containers and supply empty containers. On 9/18/13, at 1:29 p.m. a housekeeper was allowed unsupervised access to a medication room. On 9/18/13, at 1:29 p.m. housekeeper-A asked	F 431		

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F 431	Continued From page 39 registered nurse (RN)-A to let her in the fourth floor medication room to clean. Housekeeper-A entered the medication room and RN-A left the area. and let her in and then left the room and walked down the hall then returned to her office. The housekeeper emptied the garbage and mopped the floor. At 1:33 p.m. the housekeeper left the medication room and the door shut and locked. During an interview at 1:45 p.m. housekeeper-A indicated she did not know the code and asks licensed staff to let her in and they usually leave her alone in the medication room. On 9/18/13, at 1:53 p.m. RN-A stated it was usual procedure to allow housekeeping staff into the med room with the medication carts locked, nothing was on top of the carts, and all medication cupboards locked. Observation of the medication room at that time indicated that all medications were secure except for those in the unlocked refrigerator. The refrigerator contained insulin vials, insulin pens, Dulcolax suppositories, Tylenol suppositories, mantoux solution and liquid ativan (anti-anxiety medication with potential for diversion or accidental overdose). The DON, interviewed on 9/18/13, at 3:55 p.m., stated licensed staff should supervise all unlicensed staff inside the medication room. The facility's Medication Room policy effective 9/07, indicated the medication room will be locked and only licensed personnel will have access to the room.	F 431		

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

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F 441 F 441 SS=D	Continued From page 40 483.65 INFECTION CONTROL, PREVENT 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 F 441	F 441 Infection Control, Prevent Spread, Linens 1. The direct caregiver responsible for resident #143's dressing changes was re-educated on proper infection control technique related to changing gloves and washing hands between changes of gloves. Resident suffered no ill effects from the break in infection control practice. Two of residents' pressure areas are healed. The wound care specialist saw resident's wounds on 11/18/13 for a recheck and noted that the wound had normal drainage with no signs of infection. 2. All residents have the potential to be effected by a break in infection control practices. 3. The Infection Control Policy for handwashing and glove use was reviewed. All facility staff were re-educated on proper handwashing and gloving. 4. 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 throughout the day to ensure ongoing compliance. Staff will be re-educated 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	

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F 441	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate infection control technique was maintained during a pressure ulcer dressing change for 1 of 1 residents (R143) reviewed for pressure ulcers. In addition infection control practices were maintained during 1 of 1 blood glucose monitoring. Findings include: R143's pressure ulcer wound care was observed on 9/18/13, at 1:55 p.m. R143's diagnoses included Parkinson's disease, diabetes mellitus type 2, dementia, mixed incontinence, hypothyroidism, hyperlipidemia, pressure ulcer to lower back stage 3, and pressure ulcer to hip stage 2. The admission minimum data set (MDS) dated 8/18/13, indicated R143 had short and long term memory deficits; had an indwelling catheter; was always incontinent of bowel; and was totally dependent for bed mobility, transfers, toileting, and personal hygiene activities. The admission MDS further indicated R143 was admitted with 3 stage 3 pressure ulcers and one unstageable pressure ulcer due to a dressing covering it.	F 441	recommendations for ongoing compliance. 5. Completion Date: December 20, 2013 6. Responsible Persons: Administrator, DON, RN Unit Managers, ID Team	

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F 441	Continued From page 42 The care plan dated 8/27/13, indicated R143 was to be turned and repositioned every 2 hours and wound care was to be provided per physician's orders which included packing the sacral wound with normal saline wet to dry dressings twice daily, right hip ulcer wet to dry dressing changes twice daily, change duoderm every 3 days and as needed to left hip ulcer, and change duoderm dressing to right buttock ulcer every 3 days with cleansing of ulcer area with normal saline and pat dry. R143's dressing change observation was completed on 9/18/13, at 1:55 p.m.. Licensed practical nurse (LPN)-F took a pair of gloves from the uniform pocket and gathered dressing change supplies from R143's closet. LPN-F was observed to glove and remove soiled dressings from each of R143's pressure ulcers, and registered nurse (RN)-C measured the pressure ulcers. RN-C did not complete hand hygiene with glove changes between each wound. LPN-F was observed to remove the old dressing and wound packing from R143's coccyx ulcer. LPN-F disposed of old dressings and packing, removed gloves, and applied new gloves. RN-C measured R143's coccyx ulcer's length and width with a clear, disposable wound measurement chart and the depth with a sterile, cotton-tipped applicator while LPN-F recorded the measurements. RN-C disposed of the wound measurement graph, the cotton-tipped applicator, and the used gloves in a nearby garbage can, and then applied new blue disposable gloves. LPN-F stated we are expecting the nurse practitioner at any time to examine R143's ulcers.	F 441		

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F 441	Continued From page 43 On 9/18/13, at 2:15 p.m. the nurse practitioner (NP) entered R143's room. The NP was not observed to wash or sanitize [his/her] hands before donning gloves to examine each of R143's 4 pressure ulcers. The NP measured the depth of R143's right hip ulcer using a sterile cotton-tipped applicator, and with the same gloves on, examined the other three ulcers. RN-C removed the gloves and left R143's room at 2:18 p.m. without washing the hands. On 9/18/13, at 2:19 p.m. LPN-F removed the soiled gloves and left the room to get dressings and supplies for R143's wound care. At 2:21 p.m. LPN-F returned to R143's room with the new dressings. At 2:22 p.m. RN-C removed the soiled gloves and left the room, returning at 2:23 p.m. with more dressings. Neither LPN-F or RN-C were observed to wash their hands upon return to R143's room. Both RN-C and LPN-F were observed to apply new blue disposable gloves. LPN-F prepared the gauze packing and attempted to pack R143's coccyx ulcer. LPN-F reached into a right hand uniform pocket and removed a pair of bandage scissors to cut the gauze packing. At 2:27 p.m. LPN-F removed the gloves and reached into a pink wash basin if the closet, and removed several small 2 inch by 2 inch gauze dressings with bare hands. LPN-F applied new gloves, wetted the small gauze dressings with the normal saline solution, and packed the gauze into R143's coccyx ulcer. LPN-F opened a duoderm dressing package, placed a 4 inch by 4 inch gauze dressing and then the duoderm dressing over the ulcer packing and secured the dressing in place. LPN-F removed the used gloves and applied new gloves. LPN-F used sterile saline solution to	F 441		

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F 441	Continued From page 44 cleanse R143's left hip ulcer and applied a duoderm dressing to the left hip area. LPN-F removed the soiled gloves and went into the bathroom to cleanse the scissors with an alcohol wipe. LPN-F re-entered R143's room with a small disposable drinking cup and used bare hands to reach into a jar of thin gauze packing and cut the gauze with the cleansed scissors. LPN-F placed the cut gauze packing into the small drinking cup, obtained several 2 inch by 2 inch gauze dressings and placed them on the bed sheets near R143's buttocks. LPN-F applied clean gloves, poured sterile normal saline solution into the drinking glass with the cut gauze and packed the right hip wound with the gauze. LPN-F then placed the small gauze dressing over the packing, taped the dressing in place and removed the used gloves. LPN-F applied clean gloves and cleansed R143's right buttock ulcer with sterile normal saline solution and gauze, patted the ulcer area dry with another gauze dressing, and removed the used gloves. With bare hands, LPN-F applied a new duoderm dressing to R143's right buttock ulcer. At approximately 2:30 p.m. both LPN-F and RN-C left R143's room without washing hands. LPN-F, interviewed on 9/18/13, at 2:30 p.m. LPN-F stated she did not wash hands between the 4 dressing change procedures for R143. LPN-F further stated she felt changing her gloves was enough. LPN-F verified the bare hand contact with dressing supplies and wound packing, as well as the scissors and gloves removed from the uniform pocket. On 9/18/13, at 2:45 p.m. RN-C stated hands	F 441		

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	245458	A. BUILDING _____ B. WING _____	09/20/2013

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F 441	Continued From page 45 should have been washed his hands between the removal of gloves. RN-C concurred the NP did not wash her hands upon entering or leaving R143's room. On 9/18/13, at 2:55 p.m. RN-I confirmed nurses should be washing their hands between procedures and when going from dirty to clean procedures. RN-I verified bare hand contact of dressings needing to be packed inside a wound should not be happening. RN-I further verified scissors or gloves in a pocket should not be used for dressing change procedures. An undated Infection Control Policy for handwashing and glove use directed hands must be washed before and after glove use and between different procedures on the same patient as well as after contact with wounds. On 9/16/13, at 4:30 p.m. LPN-A was observed doing an accucheck (blood glucose monitoring). LPN-A entered the resident's room, washed her hands in the resident's bathroom, pulled a pair of gloves from the pocket on her shirt and donned the gloves. LPN-A cleaned the resident's finger with an alcohol wipe, poked the finger and obtained blood into the strip of the blood glucose machine. LPN-A then removed the gloves and washed her hands. LPN-A indicated staff were not supposed carry gloves in the pocket.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL	F 465		

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F 465	Continued From page 46 E 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 interview and document review, the facility failed to ensure a functioning bathtub was available for 2 of 3 residents (R73, R32) that preferred bath to shower. Findings include: R73 stated he used to get tub bath, but no more because the bathtub was not functioning. R73's diagnoses included cerebral vascular accident (CVA), osteoarthritis, chronic back pain, and generalized pain. The annual minimum data set (MDS) dated 3/18/13 indicated R73 was cognitively intact, and it was very important for him to choose between a tub bath, shower, bed bath or sponge bath. The MDS further indicated R73 required extensive assistance of 1 staff for bathing. The care plan, dated 3/15/12, indicated R73 was able to make his own daily decisions and had no cognitive impairment. The environmental director (ED)-D was interviewed on 9/18/13, and stated he was unaware the tub was not in working order. A review of the request work order, dated 4/29/13, indicated "We are missing a piece to clean the whirlpool tub jets. Need a replacement." Another request work order	F 465	F 465 Safe/Functional/Sanitary/ Comfortable Environment 1. R73 and R32 have been offered the choice of having a Tub Bath as they had expressed a preference for. Care Plans updated. The Tub on 3rd floor has been repaired and is in service. An emergency funding request is being filed for the purchase of a new Tub for 4th floor. 2. All residents have the potential to be affected by this deficient practice. 3. Offer all residents a choice in bathing each time. Educate all staff to importance of resident choice, and our obligation to honor resident preference. Care Plans will reflect resident preferences in bathing. Resident Tub(s) will be inspected for proper function and operation quarterly. Staff will promptly report any concerns regarding Tub(s) and initiate an electronic work order request. Work Request Policy will be reviewed. Education for staff will be available with regard to making an electronic work order request. 4. Resident Care Plans will be updated at quarterly care conferences to ensure resident	

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F 465	Continued From page 47 dated 8/27/13, indicated "Need the cleaning hose attachment for the whirlpool tub on the third floor. It is missing." on 8/28/13, the maintenance department responded to the work order by documenting "Checked into problem and ordered parts." An orange sticky note was attached to the request order and verified parts for the tub were on back order. On 9/19/13, at 1:27 p.m. the director of nursing (DON) stated that four months was too long for the maintenance department to repair the bath tub. R32 stated her bathing preference was a tub bath, but the bathtub didn't work. R32's diagnoses included cerebrovascular accident with left side hemiplegia, depression, edema and generalized pain. R32's The annual Minimum Data Set (MDS) dated 6/14/13, indicated it was somewhat important for R32 to choose between a bath and a shower. R32 required the assistance of one staff to bathe and did not have any rejection of care. On 9/19/13, at 9:40 a.m. nursing assistant (NA)-G indicated R32 loved a bath and would stay in there all day but now gets a shower because the tub had missing pieces. "R32 really enjoyed getting a bath and used to have a tub bath once a week and a shower once a week but if we had	F 465	preferences are honored to the extent possible. Structured audits will be conducted monthly to times six months to ensure preferences are honored and are documented. Audit findings will be reviewed by Quality Team to identify areas of improvement needed and implementation of a action plan. 5. Completion Date: December 20, 2013 6. Responsible Persons: Administrator, DON, Manager of Facilities and Maintenance, Unit Managers, ID Team	

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F 465	Continued From page 48 time they would give a tub bath instead of the shower because she enjoyed it so much." On 9/19/13, at 12:15 p.m. the ED observed the bathtub in the fourth floor. The ED did not think the tub was working and stated, "It looks like it hasn't been used in a long time."	F 465		

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

F5458022

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Essentia Health Virginia Nursing Home 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 Inspections State Fire Marshal Division 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or	K 000	POC ok 12-3-13 RECEIVED DEC 2 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc: 10-28-13

Exit: 9-18-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/27/13

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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K 000	Continued From page 1 By E-mail to: Marian.whitney@state.mn.us, and Barbara.Lundberg@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. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by: Essentia Health Virginia Nursing Home is a 4-story building with a full basement. The original building was constructed in 1936 and additions constructed in 1976 and 1999, all of Type II(222) construction. The nursing home occupies the 3rd and 4th floors only. A 3 story hospital of the same construction 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 fire 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 fire department notification automatically. The facility has a licensed capacity of 90 beds and had a census of 92 at the time of survey.	K 000		

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K 000	Continued From page 2 It is the determination of this Life Safety Code Surveyor the the fire sprinkler coverage in the resident rooms is adequate to provide complete unobstructed coverage to the exterior of the wardrobe closets in accordance with NFPA 13(99) and CMS S&C-05-38, A1.	K 000	K 050 NFPA 101 Life Safety Code Standard 10-28-13 1. Planning for the 2014 Fire Drills to be conducted at unexpected times under varying conditions, at least quarterly on each shift has taken place. This plan includes one drill per shift (day, evening, night) each quarter, at a minimum. Additional Fire Drills took place during October and November of 2013 as make-up. 2. The 2014 Planned Fire Drill schedule is complete as of November 25, 2103. An audit form has been developed to monitor compliance each of the 14 months from October 2013 through December 2014. 3. Rich Weiss, Manager, Facilities and Environmental Services, and Jeff Brown, Administrator of the Virginia Care Center are responsible for this correction and monthly monitoring to prevent a reoccurrence of this deficient practice. Both responsible parties will conduct audits and meet at least monthly to determine level compliance and any corrective action needed to maintain compliance.	
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 available documentation and interview, it was determined that fire drills were not conducted at as required by LSC(00) Section 19.7.1.2. This deficient practice could affect all occupants including residents, visitors and staff in the event of a fire emergency. Findings include: On 9-18-13 at the conclusion of the inspection, at approximately 10:30AM, based on a review of available fire drill documentation it was determined that fire drills were not conducted as required.	K 050		

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K 050	Continued From page 3 No day or afternoon shift drills were conducted during the 1st quarter of 2013. This deficient practice was confirmed by the facility Director of Maintenance (RW) at the time of exit	K 050		