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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: AQ8U

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00603

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

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

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

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

6. DATE OF SURVEY **11/09/2016** (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
X 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):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE NEII 11/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/16/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/07/2016
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5458

On October 27, 2016, and November 9, 2016, Health and Life Safety Code staff conducted revisits to verify the facility achieved and maintained compliance with deficiencies issued pursuant to September 15, 2016 survey. Based on our revisits we have determined the facility has corrected the deficiencies issued pursuan to the September 15, 2016 standard survey, effective October 21, 2016.

• State Monitoring effective October 5, 2016. (42 CFR 488.422)
In addition, the Department recommended the following enforcement remedies to the Centers for Medicare and Medicaid Services (CMS) for imposition:

• Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions (DPNA) effective December 15, 2016. (42 CFR 488.417 (b))

If DPNA goes into effect, the facility would be subject to a two year loss of NATCEP

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of statemonitoring effective October 21, 2016.

In addition, the Department recommended to the CMS Region V Office the following actions related to the remedies in our letter of September 30, 2016:

• Civil money penalty for the deficiency cited at F314, remain in effect. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective December 15, 2016 be rescinded as of October 21, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify the facility of their determination regarding the imposed remedies, NATCEP prohibition, and appeal rights.

Refer to the CMS 2567b forms for both health and life safety code.

Effective October 21, 2016, the facility is certified for 90 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245458

December 16, 2016

Ms. Deborah Morell, Administrator
Essentia Health Virginia Care Cent
901 9th Street North
Virginia, MN 55792

Dear Ms. Morell:

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 October 21, 2016 the above facility is certified for:

90 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Electronically delivered
November 21, 2016

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

RE: Project Number S5458025

Dear Ms. Morell:

On September 30, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective October 5, 2016. (42 CFR 488.422)

In addition, on September 30, 2016, the Department recommended the following enforcement remedies to the Centers for Medicare and Medicaid Services (CMS) for imposition:

- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 15, 2016. (42 CFR 488.417 (b))

Furthermore, as we notified you in our letter of September 30, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 31, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on September 15, 2016. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On November 9, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 27, 2016, 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 15, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 21, 2016. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our

standard survey, completed on September 15, 2016, as of October 21, 2016.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective October 21, 2016.

In addition, the Department recommended to the CMS Region V Office the following actions related to the remedies in our letter of September 30, 2016:

- Civil money penalty for the deficiency cited at F314, remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 15, 2016 be rescinded as of October 21, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245458 Y1	A. Building B. Wing Y2	11/9/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157	Correction	ID Prefix F0246	Correction	ID Prefix F0282	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.15(e)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	10/21/2016	LSC	10/21/2016	LSC	10/21/2016
ID Prefix F0309	Correction	ID Prefix F0314	Correction	ID Prefix F0323	Correction
Reg. # 483.25	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(h)	Completed
LSC	10/21/2016	LSC	10/21/2016	LSC	10/21/2016
ID Prefix F0334	Correction	ID Prefix F0371	Correction	ID Prefix F0431	Correction
Reg. # 483.25(n)	Completed	Reg. # 483.35(i)	Completed	Reg. # 483.60(b), (d), (e)	Completed
LSC	10/21/2016	LSC	10/21/2016	LSC	10/21/2016
ID Prefix F0465	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(h)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/21/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/mm	11/21/2016	34089	11/09/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/15/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245458 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/27/2016 Y3

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).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0018	10/21/2016	LSC	K0052	10/21/2016	LSC	K0054	10/21/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0104	10/21/2016	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	TA/mm	11/21/2016	27200	10/27/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/14/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 21 2016

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

Re: Reinspection Results - Project Number S5458025

Dear Ms. Morell:

On November 9, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 15, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00603 Y1	A. Building B. Wing Y2	11/9/2016 Y3

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	20265	Correction	ID Prefix	20565	Correction	ID Prefix	20830	Correction
Reg. #	MN Rule 4658.0085	Completed	Reg. #	MN Rule 4658.0405 Subp. 3	Completed	Reg. #	MN Rule 4658.0520 Subp. 1	Completed
LSC		10/21/2016	LSC		10/21/2016	LSC		10/21/2016
ID Prefix	20900	Correction	ID Prefix	21134	Correction	ID Prefix	21390	Correction
Reg. #	MN Rule 4658.0525 Subp. 3	Completed	Reg. #	MN RULE 4658.0670 Supb. 2.	Completed	Reg. #	MN Rule 4658.0800 Subp. 4 A-I	Completed
LSC		10/21/2016	LSC		10/21/2016	LSC		10/21/2016
ID Prefix	21426	Correction	ID Prefix	21615	Correction	ID Prefix	21685	Correction
Reg. #	MN St. Statute 144A.04 Subd. 3	Completed	Reg. #	MN Rule 4658.1340 Subp. 2	Completed	Reg. #	MN Rule 4658.1415 Subp. 2	Completed
LSC		10/21/2016	LSC		10/21/2016	LSC		10/21/2016
ID Prefix	21810	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	MN St. Statute 144.651 Subd. 6	Completed	Reg. #		Completed	Reg. #		Completed
LSC		10/21/2016	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/mm	11/21/2016	34089	11/09/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/15/2016

☐ 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: AQ8U

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 **09/15/2016** (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
X 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: **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 :
Kathie Killoran, HFE NEII 10/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/07/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/07/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5458

At the time of the recertification survey the facility was not in substantial compliance with Federal participation requirements. The facility has been given an opportunity to correct before remedies would be imposed. The most serious deficiency is isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections are required. In addition, at the time of the survey an investigation of complaint number H5458014 was conducted and found to be unsubstanitated. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 30, 2016

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

RE: Project Number S5458025, H5458014

Dear Ms. Bump:

On September 15, 2016, 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 15, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5458014. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed. In addition, at the time of the September 15, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5458014 that was found to be unsubstantiated.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Teresa.Ament@state.mn.us
Phone: (218) 302-6151 Fax: (218) 723-2359

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when they have deficiencies of actual harm or above cited. A level G deficiency (isolated deficiencies that constituted actual harm that was not immediate jeopardy) was issued. Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective October 5, 2016. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F314 (S/S=G). (42 CFR 488.430 through 488.444)

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 15, 2016. (42 CFR 488.417 (b))

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Essentia Health Virginia Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 15, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

- 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 ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 15, 2016 (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 15, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245458	A. BUILDING _____ B. WING _____	09/15/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. H Complaint H5458014 was investigated and not substantiated.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157		10/21/16

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

Electronically Signed | 10/07/2016

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F 157	Continued From page 1 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the physician was notified of the development of a new pressure ulcer for 1 of 3 residents (R41) reviewed for pressure ulcers. Findings include: Pressure Ulcer Stages according to the National Pressure Ulcer Advisory Panel Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm,	F 157	1 R 41 MD has been notified of development of new pressure ulcer. 2 All residents could be affected by this deficient practice. 3 Audits have been completed on all residents who have had a significant change in condition to ensure MD has been notified. Policy and procedure related to notification of a change in condition, development or worsening of a pressure sore were reviewed and revised. Staff educated on the importance of reporting to MD any changes in condition and the policy and procedures implemented. 4 Observational monitoring of the resident record will be completed on a minimum of 5 residents a week for a period of three months. Results will be reviewed with staff as needed. Review of results will be reviewed at the quarterly QAPI meeting. Ongoing monitoring will be at recommendation of QAPI team.	

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F 157	Continued From page 2 mushy, boggy, warmer or cooler as compared to adjacent tissue. R41's face sheet printed 9/15/16, indicated diagnoses that included diabetes, peripheral vascular disease (blood circulation disorder of the extremities), anemia (low iron levels in the blood) in chronic kidney disease, peripheral venous insufficiency (decreased circulation in the veins of the extremities), and pressure ulcer of the sacral region (triangular-shaped bone at the base of the spine). R41's quarterly Minimum Data Set (MDS) assessment dated 7/25/16, indicated R41 had moderate cognitive impairment. R41's MDS further indicated R41 required assistance of 2 staff for bed mobility, toilet use, and transfers. The MDS also identified R41 was frequently incontinent of bowel and bladder. R41's MDS indicated R41 was at risk for the development of pressure ulcers, had no unhealed or unhealed pressure ulcers, and had a pressure reducing device for chair and bed. R41's care plan dated 9/6/16, indicated R41 had an unstageable pressure ulcer to the right buttock and right outer foot. R41's care plan indicated interventions included Mighty Shakes (increased protein drinks) three times daily, notify the nurse practitioner, physician assistant, or physician if the area worsened, turn and reposition every 2 hours, wound nurse to follow weekly, dressing changes as ordered by the physician, and a referral to the surgical certified nurse practitioner. R41's care plan further indicated R41 required assist of one staff for turning and repositioning, had a geo-mattress (a pressure reduction mattress) on the bed, a special boot on the right foot at all times (start date of 12/3/11), and a pressure relieving cushion in the wheelchair. The	F 157	5 Completion date October 21 2016 6 Person responsible DON, Nurse Managers, Nurse Supervisors	

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F 157	Continued From page 3	F 157		

care plan directed staff to keep linens as free from wrinkles as possible and notify the nurse immediately regarding any redness or discoloration of the skin.
R41's Care Area Assessments (CAAs) dated 4/27/16, indicated R41 was at risk for altered skin integrity, required extensive to total assistance for activities of daily living, and was frequently incontinent of bowel and bladder. R41 was to be repositioned every 2 hours and as necessary, toileted or changed every 2 hours and as requested, and lotioned with cares. The goal was to keep R41's skin free of pressure ulcers, clean, warm and dry.
R41's Skin Risk Assessment with Braden Scale dated 7/17/16, indicated R41 was at moderate risk of skin breakdown and indicated there were no current pressure ulcers.
On 8/30/16, a progress note indicated R41's right foot was cool to touch, nurse was unable to feel the foot pulses, capillary refill and skin color were within normal limits.
On 9/7/16, a Skin Integrity Pressure Sore Event Report indicated R41 had a new outer right foot unstageable pressure ulcer measuring 0.5 cm x 1.1 cm, and was considered to be a suspected deep tissue injury. The report indicated R41 wore a heel Medix boot (designed to relieve pressure on the heel) on the right foot, and the physician was not notified.
On 9/11/16, a Skin Risk Assessment with Braden Scale (an assessment used to assist in determining a resident's risk for skin breakdown) indicated R41 was at moderate risk for skin breakdown. R41's Skin Risk Assessment note identified risk factors, including current skin issues and history of skin issues. The note indicated R41 had a pressure ulcer on the coccyx, and had slight bogginess (soft tissue

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F 157	Continued From page 4	F 157		

which indicates possible deep tissue breakdown) on the right heel, and wore a heel protector on the right foot. The assessment lacked identification of the pressure ulcer on the right foot.
On 9/12/16, a nursing home physician's progress note lacked documentation of R41's pressure ulcer on the right foot.
On 9/13/16, an office visit progress note, indicated R41 was seen by surgical nurse practitioner (NP) for wound care of an ulcer of the buttock. The NP documented the pressure ulcer was painful to R41, and R41 recently began taking protein supplements. The NP further documented the wound measured 2 cm x 1 cm x 0.1 cm. The documented plan was to treat the coccyx ulcer with the Mepilex AG (silver sulfate-for medium-exuding chronic or acute wounds where antimicrobial action is indicated), and change the dressings every 7 days or as needed. R41 was to be turned or repositioned every 1-2 hours as "this wound will not heal and will likely worsened (sic) if pressure is not kept off the wound area." The NP note lacked documentation regarding the right foot pressure ulcer.
On 9/14/16, a Skin Integrity Pressure Sore Event Sore Event Report indicated R41's coccyx pressure ulcer had increased in size to 2.7 cm x 1.4 cm with the surrounding redness measuring 4.7 cm x 3.1 cm. The documentation indicated the pressure sore was a Stage 2, though it contained slough, which would indicate the ulcer was unstageable. The report indicated the pressure ulcer had a scant amount of clear drainage. The interventions remained the same. The report lacked documentation of the pressure ulcer on the right outer foot.
On 9/14/16, at 9:25 a.m. registered nurse (RN)-D and RN-C entered R41's room to do a wound

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F 157	Continued From page 5	F 157		

check. RN-D was asked about the ulcer on R41's right foot. RN-D stated he thought R41 did have an area on her foot, and proceeded to remove R41's heel protector. RN-D noted a scabbed area on the right distal right great toe. RN-D measured the scabbed area and stated it was 0.4 cm x 0.4 cm. RN-D replaced the heel protector to R41's right foot. RN-D stated R41 had a geofoam overlay on top of a regular mattress, and had a pressure-relief cushion on her wheelchair.
Following the procedure, RN-D verified there was documentation on 9/7/16, indicating R41 had a pressure ulcer on the outside of her right foot. RN-D thought the nurse had mistakenly written right outer foot but meant the scabbed area on R41's right great toe.
On 9/14/16, at 1:31 p.m. RN-D verified R41's pressure ulcers developed at the facility about 3 weeks ago. RN-D denied seeing a pressure ulcer on the right outer foot. RN-D was unaware R41 had a pressure ulcer on the right foot.
On 9/15/16, at 9:27 a.m. RN-D verified R41 was noted to have a pressure ulcer of the right outer foot on 9/7/16.
On 9/15/16, at 1:33 p.m. RN-D went to do a wound check of R41's right foot upon surveyor's request. RN-D removed R41's right heel protector and stated R41's heel was normal and without bogginess. RN-D located the pressure ulcer on R41's right outer foot without a dressing on it and measured it. The pressure ulcer was dry and without drainage. RN-D measured the pressure ulcer and replaced R41's foot back in the heel protector. During an interview following the procedure, RN-D stated the open area was 0.7 cm x 0.8 cm with the blanchable redness around it measuring 1.0 cm x 1.0 cm. RN-D stated it was not warm to touch and had no drainage. RN-D stated it was a deep tissue injury and decided it

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F 157	Continued From page 6 was unstageable due to some eschar in the open area. RN-D verified the pressure ulcer could be caused by pressure from the boot. RN-D also verified he did not think the nurse practitioner had been notified of the pressure ulcer on R41's right foot. RN-D stated an acute care form would be filled out so the NP would look at the following day. The facility policy and procedure for Skin Monitoring/Assessment/Documentation revised 9/10, directed the RN to notify the primary physician of skin integrity changes and implement the skin protocol. Nursing was to notify nutritional services, restorative services and discuss at the IDT (interdisciplinary team) meeting.	F 157		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the call light was within reach for 1 of 35 residents (R27) reviewed for call lights. Findings include: R27's Face Sheet indicated R27's diagnoses included weakness, adult failure to thrive and	F 246	1 Resident 27 call light was put in place to enable proper usage is ensured. Care Plan was reviewed and revised as needed. 2 All residents have plans of care which must be followed by staff caring for the resident. All residents have been reviewed for their call light usage and proper placement. Their care plans, profiles, and	10/21/16

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F 246	Continued From page 7 anxiety. The quarterly Minimum Data Set (MDS) dated 8/12/16, indicated R27 was cognitively intact. R27 required limited assist of one staff with bed mobility, transfers, walking in her room and toilet use. R27 had occasional incontinence of bowel and bladder. R27 had shortness of breath, used oxygen and had a prognosis which may result in a life expectancy of six months or less. R27 received a diuretic (a medication that increases the production of urine) seven of seven days during the assessment period. R37's care plan dated 9/14/16, indicated R27 had a potential for falls due to decreased mobility and weakness. The care plan directed staff to have the call light within reach at all times, and to remind R27 to ask for assistance with activities of daily living (ADL) as needed. On 9/13/16, at 2:05 p.m. R27's call light was observed hanging on the bed post at the foot of the bed. The call light and bed post were covered with a white fleece jacket. R27 was sitting in the recliner. When asked about the call light, R27 was unable to find the call light, and then unable to reach the call light. R27 stated she used the call light when she needed something and did not know what she would do if she did not have it. R27's room was located at the end of the hall. On 9/14/16, at 10:00 a.m. R27 stated she used the call light for everything; when she needed to go to the bathroom, if she wanted a drink of water, dropped something on the floor and, "Sometimes the over bed table gets stuck and I can't reach something." R27 further stated, "Sometimes I have to apologize to the staff	F 246	NAR group lists will be updated as needed. Also all residents are reviewed by nursing during their MDS assessment period to ensure care plans, profiles and NAR group lists are updated with any changes. All residents who are able to use a call light or other adaptive device to alert staff to their needs have the potential for be affected by not having device within their reach. 3 Call Light policy and procedure were reviewed and revised as necessary. Staff were educated on the policy and procedure related to call light usage. 4 Observational audits will be completed to ensure call lights are within reach of all residents per their plan of care. A minimum of three audits will be done weekly at random times to ensure ongoing compliance for three months. 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 QAPI team. The QAPI team will make recommendations for ongoing monitoring. 5 Completion date is October 21 2016 6 Persons responsible: DON, Nurse Managers, Nurse Supervisors	

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F 246	Continued From page 8 because I put the light on so much. I feel safe with my call light because I know they will come when I put the call light on." On 9/14/16, at 10:55 a.m. nursing assistant (NA)-A stated sometimes R27 put her call light on often, usually to go to the bathroom, for a pain pill or transfer into the wheelchair. NA-A further stated sometimes R27's friend would put the call light on if he felt she needed something. On 9/15/16, at 8:00 a.m. the administrator stated R27 should be able to use the call light and would expect staff to make sure every resident's call light was within reach as directed by the care plan. On 9/15/15, at 12:15 p.m. registered nurse (RN)-A stated R27 was able to use the call light. RN-A stated she would expect staff to make sure the call light was within reach. RN-A stated all resident's care plans directed staff to have the call light within reach at all times. RN-A further stated R27 has not had a fall since coming to the facility, and R27 knows to put the call light on and ask for assist. The facility's Call Light policy dated 9/15/16, indicated call lights would be used in all resident rooms. Call lights would be within reach the resident's reach.	F 246		
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		10/21/16

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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 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 the call light was in place as directed by the care plan for 1 of 1 residents (R27) reviewed for call lights not in reach. Findings include: R27's Face Sheet indicated R27's diagnoses included weakness, adult failure to thrive and anxiety. The quarterly Minimum Data Set (MDS) dated 8/12/16, indicated R27 was cognitively intact. R27 required limited assist of one staff with bed mobility, transfers, walking in her room and toilet use. R27 had occasional incontinence of bowel and bladder. R27 had shortness of breath, used oxygen and had a prognosis which may result in a life expectancy of six months or less. R27 received a diuretic (a medication that increases the production of urine) seven of seven days during the assessment period. R37's care plan dated 9/14/16, indicated R27 had a potential for falls due to decreased mobility and weakness. The care plan directed staff to have the call light within reach at all times, and to remind R27 to ask for assistance with activities of daily living (ADL) as needed. On 9/13/16, at 2:05 p.m. R27's call light was observed hanging on the bed post at the foot of the bed. The call light and bed post were covered with a white fleece jacket. R27 was sitting in the	F 282	1 Resident 27 call light was put in place and staff ensured she was able to use it properly. Care Plan was reviewed and revised as needed. 2 All residents have plans of care which must be followed by staff caring for the resident. All residents will be reviewed for call light usage and proper placement. Their care plans, profiles and NAR group lists will be updated as needed. Also all residents are reviewed by nursing during their MDS assessment period to ensure care plans, profiles and NAR group lists are updated with any changes. 3 The Care Plan Implementation Policy was reviewed and revised as necessary. Care Plans are readily available for all staff providing direct care to the residents. Staff re educated on the Care Plan policy and the care plan intervention of call light within reach for residents. 4 Observational Audits will be completed to ensure the plans of care are being followed. A minimum of three audits will be completed weekly at various times to ensure ongoing compliance for three months. Staff will be re educated on an ongoing basis on the results of these audits. The monitoring results will be reviewed at the Quarterly QAPI meeting, the team will make recommendations for ongoing monitoring. 5 Completion date is October 21 2016 6 Persons responsible DON, Nurse Managers, Nurse Supervisors	

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recliner. When asked about the call light, R27 was unable to find the call light, and then unable to reach the call light. R27 stated she used the call light when she needed something and did not know what she would do if she did not have it. R27's room was located at the end of the hall.

On 9/14/16, at 10:00 a.m. R27 stated she used the call light for everything; when she needed to go to the bathroom, if she wanted a drink of water, dropped something on the floor and, "Sometimes the over bed table gets stuck and I can't reach something." R27 further stated, "Sometimes I have to apologize to the staff because I put the light on so much. I feel safe with my call light because I know they will come when I put the call light on."

On 9/14/16, at 10:55 a.m. nursing assistant (NA)-A stated sometimes R27 put her call light on often, usually to go to the bathroom, for a pain pill or transfer into the wheelchair. NA-A further stated sometimes R27's friend would put the call light on if he felt she needed something.

On 9/15/16, at 8:00 a.m. the administrator stated R27 should be able to use the call light and would expect staff to make sure every resident's call light was within reach as directed by the care plan.

On 9/15/15, at 12:15 p.m. registered nurse (RN)-A stated R27 was able to use the call light. RN-A stated she would expect staff to make sure the call light was within reach. RN-A stated all resident's care plans directed staff to have the call light within reach at all times. RN-A further stated R27 has not had a fall since coming to the facility, and R27 knows to put the call light on and

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F 282	Continued From page 11 ask for assist. A care plan policy was requested and not provided.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate positioning was provided during meal times for 1 of 1 (R53) resident reviewed for positioning. Findings include: R53's Face Sheet identified R53's diagnoses to include cerebrovascular disease (stroke) with hemiparesis (severe weakness) and hemiplegia (paralysis on one side), depression, and unspecified abnormal involuntary movements. R53's quarterly Minimum Data Set (MDS) dated 8/11/16, indicated R53's cognition was intact; required supervision with eating; had upper and lower extremity range of motion impairment on one side; and utilized a wheelchair for mobility. R53's Care Area Assessment (CAA) on activities	F 309	1 Resident 53 has had an OT eval related to w/c positioning during meals and the need for any adaptive equipment. Restorative Services has supplied 53 with a tray table that is the appropriate height for him to have the proper positioning at meals. 2 All residents will be reviewed to ensure appropriate positioning during mealtimes and when in their wheel chairs. All residents require w/c positioning assessments upon admit, quarterly, annually, with any significant change in condition and with the use of a new w/c and prn. 3 The policies and procedures were reviewed and revised as appropriate. Staff were reeducated on the policies and procedures, including monitoring of appropriate positioning during meal times.	10/21/16

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F 309	Continued From page 12 of daily living (ADL) - functional status dated 2/15/16, indicated R53 required extensive assist of one staff for all ADL's which included set up with R53's meals and beverages. R53's fall CAA dated 2/15/16, indicated R53's primary mode of transportation was his motorized wheelchair. R53's care plan dated 5/15/16, directed staff to set up R53's meal and then R53 was able to eat independently. In addition, R53 was independent with his electric wheelchair mobility after extensive transfer from staff. R53's Device Assessment dated 8/10/16, indicated R53 utilized an electric wheelchair for mobility. This assessment lacked an assessment for positioning during meal time. R53's Wheelchair Positioning Check List dated 8/12/16, indicated R53 utilized an electric wheelchair for mobility and that R53 could safely operate the chair throughout the unit. This check list lacked an assessment for positioning during meal time. On 9/12/16, at 5:16 p.m. R53 was observed seated in his motorized wheelchair wearing a clothing protector, and sitting at a circular table in the dining room. R53's wheelchair was positioned parallel to the circular table, with his right side (unaffected side) closest to the table. The distance from the table to the right side of R53's wheelchair was about four inches, and R53's wheelchair seat was raised about four to five inches above the dining room table. R53's wheelchair was unable to fit under the table. R53 utilized weighted silverware, and proceeded to independently feed himself. R53 was observed having to twist his upper torso and neck to the	F 309	4 At a minimum three observational audits will be completed weekly at random times to ensure all residents have appropriate seating during meals. Results of audits will be reported to quarterly QAPI team. The QAPI team will make recommendations for ongoing monitoring. 5 Compliance date is October 21 2016 6 Responsible: DON ,Nurse Managers, Nursing Supervisors	

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right in order to visualize and reach his place setting. R53 took his fork and stabbed the watermelon pieces, then brought them to his mouth. R53's clothing protector fell off of his right shoulder due to his having to twist and lean to the right while eating. R53 was able to reposition his clothing protector back into place onto his right shoulder. Each time R53 took items of food off of his plate; he needed to twist his upper torso and neck to the right. R53 was observed twice to spill pieces of red gelatin with whipped topping while bringing the spooned gelatin to his mouth. R53 utilized the weighted spoon to pick up the gelatin which had spilled onto his clothing protector and then placed the gelatin into his mouth. At 5:30 p.m. R53's wheelchair was noted to have spots of red gelatin and whipped topping spilled down the right side of his wheelchair and adhered to the right outside side bar and onto the top of the right wheel hub casing.

On 9/14/16, at 8:35 a.m. R53 was seated in his motorized wheelchair with a clothing protector on at the same circular table and in the same position as noted above on 9/12/16, at 5:16 p.m. R53 was observed having to twist his upper torso and neck to the right to visualize and reach his breakfast meal. R53's right hand had a tremor noted as he utilized his fingers more to bring the watermelon pieces and scrambled egg breakfast sandwich to his mouth. Several times when R53 brought the egg sandwich to his mouth, pieces of the scrambled egg spilled out of the back and side of the sandwich landing on his clothing protector or fell to the floor between his wheelchair and the table. R53 utilized his fingers and picked up the pieces of egg which had fallen on to his clothing protector and put them into his mouth. At the completion of breakfast, chunks of

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scrambled egg were noted on the floor between the table and where R53's wheelchair had been positioned.

On 9/14/16, at 12:25 p.m. R53 was seated in his motorized wheelchair with a clothing protector on at the same circular table and in the same position as noted above on 9/12/16, 5:16 p.m. and 9/14/16, 8:35 a.m. during dining observations. Again, R53 was observed having to twist his upper torso and neck to the right to visualize and reach his meal. R53 continued to feed himself independently after nursing assistant (NA)-B set up his place setting and applied a clothing protector. R53 was observed to spill food onto his clothing protector and the floor before the bites of food reached R53's mouth. At the completion of R53's lunch, pieces of food (peaches, cottage cheese and BBQ chicken) were noted on the floor between the table and where R53's wheelchair had been positioned.

On 9/12/16, at 5:30 p.m. R53 stated he sat the way he did at the dining room table because the table was too short for his wheelchair to fit under the table.

On 9/14/16, at 12:38 p.m. registered nurse (RN)-D confirmed R53's wheelchair was positioned at an angle to the round table; which did not allow R53 to be positioned in direct alignment with his table setting. RN-D confirmed R53's motorized wheelchair would not fit under the dining room table, nor did RN-D believe any of the tables they currently had in the dining room were capable of being elevated high enough to accommodate R53's wheelchair to be positioned under the table. RN-D stated R53 had been positioned this way for meal time as long as

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RN-D could remember. RN-D stated the facility had tried other things like a TV tray type table, and that should be documented in R53's medical record. RN-D was unsure if R53 had ever been evaluated by occupational therapy (OT) for wheelchair positioning while eating. RN-D confirmed R53 needed to twist his upper torso and neck to the right to reach his food.

On 9/14/16, at 12:55 p.m. RN-D confirmed R53's medical record lacked documentation of any attempts tried to accommodate R53's positioning at the dining room table. RN-D also confirmed R53 had not been assessed for wheelchair positioning while eating.

On 9/14/16, at 1:13 p.m. R53 stated he had worked with physical therapy and occupational therapy staff in the past, all though they had not worked with him regarding positioning at the dining room table. R53 stated the staff had not tried other things such as a raised table nor did R53 think any of the tables in the dining room raised high enough for him to fit his wheelchair under. R53 stated he was kind of shaky when he ate. R53's wheelchair was noted to have BBQ sauce and the same red gelatin stains on the side and hub casing of R53's wheelchair. R53 confirmed the staff cleaned his wheelchair every Thursday night.

On 9/14/16, at 1:43 p.m. occupational therapist (OT)-A confirmed the rehabilitation staff had not assessed or evaluated R53 for wheelchair positioning at the dining room table. OT-A stated with her clinical judgement it would be more appropriate for R53 to be positioned more straight on and aligned with his place setting then having R53 seated off to the side and having to twist to

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F 309	Continued From page 16 reach his food. On 9/15/16, at 12:48 p.m. director of nursing (DON) stated she was unsure if the facility had a table which was high enough to place R53's wheelchair under, but a table could be obtained for him. The facility Wheelchair Positioning policy dated 9/15/16, indicated nursing staff would refer all positioning concerns to restorative services. Referrals for wheelchair positioning would be made to the physical therapy/OT department as needed. In addition, wheelchair evaluation would be completed quarterly and with any significant change in condition.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care and services were provided to prevent the development of, and worsening of pressure ulcers for 1 of 3 residents (R41) reviewed for pressure ulcers. This resulted in actual harm for	F 314	1 R41 MD has been notified of pressure sores and has evaluated her, Surgical NP has also seen her and has changed orders. No direct pressure to ulcer on coccyx, assure silver Mepilex to ulcer at all times, F/U apt in two weeks. We will	10/21/16

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F 314	Continued From page 17 R41 who developed multiple unstageable pressure ulcers. Findings include: Pressure Ulcer Stages according to the National Pressure Ulcer Advisory Panel Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. R41's face sheet printed 9/15/16, indicated diagnoses that included diabetes, peripheral vascular disease (blood circulation disorder of the extremities), anemia (low iron levels in the blood) in chronic kidney disease, peripheral venous insufficiency (decreased circulation in the veins of the extremities), and pressure ulcer of the sacral region (triangular-shaped bone at the base of the spine). R41's quarterly Minimum Data Set (MDS) assessment dated 7/25/16, indicated R41 had moderate cognitive impairment. R41's MDS further indicated R41 required assistance of 2 staff for bed mobility, toilet use, and transfers. The MDS also identified R41 was frequently incontinent of bowel and bladder. R41's MDS indicated R41 was at risk for the development of pressure ulcers, had no unhealed or unhealed	F 314	update her sooner if needed. Heels are now free floated, special boot on right foot discontinued. Turning and repositioning schedule has been reviewed and revised. Dietary review has been done. A new w/c cushion has been provided to help relieve pressure and decrease pain. A significant change MDS has been scheduled. Care plan has been reviewed and revised. 2 All residents who currently have a pressure ulcer and/or are at a high risk for pressure ulcers have the potential to be affected by this deficient practice. All residents with pressure ulcers have been reviewed to ensure implementation of interventions , follow up and monitoring are in place. 3 Policy and procedures related to pressure ulcer care and prevention have been reviewed and revised. Key Nursing staff are being sent for further education. All staff have been educated on policies and procedures, reporting practices, pressure ulcer interventions. New assessments, tracking tools, monitoring systems implemented in the EMR. Staff educated on new systems. Weekly Skin meetings scheduled with IDT. 4. Audits of all residents with current pressure ulcers will be completed weekly. Audits of resident at risk for pressure ulcers will include 3 residents per week for a period of three months. Results will be reviewed with staff as needed, review with quarterly QAPI team. QAPI team will recommend ongoing monitoring as needed. 5 Completion date October 21 2016 6 Responsible person DON. Nurse	

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F 314	Continued From page 18 pressure ulcers, and had a pressure reducing device for chair and bed. R41's care plan dated 9/6/16, indicated R41 had an unstageable pressure ulcer to the right buttock and right outer foot. R41's care plan indicated interventions included Mighty Shakes (increased protein drinks) three times daily, notify the nurse practitioner, physician assistant, or physician if the area worsened, turn and reposition every 2 hours, wound nurse to follow weekly, dressing changes as ordered by the physician, and a referral to the surgical certified nurse practitioner. R41's care plan further indicated R41 required assist of one staff for turning and repositioning, had a geo-mattress (a pressure reduction mattress) on the bed, a special boot on the right foot at all times (start date of 12/3/11), and a pressure relieving cushion in the wheelchair. The care plan directed staff to keep linens as free from wrinkles as possible and notify the nurse immediately regarding any redness or discoloration of the skin. R41's Care Area Assessments (CAAs) dated 4/27/16, indicated R41 was at risk for altered skin integrity, required extensive to total assistance for activities of daily living, and was frequently incontinent of bowel and bladder. R41 was to be repositioned every 2 hours and as necessary, toileted or changed every 2 hours and as requested, and lotioned with cares. The goal was to keep R41's skin free of pressure ulcers, clean, warm and dry. R41's Skin Risk Assessment with Braden Scale dated 7/17/16, indicated R41 was at moderate risk of skin breakdown and indicated there were no current pressure ulcers. On 8/20/16, a Skin Integrity Pressure Sore Event Report indicated R41 had a new occurrence of a Stage II pressure ulcer on the coccyx measuring	F 314	Manager, Nurse Supervisor	

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0.5 centimeters (cm) x 0.5 cm, with a shiny, moist, granular appearance of pink or red tissue. Interventions included a pressure reducing device for bed and chair, pressure ulcer care and dressings to the pressure ulcer, along with pain management. The related progress note indicated the Mepilex (foam) dressing was initiated and the nurse practitioner was notified. A progress note dated 8/20/16, indicated a new open area measuring 0.5 cm x 0.5 cm on the coccyx had been identified, as noted on the Skin Event Report. The progress notes indicated R41 had received orders from the nurse practitioner for a Mepilex dressing to be changed every 3 days and as necessary.

On 8/21/16, a Physician Order Report directed nursing to apply a Mepilex (foam) dressing to sacral/coccyx ulcer and change it every 3 days and as necessary. An order of 9/6/16, directed nursing to refer R41 to a wound care nurse practitioner for a wound consult of the unstageable pressure ulcer to the buttock. The physician orders lacked orders for treatment to the right foot pressure ulcer.

On 8/29/16, a Skin Integrity Pressure Sore Event Report indicated R41's left buttock pressure ulcer (area incorrectly identified by the facility) had increased in size to 1.4 cm x 0.6 cm and was unstageable, 100% covered with slough (yellow or white tissue that adheres to the ulcer bed). Interventions remained the same in addition to a turning and repositioning program.

On 8/30/16, a progress note indicated R41's right foot was cool to touch, nurse was unable to feel the foot pulses, capillary refill and skin color were within normal limits.

On 9/4/16, a progress note indicated R41's right buttock pressure ulcer (area incorrectly identified by the facility) was larger and measured 3 cm x

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2.5 cm with a 0.9 cm x 1.5 cm slough/eschar in the center. Yellowish drainage with a foul odor was noted. The physician's assistant was to be notified on that Tuesday, 9/6/16.
On 9/6/16, a nutrition progress note indicated the dietary tech was notified on that date, of R41's pressure ulcer on the buttocks (area incorrectly identified by the facility), with recent weight loss and decreased intake. The dietary tech was notified that the registered nurse (RN) had initiated Mighty Shake supplements. The nutrition note indicated R41 was receiving a multivitamin and would be monitored. On 9/9/16, a nutrition progress note indicated R41 had a significant change initiated due to skin issues. The progress note indicated R41 had a 3% weight loss over a month and had been started on Mighty shake supplements. The progress notes lacked documentation of the pressure ulcer on R41's right outer foot. A nutrition progress note dated 9/13/16, indicated R41 had two pressure areas, without identifying the location of either pressure ulcer.
On 9/7/16, a Skin Integrity Pressure Sore Event Report indicated R41 had a new outer right foot unstageable pressure ulcer measuring 0.5 cm x 1.1 cm, and was considered to be a suspected deep tissue injury. The report indicated R41 wore a heel Medix boot (designed to relieve pressure on the heel) on the right foot, and the physician was not notified.
On 9/7/16, a Skin Integrity Pressure Sore Event Report indicated R41's right buttock pressure ulcer (area incorrectly identified by the facility) increased in size to 1.1 cm x 2.1 cm with the surrounding redness measuring 3.3 cm x 3.1 cm. The pressure ulcer was unstageable, was covered with slough, and had a scant amount of drainage. R41's interventions remained the same

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with the addition of a nutrition or hydration intervention to manage skin problems. Measures indicated a geo mat was applied to the bed and an appointment was made with a wound care nurse practitioner.
On 9/11/16, a Tissue Tolerance Assessment (a test which helps determine time period the resident's skin tolerates continued pressure to an area) indicated R41 had an initial redness of the coccyx (tail bone) and buttocks which dissipated immediately with offloading (relieveing pressure to an area) in bed and chair.
On 9/11/16, a Skin Risk Assessment with Braden Scale (an assessment used to assist in determining a resident's risk for skin breakdown) indicated R41 was at moderate risk for skin breakdown. R41's Skin Risk Assessment note identified risk factors, including current skin issues and history of skin issues. The note indicated R41 had a pressure ulcer on the coccyx, and had slight bogginess (soft tissue which indicates possible deep tissue breakdown) on the right heel, and wore a heel protector on the right foot.
On 9/12/16, a nursing home physician's progress note lacked documentation of R41's pressure ulcers.
On 9/13/16, an office visit progress note, indicated R41 was seen by surgical nurse practitioner (NP) for wound care of an ulcer of the buttock. The NP documented the pressure ulcer was painful to R41, and R41 recently began taking protein supplements. The NP further documented the wound measured 2 cm x 1 cm x 0.1 cm. The documented plan was to treat the coccyx ulcer with the Mepilex AG (silver sulfate-for medium-exuding chronic or acute wounds where antimicrobial action is indicated), and change the dressings every 7 days or as

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needed. R41 was to be turned or repositioned every 1-2 hours as "this wound will not heal and will likely worsened (sic) if pressure is not kept off the wound area." The NP note lacked documentation regarding the right foot pressure ulcer.

On 9/14/16, a Skin Integrity Pressure Sore Event Sore Event Report indicated R41's coccyx pressure ulcer had increased in size to 2.7 cm x 1.4 cm with the surrounding redness measuring 4.7 cm x 3.1 cm. The documentation indicated the pressure sore was a Stage 2, though it contained slough, which would indicate the ulcer was unstageable. The report indicated the pressure ulcer had a scant amount of clear drainage. The interventions remained the same. The report lacked documentation of the pressure ulcer on the right outer foot.

On 9/14/16, at 9:25 a.m. registered nurse (RN)-D and RN-C entered R41's room to do a wound check. R41 was lying in bed on her back. RN-D and RN-C turned R41 to the left, and RN-D peeled back the dressing that was positioned on R41's right coccyx area. RN-D measured the open area, which was described as peanut shaped with slough at the base, blanchable, with redness around it. The dressing had a small amount of serous drainage on it. RN-D placed the same dressing over the pressure ulcer. R41 was returned to her back. RN-D was asked about the ulcer on R41's right foot. RN-D stated he thought R41 did have an area on her foot, and proceeded to remove R41's heel protector. RN-D noted a scabbed area on the right distal right great toe. RN-D measured the scabbed area and stated it was 0.4 cm x 0.4 cm. RN-D replaced the heel protector to R41's right foot. RN-D stated R41 had a geofoam overlay on top of a regular mattress, and had a pressure-relief cushion on

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her wheelchair. Following the procedure, RN-D verified there was documentation on 9/7/16, indicating R41 had a pressure ulcer on the outside of her right foot. RN-D thought the nurse had mistakenly written right outer foot but meant the scabbed area on R41's right great toe.
On 9/14/16, at 1:31 p.m. RN-D verified R41's pressure ulcers developed at the facility about 3 weeks ago. RN-D stated there was little to no drainage on the dressing, so he did not change the dressing. R41 had been seen by the wound care nurse practitioner the previous day, so had a new dressing put on at that time. RN-D stated R41's pain is managed with a Fentanyl (narcotic medication) patch and Tylenol. RN-D verified R41 is repositioned every 2 hours and as necessary, and stated R41 is compliant with that. RN-D denied seeing a pressure ulcer on the right outer foot. RN-D was unaware R41 had a pressure ulcer on the right foot.
On 9/15/16, at 8:42 a.m. nursing assistant (NA)-E stated R41 had an open area on her bottom and a red area on her foot, which has improved since she got her new mattress. NA-E stated R41's mattress was put on her bed last week. NA-E stated R41 had a regular mattress prior to receiving the new mattress.
On 9/15/16, at 9:27 a.m. RN-D stated before R41 had skin breakdown, she was turned and repositioned every 2 hours and as necessary. Food and fluid intake was to be encouraged, R41 was to be promptly cleaned and dried after incontinence, linens were to be free from wrinkles, and staff were to monitor and report signs of breakdown. RN-D stated R41 had a pressure relieving cushion in the wheelchair, and got the new geofoam overlay on 9/9/16. RN-D stated initially after skin breakdown, an order for a Mepilex dressing was obtained. RN-D stated R41

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had been on a multi-vitamin prior to skin breakdown and started receiving Mighty Shakes on 9/6/16. RN-D stated nursing starts interventions and if they don't work out, they notify dietary, and verified the dietary department was not notified until 9/6/16. RN-D verified R41 was noted to have a pressure ulcer of the right outer foot on 9/7/16.

On 9/15/16, at 10:17 a.m. the director of nursing (DON) verified R41 had developed pressure ulcers and had risk factors prior to skin breakdown. The DON stated R41 had not received Mighty Shakes prior to skin breakdown, though had been on a multi-vitamin and had been repositioned every 2 to 3 hours. The DON stated a Mepilex dressing was initiated and a new mattress was put on her bed. The DON verified dietary should have been notified right away. The DON stated they had a new consultant dietician and the dietary tech was on vacation, though the nurse could have initiated the Mighty Shakes, and the dietician could have been called. The DON stated R41 was on a pressure reducing mattress previously and on 9/9/16, a geo-foam overlay was put on R41's bed. The DON stated R41 wears a heel protector and hadn't had any breakdown of the heel. The DON verified R41 has not had occupational therapy assessments for positioning.

On 9/15/16, at 1:33 p.m. RN-D went to do a wound check of R41's right foot upon surveyor's request. RN-D removed R41's right heel protector and stated R41's heel was normal and without bogginess. RN-D located the pressure ulcer on R41's right outer foot without a dressing on it and measured it. The pressure ulcer was dry and without drainage. RN-D measured the pressure ulcer and replaced R41's foot back in the heel protector. During an interview following the

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F 314	Continued From page 25 procedure, RN-D stated the open area was 0.7 cm x 0.8 cm with the blanchable redness around it measuring 1.0 cm x 1.0 cm. RN-D stated it was not warm to touch and had no drainage. RN-D stated it was a deep tissue injury and decided it was unstageable due to some eschar in the open area. RN-D verified the pressure ulcer could be caused by pressure from the boot. RN-D also verified he did not think the nurse practitioner had been notified of the pressure ulcer on R41's right foot. RN-D stated an acute care form would be filled out so the NP would look at the following day. Despite the increase in size of the pressure ulcer on the coccyx, the facility failed to reassess to promote the healing of the pressure ulcer, and failed to reassess to prevent the development of the pressure ulcer on the right foot. The facility policy and procedure for Skin Monitoring/Assessment/Documentation revised 9/10, directed the RN to assess reported signs of impaired skin and monitor weekly. The RN was to initiate a "Weekly Skin Monitor" and appropriate treatment. The policy directed the RN to notify the primary physician of skin integrity changes and implement the skin protocol. The policy further directed a tissue tolerance to be completed on all residents upon admission and with any change in positioning and/or skin integrity. Nursing was to notify nutritional services, restorative services and discuss at the IDT (interdisciplinary team) meeting.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		10/21/16

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F 323	Continued From page 26 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide an appropriate mattress to decrease the risk for entrapment for 1 of 3 residents (R78) reviewed for accidents. Findings include: R78's face sheet printed 9/15/16, indicated diagnoses that included osteoporosis, history of falling, fracture of left hip, cancer and anxiety. R78's comprehensive admission Minimum Data Set (MDS) assessment dated 7/20/16, indicated R78 had a severe cognitive impairment for daily decision making, required extensive assistance of 2 staff for bed mobility, and had no falls since admission. R78's Care Area Summary (CAA) for activities of daily living (ADLs) dated 7/21/16, indicated R78 required staff assist with ADLs and had impaired balance. The CAA indicated R78 had a left hip fracture and had initially been admitted with palliative (comfort) care orders. R78's CAA for Cognitive Loss/Dementia dated 7/21/15, indicated R78 was confused, but was able to make her needs known. R78's Care Plan dated 9/12/16, indicated R78 was to receive comfort cares related to a left hip fracture and decline in health. R78's Care Plan	F 323	1 Resident 78 had been provided a new appropriate mattress to decrease risk for entrapment. R 78 discharged from facility on 10/3. 2 All residents could be at risk of entrapment if mattress is not appropriate length. All residents currently in the facility have had their beds evaluated to ensure the mattress was appropriate length to decrease risk of entrapment. 3 All residents will have mattress assessed upon admit and with any change of mattress or bed to ensure it is appropriate. 4 The device policy was revised and a new procedure put into place to ensure resident safety. Staff were reeducated on the policies and procedures. New equipment was obtained. 5 At a minimum three observational audits per week will completed for a minimum of 3 months to ensure compliance. Results of audits will be reviewed at quarterly QAPI meeting and ongoing monitoring will be at the recommendation of the QAPI team. 5 Completion October 21 2016 6 Responsible persons: DON, Nurse Managers, Nurse Supervisors	

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revised 7/8/16, indicated R78 was at risk for falls, had a history of falls with a left hip fracture, was non-weight-bearing, had episodes of confusion, and received high-risk medications. Staff were directed to keep her call light within reach at all times, keep frequently used items within reach, keep room free from clutter and a clear path to the bathroom and to closet. Staff were to remind R78 to ask for assistance with ADLs as needed and to ensure she wore nonskid footwear. R78's care plan indicated R78's bed was to be kept at a regular height so R78 could rise from the bed with her feet on the floor, and indicated R78 required total assistance of one for bed mobility, and R78 used the side rails. In addition, R78 required total assistance of 2 staff for transfers with a lift.

On 9/13/16, at 3:00 p.m. the space between the headboard and the top of the mattress on R78's bed was noted to be greater than 4 3/4 inches.

On 9/13/16 at 6:50 p.m. registered nurse (RN)-E stated it appeared that it was the wrong mattress for the frame on R78's bed. RN-E verified the space could be an entrapment risk for R78, as she was not very mobile and needed assistance for bed mobility.

On 9/13/16, at 7:20 p.m. RN-E measured the distance between the mattress and the headboard and stated it was almost 8". This measurement was before the mattress was compressed. The director of nursing (DON) verified the space between the mattress and the headboard was too large. DON verified the facility did not have an assessment process in place for the mattresses at this time. DON stated they would measure the remainder of the beds in the facility and replace the mattress if needed.

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F 323	Continued From page 28 On 9/15/16, at 9:11 a.m. RN-D verified there no assessments for the fit of the mattress on the bed or positioning of the mattress. The facility policy and procedure for Bed Safety dated 9/8/14, directed nursing staff and restorative to evaluate mattresses to ensure they were the appropriate length so the resident would not be at risk for entrapment with any changes in mattress, mattress type or after maintenance has worked on the bed.	F 323		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal 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	F 334		10/21/16

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F 334	Continued From page 29 influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical 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.	F 334		

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F 334	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to administer recommended pneumococcal vaccinations for 9 of 11 residents (R95, R40, R1, R68, R23, R92, R99, R11, R137) reviewed for immunizations. Findings include: CDC recommendations: Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 [pneumococcal polysaccharide vaccine 23] should receive a dose of PCV13. The dose of PCV13 should be administered at least one year after the most recent PPSV23 dose. Immunization reports were reviewed for five residents chosen randomly from the facility census report. The reports indicted 5 of 5 residents had not received pneumococcal vaccinations per Center for Disease Control (CDC) recommendations (R95, R40, R1, R68, R23). R95's Face Sheet indicated R95 was admitted on 12/18/15, was 98 years old, and had diagnoses that included hypertension and atrial fibrillation. R95's annual Minimum Data Set (MDS) dated 6/10/16 indicated R95's pneumococcal vaccinations were up to date. R95's Minnesota Immunization Information Connection (MIIC) report, printed 9/14/16, indicated R95 received a Pneumo-PPSV23 on 1/8/2008. R40's Face Sheet indicated R40 was admitted on	F 334	1 R 95,40,1, 68, 23, 92 Education on potential risks and benefits of vaccine (VIS) was provided to representatives and consent obtained and Pneumovax have been administered. R 99,11,137 are deceased. 2 All residents have the potential for be affected by the deficient practice in this area. All residents or their Representatives have been sent out informational letters with VIS and consent forms included. Consents or refusals will be documented in the residents record. 3 the Influenza and Pneumococcal vaccination policy was reviewed and revised as necessary. All nursing staff were reeducated on the process of offering the Pneumococcal and influenza vaccines and providing information about the potential risks and benefits of the vaccine. Informational flyers and a consent form are a part of the Admission Packet for each resident. The letter that is sent out to residents and families has been reviewed and revised. 4 Audits will be completed within one week after admission to this facility to ensure ongoing compliance with administration of Pneumococcal and Influenza Vaccine per CDC recommendations.Three Random chart audits will be completed each week to ensure ongoing compliance. The monitoring results will be reviewed with the quarterly QAPI team, the QAPI team	

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F 334	Continued From page 31 9/23/15, was 84 years old, and had diagnoses that included dementia, hypertension, and weakness. R40's quarterly MDS dated 6/23/16, lacked information regarding R40's pneumococcal vaccination status. R40's medical record lacked documentation of pneumococcal immunization status, and a MIIC report was not provided by the facility. R1's face sheet indicated R1 was admitted on 12/9/14, was 86 years old, and had diagnoses that included chronic pain, atherosclerotic heart disease, and a history of bronchitis. R1's quarterly MDS dated 6/14/16, indicated R1's pneumococcal vaccinations were up to date. R1's Immunizations/Injection Summary Report indicted R1 had received the Pneumovax 23 on 10/7/97, and 3/6/3. R68's face sheet indicated R68 was admitted on 4/1/16, was 98 years old, and had diagnoses that included diabetes, hypertension, and a history of a stroke. R68's quarterly MDS dated 7/7/16, indicated R68's pneumococcal vaccinations were up to date. R68's medical record lacked documentation of pneumococcal immunization status, however an undated handwritten note sheet received from the facility on 9/14/16, indicated R68 had received the Pneumovax 23 vaccination on 10/30/1996. R23's face sheet indicated R23 was admitted on 2/8/16, was 87 years old, and had diagnoses that included congestive heart failure, chronic atrial fibrillation, chronic respiratory failure, and diabetes. R23's quarterly MDS dated 8/9/16, indicated R23's pneumococcal vaccinations were not up to date. R23's medical record lacked documentation of pneumococcal immunization	F 334	will make recommendations for ongoing monitoring. 5 Completion date October 21 2016 6 Persons responsible DON, Infection Nurse, Nurse Mangers, Nurse Supervisors	

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status.

Four residents diagnosed with pneumonia in the last year (R92, R99, R11, R137) were reviewed.

R92's face sheet indicated R92 was admitted on 6/22/15, was 82 years old, and had diagnoses that included stomach cancer, congestive heart failure, chronic obstructive pulmonary disease and pneumonia. R92's quarterly MDS dated 3/22/16, indicated R92's pneumococcal immunizations were up to date. A Hospital Discharge Summary dated 6/24/16, indicated R92 had been hospitalized with acute respiratory failure with hypoxemia and pneumonia of right lower lobe. R92 was discharged back to the facility to receive oral and intravenous antibiotics. R92's medical record lacked documentation of pneumococcal immunization status however, the facility provided a handwritten list that indicated R92 had received Prevnar 13 (PCV13) on 3/6/15, and PPSV23 on 6/8/15.

R99's face sheet indicated R99 was admitted on 9/17/15, was 75 years old, with diagnoses that included weakness, chronic obstructive pulmonary disease (COPD), dependence on supplemental oxygen, chronic respiratory failure, and pneumonia. R99's significant change MDS dated 7/29/16, indicated pneumococcal vaccinations were offered and declined, while the previous MDS, a quarterly on 6/16/16, indicated R99's pneumococcal vaccinations were up to date. R99's Emergency Department notes dated 2/18/16, diagnosed R99 with acute lower respiratory infection, and pneumonia to both lower lobes due to an infectious organism. R99's medical record lacked documentation of his pneumococcal immunization status however, the

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 33	F 334		

facility provided a handwritten list indicating R99 had received pneumococcal vaccine on 9/25/05, but it did not indicate what type of vaccination.

R11's face sheet indicated R11 was admitted on 7/17/08, was 94 years old, with diagnoses that included atrial fibrillation and heart failure. R11's quarterly MDS dated 5/3/16, indicated that R11's pneumococcal vaccinations were up to date. On 4/21/16, a chest x-ray indicated "subtle bilateral lower lung field airspace opacities suggestive of pneumonia versus atelectasis." The physician's assistant progress note dated 4/26/16, indicated R11 had been hospitalized for pneumonia from 4/21/16, to 4/23/16. R11's medical record lacked documentation of the pneumococcal immunization status however, the facility provided a handwritten list indicating R11 had received the PPSV23 vaccination on 1/1/86, and 11/3/96.

R137's face sheet indicated R137 was admitted 4/27/11, was 89 years old, and had diagnoses that included Parkinson's disease, asthma and pneumonia. An undated Resident vaccination and Mantoux record indicated R137 had received a pneumococcal vaccination in 2009, and the source was listed as "per admission assessment." A resident pneumococcal consent dated 10/30/15, indicated R137 had received a pneumococcal vaccination "4 years ago." R137's spouse also wrote on this form that she hoped R137 was eligible for another vaccination.

A nurse practitioner's progress note dated 4/13/16, indicated influenza like illnesses and the provider was going to proceed with treatment for pneumonia. The progress note also indicated R137's chest x-ray was questionable for infiltrate. A death Record Worksheet dated 4/22/16,

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F 334	Continued From page 34 indicated R137 died on 4/20/16, with the immediate cause listed as pneumonia. CDC recommendations for pneumococcal vaccines include: one dose of PCV13 (also called Prevnar 13) is recommended for all adults aged 65 or older who've not previously received the vaccine. A dose of PPSV23 (also called Pneumovax 23) should be given at least one year later. For adults 65 years or older who have already received one or more doses of PPSV23, the dose of PCV13 should be given at least one year after receiving the most recent dose of PPSV23. On 9/15/16, at 9:19 a.m. registered nurse (RN)-B stated the old policy (revised 2004) was the one the facility was using. RN-B stated they were aware there were new CDC recommendations, but they were confusing and had not yet been implemented. On 9/15/16, at 9:25 a.m. the director of nursing (DON) stated the pneumococcal vaccinations were to be reviewed and offered if not up to date within the first 24 hours after admission. The DON stated it must have been overlooked and not enforced. The DON stated they knew they had to work on it [pneumococcal immunizations].	F 334		
F 371 SS=F	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	F 371		10/21/16

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F 371	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the meat slicer and the malt blender were appropriately cleaned to prevent food-borne illnesses. This had the potential to affect all 68 residents who received food served from the kitchen. Findings include: On 9/12/16, at 11:29 a.m. the meat slicer was observed to have greasy debris on the bottom edge of the blade, under the guide/guard. The dietary manager (DM) verified the meat slicer had just been cleaned and was ready for use. The DM ran her finger over the debris and verified it was greasy. In addition, the malt blender had a white debris at the top of the blending unit. DM verified, and stated it would be cleaned. On 9/15/16, at 1:05 p.m. the meat slicer had been cleaned of the greasy debris. The malt blender still had white debris at the top of the blending unit. DM verified the findings and removed the malt blender to be cleaned. The facility policy and procedure for Proper Cleaning and Sanitizing of Equipment dated 5/11/15, directed dietary staff to clean the meat slicer after each use and to clean the blade carefully. The policy directed the mixer was to be cleaned after each use.	F 371	1. Meat slicer was cleaned properly. The malt blender was taken out of use. 2. All residents have the potential to be placed at risk by deficient practice. 3. All Kitchen staff were reeducated on proper cleaning of equipment. Policies and procedures were reviewed and revised. 4. Observational audits will be completed at a minimum of 3 times a week on random shifts by Dietary Supervisors to ensure food prep equipment is clean and sanitary for 3 months. Results of the audits will be reviewed at the quarterly QAPI meeting. The QAPI Team will make recommendations for ongoing monitoring. 5. Completion date is October 21 2016 6. Persons responsible Dietary Manager, Dietary Supervisors	

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F 431	Continued From page 36	F 431		
F 431 SS=E	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 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:	F 431		10/21/16

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F 431	Continued From page 37 Based on observation, interview, and document review, the facility failed to ensure storage and security of Fentanyl patches (which needed to be destroyed) was maintained on 2 of 2 units (3rd and 4th floor). Findings include: On 9/12/16, at 4:02 p.m. licensed practical nurse (LPN)-A completed a medication administration pass for resident (R16) which included removal and placement of a Fentanyl transdermal patch (a narcotic medicated adhesive patch placed on the skin to deliver a specific dose). LPN-A obtained R16's Fentanyl patch from a double locked narcotic drawer in the medication cart. LPN-A reconciled the number of Fentanyl patches left in the package for R16 and recorded this in the narcotic log book. LPN-A recorded under the "verified" section of the narcotic log book for R16's Fentanyl patch "disposed of old patch" and placed LPN-A's initials followed by a slash mark. LPN-A stated the disposal of the Fentanyl patches needed to be dual witnessed and because the other nurse wasn't close by, LPN-A would dispose of the Fentanyl patch later in a container in the medication room. LPN-A donned a pair of gloves and proceeded to remove R16's Fentanyl patch which was located on R16's left front shoulder and placed the new Fentanyl patch which LPN-A had dated 9/12/16, on R16's left shoulder. LPN-A removed the glove on her right hand, exited R16's room and went directly to the medication cart located in the doorway of R16's room. LPN-A placed the Fentanyl patch she had just removed in a clear unmarked medication cup, unlocked the medication cart and placed the unmarked clear medication cup in the top drawer of the medication cart. LPN-A removed the glove	F 431	1 There were no residents affected by deficient action 2 The policy and procedure was reviewed and revised to ensure storage and security of Fentanyl patches is maintained in the facility. 3 The policy and procedure for removal, storage and security was reviewed with staff. Upon removal of a Fentanyl patch from a resident it is to be placed in the narcotic drawer of the medication cart until it can be properly disposed of in the black box in the medication room. As soon as the second nurse is available(within 2 hours at the latest)the patch will be placed in the black box and the 2 nurses will cosign of its disposal in the narcotic record for that individual resident. The black box is kept in a locked cabinet in the medication room and the black box is in a locked cage. Once it is almost full, the nurse will notify the EV Supervisor or his designee that it needs to be removed. The nurse will then press the yellow top down, so it is tamper resistant. The janitor will then come up to the medication room, both the janitor and the nurse will cosign that the black box has exchanged hands and the janitor will take it for proper disposal. 4 Observational audits will be completed to ensure Fentanyl patches are removed, stored and kept secured. A minimum of 3 audit will be done weekly for three months, the results will be reviewed with staff on an ongoing basis. The results of these audits will be reported to the quarterly QAPI team. The QAPI team will make recommendations for ongoing	

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F 431	Continued From page 38 from her left hand and washed her hands. LPN-A again stated she would dispose of the used Fentanyl patch with another nurse later. On 9/12/16, at 4:40 p.m. LPN-A confirmed the disposal of R16's removed Fentanyl patch wouldn't be destroyed until shift change around 10:30 p.m. LPN-A verified this was the routine practice for disposal of the Fentanyl patches. At this time, registered nurse (RN)-B and RN-C were observed seated at the nursing station directly down the hallway from where LPN-A had been passing medications. On 9/13/16, at 4:31 p.m. LPN-B attempted to remove and apply a new Fentanyl patch on R95. LPN-B obtained the Fentanyl patch from the double locked narcotic drawer in the medication cart. LPN-B cut the very top of the Fentanyl packaging sleeve and wrote 9/13 on the Fentanyl patch. LPN-B entered R95's room and attempted to remove and place a new Fentanyl patch. R95 refused to have LPN-B remove the old Fentanyl patch or place the new Fentanyl patch. LPN-B stated she would re-approach R95 later and proceeded to place the new Fentanyl patch in the packaging sleeve and double locked it in the medication cart narcotic drawer. LPN-B stated the used Fentanyl patches needed to be dual witnessed with another nurse and disposed of in the black box in the medication room. On 9/13/16, at 6:02 p.m. LPN-B stated RN-F had been able to place the Fentanyl patch on R95 and they had saved it to demonstrate the disposal process. LPN-B obtained the R95's used Fentanyl patch from the double locked narcotic drawer in the medication cart. Both LPN-B and RN-F were present in the medication room.	F 431	monitoring. 5 Completion date. October 21 2016 6 Responsible persons: DON, Nurse Managers, Nurse Supervisors	

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LPN-B opened an unlocked cupboard which had a wire holder that was secured to the inside cupboard door. There was a black biohazardous waste container secured in the wire holder. LPN-B placed the used Fentanyl patch in the black biohazardous container and LPN-B and RN-F co-signed in the narcotic book which indicated the disposal of R95's Fentanyl patch. LPN-B and RN-F confirmed the door to the cupboard had a lock on the outside of the cupboard, however the cupboard was not locked.

On 9/13/16, at 6:20 p.m. LPN-C confirmed the process for destroying Fentanyl patches included two nurses witnessed the disposal of the Fentanyl patch. This was completed at the end of the shift (around 10:30 p.m.) and usually completed with the two LPN's who were ending their shift. LPN-C stated she kept the Fentanyl patches which needed to be disposed of at the end of the shift in the top drawer of the medication cart. LPN-C confirmed this drawer was not double locked. LPN-C confirmed she had witnessed the disposal of R16's Fentanyl patch that had been removed on 9/12/16, around 4:00 p.m. with LPN-A at 10:30 p.m. on 9/12/16.

On 9/14/16, at 2:06 p.m. LPN-D stated the Fentanyl patches were disposed of in the biohazard bins located in the unlocked cupboards in the medication rooms. LPN-D stated when the biohazard bins were filled they were removed from the wired casing and placed in the soiled utility room for the janitor to pick up. LPN-D confirmed the soiled utility room had a key pad access which all RN's, LPN's, housekeepers, janitors, and nursing assistants had access. LPN-D thought the janitors came and picked the containers up within two hours of it being

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F 431	Continued From page 40 requested. On 9/15/16, at 10:20 a.m. environmental services director (ESD) stated the janitors picked up the biohazard boxes which contained the Fentanyl patches from the soiled utility rooms on the units. On 9/15/16, at 12:14 p.m. LPN-E confirmed she placed the used Fentanyl patches into the top drawer of the medication cart, and at the end of the shift when the two nursing staff conduct a narcotic count, they dispose of the patch in the biohazard bin in the medication room. Each of the nurses sign the narcotic log. LPN-E confirmed the top drawer of the medication cart was not a double locked compartment. On 9/15/16, at 12:17 p.m. RN-D confirmed the usual schedule for removal and replacement of Fentanyl patches was between 3:00 p.m. and 5:00 p.m. The patch that was removed would be stored in the top drawer of the medication cart until the end of the shift and at that time would be destroyed with two nursing staff. On 9/15/16, at 12:25 p.m. janitor (J)-A confirmed there were times when she had picked up the full black box biohazard waste bins in the soiled utility rooms (which all RN's, LPN's, NA's, housekeepers, and janitors had access). On 9/15/16, at 12:37 p.m. director of nursing (DON) confirmed the used Fentanyl patches were a transdermal medication and required the staff to wear gloves during placement and removal of the patches as if touched the staff had the potential to receive the effects of the narcotic. DON confirmed the used Fentanyl patches should be treated as a narcotic, and double	F 431		

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locked if not immediately disposed. However, it was her expectation that the Fentanyl patches were disposed of immediately following removal of the patch and dual witnessed by an RN and/or LPN. If for some reason the Fentanyl patch could not be immediately disposed of, the used patch should be double locked in the narcotic drawer of the medication cart. DON confirmed there was the potential for diversion when the Fentanyl patches where not disposed of for five to six hours after they had been removed. DON verified the cupboard in the medication room which stored the black biohazard bins should be locked as the contents of the bins were considered to be narcotics and the facility policy was for all narcotics to be double locked. In addition, DON verified the filled black biohazard containers should not be left in the soiled utility room for pick up.

On 9/15/16, at 2:38 p.m. the administrator confirmed the filled black biohazard containers should not be placed in the soiled utility room for pick up. In addition, the time from the removal of the Fentanyl patch to when it was witnessed to be destroyed should not be five to six hours.

The facility Fentanyl Patch Procedure policy dated 4/15/13, directed staff to remove the patch, and two nurses must co-sign the destruction in the narcotic book with the patch being placed in the black box in the medication room. Policy lacked a time frame of what was acceptable from removal of the patch to when it should be witnessed and placed in the black box.

Narcotic Monitoring and Accountability policy dated 4/28/14, indicated all narcotics were kept locked in narcotic drawers of the medication carts

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F 431	Continued From page 42 or the medication room, and both must be double locked when not supervised.	F 431		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a safe, clean and homelike environment in 6 of 35 resident room (Rooms 307, 314, 317, 323, 326, 402). Findings include: On 9/15/16, 9:45 a.m. during an environmental tour, the manager of facilities and environmental services (FM) verified the following environmental findings: Room 307: the bathroom floor was dirty and the wall at the entrance to the bathroom had a gouged area that was approximately 1 foot x 2 inches in size. Room 314: the siderail on the side of the bed by the window was soiled with a dark colored sticky substance. Room 317: the door frame to the bathroom had deep gouges. The lower outer corner of the bathroom door was chipped and missing approximately 3 inches x 3 inches making it a	F 465	1 Rooms, 307, 314, 317, 323, 326 and 402. Have been cleaned, repaired and painted. Work orders were completed in all rooms that needed repair. 2 All residents have the potential to be affected by the deficient practice. The Housekeeping Supervisor or designee will do a walk through of each resident room to audit other areas for cleanliness and repair prior to 10/21/16. Work orders will be completed on all areas with the need of cleaning or repair. 3 Housekeepers do a daily checklist of areas that are in need of repair in their areas. When a need is noted, they are to place an online work order. The Maintenance Dept. gets the work order and completes repairs based on priorities. All staff are to report if there is a maintenance concern. Staff have been educated on the online process for completing work. 4 Observational audits will be completed weekly on at a minimum 3 random rooms by EVS Supervisor or designee to ensure	10/21/16

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F 465	Continued From page 43 rough and uncleanable surface. Room 323: had a build up of dirt around the non-skid strips on the bathroom floor in front of the toilet and the tiles under sink were stained a brown color. The doorway to the bathroom was badly gouged approximately 2 feet up from the floor. Room 326: a storage cupboard over the toilet had brown rust along the bottom lower edge. Room 402: in the bathroom the caulking around the base of the toilet was missing and the open space had dirt in it. The toilet riser had feces on back of the seat and down the back of the inside of the riser. During the tour the FM stated siderails should be washed when the beds were washed but did not know how often the beds were washed or when done last. When rooms were remodeled, the bathroom cabinets were replaced with shelves. There was not a plan for any further remodeling. The FM stated the facility has a computer system that any staff could use to inform maintenance of needed cleaning or repairs. The facility also had a routine maintenance computer system with scheduled equipment and facility areas to check . The facility's Maintenance Work Orders policy dated 2/15, indicated all work requests must be requested using the intranet work order system. Only tenants that do not have the intranet work order system were allowed to use the written work order form.	F 465	rooms are clean and well maintained. Results will be reviewed by the quarterly QAPI team and recommendations will be made for ongoing audits. Policy and Procedure for maintenance and cleaning of rooms is in place. 5 Completion date October 21 2016 6 Persons Responsible: EVS Supervisor, Maintenance Supervisor, ES Manager	

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

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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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Essentia Health Virginia Convalescent Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/10/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245458	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/14/2016**

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

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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Virginia Regional Medical Center is a 4-story building with full basement. The original building was constructed in 1936 and additions constructed in 1976 and 1999, all of Type II(222). The nursing home occupies the 3rd and 4th floors. A 3 story hospital of the same construction type adjoins the nursing home, and is separated by a 2 hour fire rated barrier, with 1&1/2 hour rated self closing doors. Therefore, the nursing home was inspected as one building. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a licensed capacity of 90 beds and had a census of 68 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility had 1 of several corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.6.3.2. This deficient practice could affect 20 of 68 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 11:00 a.m. to 3:30 p.m.	K 018	1 Door latch and strike plate were put on the door that did not meet code. 2 This was completed on 9/15/2016 3 3 Person responsible EV Manager or designee	10/21/16

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K 018	Continued From page 3 on 09/14/2016, observations and staff interviews revealed that the corridor door to staff office 4503 on the 4th floor was not equipped with door latching hardware and would not positively latch into the frame when tested during the facility tour. This deficient condition was verified by a Maintenance Supervisor.	K 018		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4., 19.3.6.3.2, 19.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 68 of 68 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:00 a.m. to 3:30 p.m. on 09/14/2016, during a review of all available fire alarm maintenance/testing documentation for the last 12 months and an interview with the Maintenance Supervisor, it was revealed that the	K 052	1 Process has been reviewed. Smoke Detector Sensitivity testing is done automatically by the main fire panel and will be manually tested and logged by the vendor during the annual testing of the fire alarm system components. The annual testing log has been amended to verify the annual sensitivity testing. 2 Completion date by October 21 2016 3 Person responsible EV Manager or designee	10/21/16

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K 052	Continued From page 4 facility failed to document and/or verify 6 of 12 monthly tests of the digital alarm communicator transmitter (DACT). This deficient condition was verified by a Maintenance Supervisor.	K 052		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code 1999 edition, section 7-3.2.1. This deficient practice could affect 68 of 68 residents,as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:00 a.m. to 3:30 p.m. on 09/14/2016, during a review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Staff revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. This deficient condition was verified by a Maintenance Supervisor.	K 054	1 Process has been changed where notification will be to the Fire Dept. monthly instead of quarterly. 2 Completion date October 21 2016 3 Responsible person EV Manager or designee	10/21/16

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K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 5-1.2 and 5.2. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect 68 of 68 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:00 a.m. to 3:30 p.m. on 09/14/2016, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and confirmed by an interview with the Maintenance Supervisor, that the facility could not provide any current testing documentation verifying that the fire and smoke dampers has been tested or inspected within the last 4 years. This deficient condition was verified by a Maintenance Supervisor.	K 104	1 Maintenance Staff is in the process of testing all fire and smoke dampers. Preventative Maintenance Schedule has been revised to testing and inspecting every 4 years. 2 Completion date will be October 21 2016 3 Responsible person EV Manager or designee	10/21/16

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 30, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S54580258 and H5458014

Dear Ms. Bump:

The above facility was surveyed on September 12, 2016 through September 15, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5458014. that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Teresa Ament at (218) 302-6151 or email: teresa.ament@state.mn.us**.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00603	A. BUILDING: _____ B. WING _____	09/15/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 9/12/16 through 9/15/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. H Complaint H5458014 was investigated and not substantiated. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000		

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2 000	Continued From page 2 APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the	2 265		10/21/16

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2 265	Continued From page 3 resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the physician was notified of the development of a new pressure ulcer for 1 of 3 residents (R41) reviewed for pressure ulcers. Findings include: Pressure Ulcer Stages according to the National Pressure Ulcer Advisory Panel Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. R41's face sheet printed 9/15/16, indicated diagnoses that included diabetes, peripheral vascular disease (blood circulation disorder of the extremities), anemia (low iron levels in the blood) in chronic kidney disease, peripheral venous insufficiency (decreased circulation in the veins of the extremities), and pressure ulcer of the sacral	2 265	Corrected	

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2 265	Continued From page 4	2 265		

region (triangular-shaped bone at the base of the spine).
R41's quarterly Minimum Data Set (MDS) assessment dated 7/25/16, indicated R41 had moderate cognitive impairment. R41's MDS further indicated R41 required assistance of 2 staff for bed mobility, toilet use, and transfers. The MDS also identified R41 was frequently incontinent of bowel and bladder. R41's MDS indicated R41 was at risk for the development of pressure ulcers, had no unhealed or unhealed pressure ulcers, and had a pressure reducing device for chair and bed.
R41's care plan dated 9/6/16, indicated R41 had an unstageable pressure ulcer to the right buttock and right outer foot. R41's care plan indicated interventions included Mighty Shakes (increased protein drinks) three times daily, notify the nurse practitioner, physician assistant, or physician if the area worsened, turn and reposition every 2 hours, wound nurse to follow weekly, dressing changes as ordered by the physician, and a referral to the surgical certified nurse practitioner. R41's care plan further indicated R41 required assist of one staff for turning and repositioning, had a geo-mattress (a pressure reduction mattress) on the bed, a special boot on the right foot at all times (start date of 12/3/11), and a pressure relieving cushion in the wheelchair. The care plan directed staff to keep linens as free from wrinkles as possible and notify the nurse immediately regarding any redness or discoloration of the skin.
R41's Care Area Assessments (CAAs) dated 4/27/16, indicated R41 was at risk for altered skin integrity, required extensive to total assistance for activities of daily living, and was frequently incontinent of bowel and bladder. R41 was to be repositioned every 2 hours and as necessary, toileted or changed every 2 hours and as

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2 265	Continued From page 5	2 265		

requested, and lotioned with cares. The goal was to keep R41's skin free of pressure ulcers, clean, warm and dry.
R41's Skin Risk Assessment with Braden Scale dated 7/17/16, indicated R41 was at moderate risk of skin breakdown and indicated there were no current pressure ulcers.
On 8/30/16, a progress note indicated R41's right foot was cool to touch, nurse was unable to feel the foot pulses, capillary refill and skin color were within normal limits.
On 9/7/16, a Skin Integrity Pressure Sore Event Report indicated R41 had a new outer right foot unstageable pressure ulcer measuring 0.5 cm x 1.1 cm, and was considered to be a suspected deep tissue injury. The report indicated R41 wore a heel Medix boot (designed to relieve pressure on the heel) on the right foot, and the physician was not notified.
On 9/11/16, a Skin Risk Assessment with Braden Scale (an assessment used to assist in determining a resident's risk for skin breakdown) indicated R41 was at moderate risk for skin breakdown. R41's Skin Risk Assessment note identified risk factors, including current skin issues and history of skin issues. The note indicated R41 had a pressure ulcer on the coccyx, and had slight bogginess (soft tissue which indicates possible deep tissue breakdown) on the right heel, and wore a heel protector on the right foot. The assessment lacked identification of the pressure ulcer on the right foot.
On 9/12/16, a nursing home physician's progress note lacked documentation of R41's pressure ulcer on the right foot.
On 9/13/16, an office visit progress note, indicated R41 was seen by surgical nurse practitioner (NP) for wound care of an ulcer of the buttock. The NP documented the pressure ulcer was painful to R41, and R41 recently began

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2 265	Continued From page 6 taking protein supplements. The NP further documented the wound measured 2 cm x 1 cm x 0.1 cm. The documented plan was to treat the coccyx ulcer with the Mepilex AG (silver sulfate-for medium-exuding chronic or acute wounds where antimicrobial action is indicated), and change the dressings every 7 days or as needed. R41 was to be turned or repositioned every 1-2 hours as "this wound will not heal and will likely worsened (sic) if pressure is not kept off the wound area." The NP note lacked documentation regarding the right foot pressure ulcer. On 9/14/16, a Skin Integrity Pressure Sore Event Sore Event Report indicated R41's coccyx pressure ulcer had increased in size to 2.7 cm x 1.4 cm with the surrounding redness measuring 4.7 cm x 3.1 cm. The documentation indicated the pressure sore was a Stage 2, though it contained slough, which would indicate the ulcer was unstageable. The report indicated the pressure ulcer had a scant amount of clear drainage. The interventions remained the same. The report lacked documentation of the pressure ulcer on the right outer foot. On 9/14/16, at 9:25 a.m. registered nurse (RN)-D and RN-C entered R41's room to do a wound check. RN-D was asked about the ulcer on R41's right foot. RN-D stated he thought R41 did have an area on her foot, and proceeded to remove R41's heel protector. RN-D noted a scabbed area on the right distal right great toe. RN-D measured the scabbed area and stated it was 0.4 cm x 0.4 cm. RN-D replaced the heel protector to R41's right foot. RN-D stated R41 had a geofoam overlay on top of a regular mattress, and had a pressure-relief cushion on her wheelchair. Following the procedure, RN-D verified there was documentation on 9/7/16, indicating R41 had a pressure ulcer on the outside of her right foot.	2 265		

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2 265	Continued From page 7 RN-D thought the nurse had mistakenly written right outer foot but meant the scabbed area on R41's right great toe. On 9/14/16, at 1:31 p.m. RN-D verified R41's pressure ulcers developed at the facility about 3 weeks ago. RN-D denied seeing a pressure ulcer on the right outer foot. RN-D was unaware R41 had a pressure ulcer on the right foot. On 9/15/16, at 9:27 a.m. RN-D verified R41 was noted to have a pressure ulcer of the right outer foot on 9/7/16. On 9/15/16, at 1:33 p.m. RN-D went to do a wound check of R41's right foot upon surveyor's request. RN-D removed R41's right heel protector and stated R41's heel was normal and without bogginess. RN-D located the pressure ulcer on R41's right outer foot without a dressing on it and measured it. The pressure ulcer was dry and without drainage. RN-D measured the pressure ulcer and replaced R41's foot back in the heel protector. During an interview following the procedure, RN-D stated the open area was 0.7 cm x 0.8 cm with the blanchable redness around it measuring 1.0 cm x 1.0 cm. RN-D stated it was not warm to touch and had no drainage. RN-D stated it was a deep tissue injury and decided it was unstageable due to some eschar in the open area. RN-D verified the pressure ulcer could be caused by pressure from the boot. RN-D also verified he did not think the nurse practitioner had been notified of the pressure ulcer on R41's right foot. RN-D stated an acute care form would be filled out so the NP would look at the following day. The facility policy and procedure for Skin Monitoring/Assessment/Documentation revised 9/10, directed the RN to notify the primary physician of skin integrity changes and implement the skin protocol. Nursing was to notify nutritional services, restorative services and discuss at the	2 265		

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2 265	Continued From page 8 IDT (interdisciplinary team) meeting. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to physician's are notified when a resident has a change in condition. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the call light was in place as directed by the care plan for 1 of 1 residents (R27) reviewed for call lights not in reach. Findings include: R27's Face Sheet indicated R27's diagnoses included weakness, adult failure to thrive and anxiety.	2 565	Corrected	10/21/16

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2 565	Continued From page 9 The quarterly Minimum Data Set (MDS) dated 8/12/16, indicated R27 was cognitively intact. R27 required limited assist of one staff with bed mobility, transfers, walking in her room and toilet use. R27 had occasional incontinence of bowel and bladder. R27 had shortness of breath, used oxygen and had a prognosis which may result in a life expectancy of six months or less. R27 received a diuretic (a medication that increases the production of urine) seven of seven days during the assessment period. R37's care plan dated 9/14/16, indicated R27 had a potential for falls due to decreased mobility and weakness. The care plan directed staff to have the call light within reach at all times, and to remind R27 to ask for assistance with activities of daily living (ADL) as needed. On 9/13/16, at 2:05 p.m. R27's call light was observed hanging on the bed post at the foot of the bed. The call light and bed post were covered with a white fleece jacket. R27 was sitting in the recliner. When asked about the call light, R27 was unable to find the call light, and then unable to reach the call light. R27 stated she used the call light when she needed something and did not know what she would do if she did not have it. R27's room was located at the end of the hall. On 9/14/16, at 10:00 a.m. R27 stated she used the call light for everything; when she needed to go to the bathroom, if she wanted a drink of water, dropped something on the floor and, "Sometimes the over bed table gets stuck and I can't reach something." R27 further stated, "Sometimes I have to apologize to the staff because I put the light on so much. I feel safe with my call light because I know they will come	2 565		

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2 565	Continued From page 10 when I put the call light on." On 9/14/16, at 10:55 a.m. nursing assistant (NA)-A stated sometimes R27 put her call light on often, usually to go to the bathroom, for a pain pill or transfer into the wheelchair. NA-A further stated sometimes R27's friend would put the call light on if he felt she needed something. On 9/15/16, at 8:00 a.m. the administrator stated R27 should be able to use the call light and would expect staff to make sure every resident's call light was within reach as directed by the care plan. On 9/15/15, at 12:15 p.m. registered nurse (RN)-A stated R27 was able to use the call light. RN-A stated she would expect staff to make sure the call light was within reach. RN-A stated all resident's care plans directed staff to have the call light within reach at all times. RN-A further stated R27 has not had a fall since coming to the facility, and R27 knows to put the call light on and ask for assist. A care plan policy was requested and not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are followed. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 565		

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2 565	Continued From page 11 (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate positioning was provided during meal times for 1 of 1 (R53) resident reviewed for positioning. Findings include: R53's Face Sheet identified R53's diagnoses to include cerebrovascular disease (stroke) with hemiparesis (severe weakness) and hemiplegia (paralysis on one side), depression, and unspecified abnormal involuntary movements. R53's quarterly Minimum Data Set (MDS) dated 8/11/16, indicated R53's cognition was intact; required supervision with eating; had upper and lower extremity range of motion impairment on	2 830	Corrected	10/21/16

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2 830	Continued From page 12 one side; and utilized a wheelchair for mobility. R53's Care Area Assessment (CAA) on activities of daily living (ADL) - functional status dated 2/15/16, indicated R53 required extensive assist of one staff for all ADL's which included set up with R53's meals and beverages. R53's fall CAA dated 2/15/16, indicated R53's primary mode of transportation was his motorized wheelchair. R53's care plan dated 5/15/16, directed staff to set up R53's meal and then R53 was able to eat independently. In addition, R53 was independent with his electric wheelchair mobility after extensive transfer from staff. R53's Device Assessment dated 8/10/16, indicated R53 utilized an electric wheelchair for mobility. This assessment lacked an assessment for positioning during meal time. R53's Wheelchair Positioning Check List dated 8/12/16, indicated R53 utilized an electric wheelchair for mobility and that R53 could safely operate the chair throughout the unit. This check list lacked an assessment for positioning during meal time. On 9/12/16, at 5:16 p.m. R53 was observed seated in his motorized wheelchair wearing a clothing protector, and sitting at a circular table in the dining room. R53's wheelchair was positioned parallel to the circular table, with his right side (unaffected side) closest to the table. The distance from the table to the right side of R53's wheelchair was about four inches, and R53's wheelchair seat was raised about four to five inches above the dining room table. R53's wheelchair was unable to fit under the table. R53 utilized weighted silverware, and proceeded to	2 830		

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2 830	Continued From page 13	2 830		

independently feed himself. R53 was observed having to twist his upper torso and neck to the right in order to visualize and reach his place setting. R53 took his fork and stabbed the watermelon pieces, then brought them to his mouth. R53's clothing protector fell off of his right shoulder due to his having to twist and lean to the right while eating. R53 was able to reposition his clothing protector back into place onto his right shoulder. Each time R53 took items of food off of his plate; he needed to twist his upper torso and neck to the right. R53 was observed twice to spill pieces of red gelatin with whipped topping while bringing the spooned gelatin to his mouth. R53 utilized the weighted spoon to pick up the gelatin which had spilled onto his clothing protector and then placed the gelatin into his mouth. At 5:30 p.m. R53's wheelchair was noted to have spots of red gelatin and whipped topping spilled down the right side of his wheelchair and adhered to the right outside side bar and onto the top of the right wheel hub casing.

On 9/14/16, at 8:35 a.m. R53 was seated in his motorized wheelchair with a clothing protector on at the same circular table and in the same position as noted above on 9/12/16, at 5:16 p.m. R53 was observed having to twist his upper torso and neck to the right to visualize and reach his breakfast meal. R53's right hand had a tremor noted as he utilized his fingers more to bring the watermelon pieces and scrambled egg breakfast sandwich to his mouth. Several times when R53 brought the egg sandwich to his mouth, pieces of the scrambled egg spilled out of the back and side of the sandwich landing on his clothing protector or fell to the floor between his wheelchair and the table. R53 utilized his fingers and picked up the pieces of egg which had fallen on to his clothing protector and put them into his

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2 830	Continued From page 14 mouth. At the completion of breakfast, chunks of scrambled egg were noted on the floor between the table and where R53's wheelchair had been positioned. On 9/14/16, at 12:25 p.m. R53 was seated in his motorized wheelchair with a clothing protector on at the same circular table and in the same position as noted above on 9/12/16, 5:16 p.m. and 9/14/16, 8:35 a.m. during dining observations. Again, R53 was observed having to twist his upper torso and neck to the right to visualize and reach his meal. R53 continued to feed himself independently after nursing assistant (NA)-B set up his place setting and applied a clothing protector. R53 was observed to spill food onto his clothing protector and the floor before the bites of food reached R53's mouth. At the completion of R53's lunch, pieces of food (peaches, cottage cheese and BBQ chicken) were noted on the floor between the table and where R53's wheelchair had been positioned. On 9/12/16, at 5:30 p.m. R53 stated he sat the way he did at the dining room table because the table was too short for his wheelchair to fit under the table. On 9/14/16, at 12:38 p.m. registered nurse (RN)-D confirmed R53's wheelchair was positioned at an angle to the round table; which did not allow R53 to be positioned in direct alignment with his table setting. RN-D confirmed R53's motorized wheelchair would not fit under the dining room table, nor did RN-D believe any of the tables they currently had in the dining room were capable of being elevated high enough to accommodate R53's wheelchair to be positioned under the table. RN-D stated R53 had been positioned this way for meal time as long as	2 830		

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2 830	Continued From page 15 RN-D could remember. RN-D stated the facility had tried other things like a TV tray type table, and that should be documented in R53's medical record. RN-D was unsure if R53 had ever been evaluated by occupational therapy (OT) for wheelchair positioning while eating. RN-D confirmed R53 needed to twist his upper torso and neck to the right to reach his food. On 9/14/16, at 12:55 p.m. RN-D confirmed R53's medical record lacked documentation of any attempts tried to accommodate R53's positioning at the dining room table. RN-D also confirmed R53 had not been assessed for wheelchair positioning while eating. On 9/14/16, at 1:13 p.m. R53 stated he had worked with physical therapy and occupational therapy staff in the past, all though they had not worked with him regarding positioning at the dining room table. R53 stated the staff had not tried other things such as a raised table nor did R53 think any of the tables in the dining room raised high enough for him to fit his wheelchair under. R53 stated he was kind of shaky when he ate. R53's wheelchair was noted to have BBQ sauce and the same red gelatin stains on the side and hub casing of R53's wheelchair. R53 confirmed the staff cleaned his wheelchair every Thursday night. On 9/14/16, at 1:43 p.m. occupational therapist (OT)-A confirmed the rehabilitation staff had not assessed or evaluated R53 for wheelchair positioning at the dining room table. OT-A stated with her clinical judgement it would be more appropriate for R53 to be positioned more straight on and aligned with his place setting then having R53 seated off to the side and having to twist to reach his food.	2 830		

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2 830	Continued From page 16 On 9/15/16, at 12:48 p.m. director of nursing (DON) stated she was unsure if the facility had a table which was high enough to place R53's wheelchair under, but a table could be obtained for him. The facility Wheelchair Positioning policy dated 9/15/16, indicated nursing staff would refer all positioning concerns to restorative services. Referrals for wheelchair positioning would be made to the physical therapy/OT department as needed. In addition, wheelchair evaluation would be completed quarterly and with any significant change in condition. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure appropriate positioning during meals is provided. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:	2 900		10/21/16

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2 900	Continued From page 17 A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care and services were provided to prevent the development of, and worsening of pressure ulcers for 1 of 3 residents (R41) reviewed for pressure ulcers. This resulted in actual harm for R41 who developed multiple unstageable pressure ulcers. Findings include: Pressure Ulcer Stages according to the National Pressure Ulcer Advisory Panel Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to	2 900	Corrected	

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2 900	Continued From page 18 adjacent tissue. R41's face sheet printed 9/15/16, indicated diagnoses that included diabetes, peripheral vascular disease (blood circulation disorder of the extremities), anemia (low iron levels in the blood) in chronic kidney disease, peripheral venous insufficiency (decreased circulation in the veins of the extremities), and pressure ulcer of the sacral region (triangular-shaped bone at the base of the spine). R41's quarterly Minimum Data Set (MDS) assessment dated 7/25/16, indicated R41 had moderate cognitive impairment. R41's MDS further indicated R41 required assistance of 2 staff for bed mobility, toilet use, and transfers. The MDS also identified R41 was frequently incontinent of bowel and bladder. R41's MDS indicated R41 was at risk for the development of pressure ulcers, had no unhealed or unhealed pressure ulcers, and had a pressure reducing device for chair and bed. R41's care plan dated 9/6/16, indicated R41 had an unstageable pressure ulcer to the right buttock and right outer foot. R41's care plan indicated interventions included Mighty Shakes (increased protein drinks) three times daily, notify the nurse practitioner, physician assistant, or physician if the area worsened, turn and reposition every 2 hours, wound nurse to follow weekly, dressing changes as ordered by the physician, and a referral to the surgical certified nurse practitioner. R41's care plan further indicated R41 required assist of one staff for turning and repositioning, had a geo-mattress (a pressure reduction mattress) on the bed, a special boot on the right foot at all times (start date of 12/3/11), and a pressure relieving cushion in the wheelchair. The care plan directed staff to keep linens as free from wrinkles as possible and notify the nurse	2 900		

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	00603	A. BUILDING: _____ B. WING _____	09/15/2016

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2 900	Continued From page 19 immediately regarding any redness or discoloration of the skin. R41's Care Area Assessments (CAAs) dated 4/27/16, indicated R41 was at risk for altered skin integrity, required extensive to total assistance for activities of daily living, and was frequently incontinent of bowel and bladder. R41 was to be repositioned every 2 hours and as necessary, toileted or changed every 2 hours and as requested, and lotioned with cares. The goal was to keep R41's skin free of pressure ulcers, clean, warm and dry. R41's Skin Risk Assessment with Braden Scale dated 7/17/16, indicated R41 was at moderate risk of skin breakdown and indicated there were no current pressure ulcers. On 8/20/16, a Skin Integrity Pressure Sore Event Report indicated R41 had a new occurrence of a Stage II pressure ulcer on the coccyx measuring 0.5 centimeters (cm) x 0.5 cm, with a shiny, moist, granular appearance of pink or red tissue. Interventions included a pressure reducing device for bed and chair, pressure ulcer care and dressings to the pressure ulcer, along with pain management. The related progress note indicated the Mepilex (foam) dressing was initiated and the nurse practitioner was notified. A progress note dated 8/20/16, indicated a new open area measuring 0.5 cm x 0.5 cm on the coccyx had been identified, as noted on the Skin Event Report. The progress notes indicated R41 had received orders from the nurse practitioner for a Mepilex dressing to be changed every 3 days and as necessary. On 8/21/16, a Physician Order Report directed nursing to apply a Mepilex (foam) dressing to sacral/coccyx ulcer and change it every 3 days and as necessary. An order of 9/6/16, directed nursing to refer R41 to a wound care nurse practitioner for a wound consult of the	2 900		

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2 900	Continued From page 20 unstageable pressure ulcer to the buttock. The physician orders lacked orders for treatment to the right foot pressure ulcer. On 8/29/16, a Skin Integrity Pressure Sore Event Report indicated R41's left buttock pressure ulcer (area incorrectly identified by the facility) had increased in size to 1.4 cm x 0.6 cm and was unstageable, 100% covered with slough (yellow or white tissue that adheres to the ulcer bed). Interventions remained the same in addition to a turning and repositioning program. On 8/30/16, a progress note indicated R41's right foot was cool to touch, nurse was unable to feel the foot pulses, capillary refill and skin color were within normal limits. On 9/4/16, a progress note indicated R41's right buttock pressure ulcer (area incorrectly identified by the facility) was larger and measured 3 cm x 2.5 cm with a 0.9 cm x 1.5 cm slough/eschar in the center. Yellowish drainage with a foul odor was noted. The physician's assistant was to be notified on that Tuesday, 9/6/16. On 9/6/16, a nutrition progress note indicated the dietary tech was notified on that date, of R41's pressure ulcer on the buttocks (area incorrectly identified by the facility), with recent weight loss and decreased intake. The dietary tech was notified that the registered nurse (RN) had initiated Mighty Shake supplements. The nutrition note indicated R41 was receiving a multivitamin and would be monitored. On 9/9/16, a nutrition progress note indicated R41 had a significant change initiated due to skin issues. The progress note indicated R41 had a 3% weight loss over a month and had been started on Mighty shake supplements. The progress notes lacked documentation of the pressure ulcer on R41's right outer foot. A nutrition progress note dated 9/13/16, indicated R41 had two pressure areas, without identifying the location of either pressure	2 900		

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2 900	Continued From page 21 ulcer. On 9/7/16, a Skin Integrity Pressure Sore Event Report indicated R41 had a new outer right foot unstageable pressure ulcer measuring 0.5 cm x 1.1 cm, and was considered to be a suspected deep tissue injury. The report indicated R41 wore a heel Medix boot (designed to relieve pressure on the heel) on the right foot, and the physician was not notified. On 9/7/16, a Skin Integrity Pressure Sore Event Report indicated R41's right buttock pressure ulcer (area incorrectly identified by the facility) increased in size to 1.1 cm x 2.1 cm with the surrounding redness measuring 3.3 cm x 3.1 cm. The pressure ulcer was unstageable, was covered with slough, and had a scant amount of drainage. R41's interventions remained the same with the addition of a nutrition or hydration intervention to manage skin problems. Measures indicated a geo mat was applied to the bed and an appointment was made with a wound care nurse practitioner. On 9/11/16, a Tissue Tolerance Assessment (a test which helps determine time period the resident's skin tolerates continued pressure to an area) indicated R41 had an initial redness of the coccyx (tail bone) and buttocks which dissipated immediately with offloading (relieveing pressure to an area) in bed and chair. On 9/11/16, a Skin Risk Assessment with Braden Scale (an assessment used to assist in determining a resident's risk for skin breakdown) indicated R41 was at moderate risk for skin breakdown. R41's Skin Risk Assessment note identified risk factors, including current skin issues and history of skin issues. The note indicated R41 had a pressure ulcer on the coccyx, and had slight bogginess (soft tissue which indicates possible deep tissue breakdown) on the right heel, and wore a heel protector on the	2 900		

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2 900	Continued From page 22 right foot. On 9/12/16, a nursing home physician's progress note lacked documentation of R41's pressure ulcers. On 9/13/16, an office visit progress note, indicated R41 was seen by surgical nurse practitioner (NP) for wound care of an ulcer of the buttock. The NP documented the pressure ulcer was painful to R41, and R41 recently began taking protein supplements. The NP further documented the wound measured 2 cm x 1 cm x 0.1 cm. The documented plan was to treat the coccyx ulcer with the Mepilex AG (silver sulfate-for medium-exuding chronic or acute wounds where antimicrobial action is indicated), and change the dressings every 7 days or as needed. R41 was to be turned or repositioned every 1-2 hours as "this wound will not heal and will likely worsened (sic) if pressure is not kept off the wound area." The NP note lacked documentation regarding the right foot pressure ulcer. On 9/14/16, a Skin Integrity Pressure Sore Event Sore Event Report indicated R41's coccyx pressure ulcer had increased in size to 2.7 cm x 1.4 cm with the surrounding redness measuring 4.7 cm x 3.1 cm. The documentation indicated the pressure sore was a Stage 2, though it contained slough, which would indicate the ulcer was unstageable. The report indicated the pressure ulcer had a scant amount of clear drainage. The interventions remained the same. The report lacked documentation of the pressure ulcer on the right outer foot. On 9/14/16, at 9:25 a.m. registered nurse (RN)-D and RN-C entered R41's room to do a wound check. R41 was lying in bed on her back. RN-D and RN-C turned R41 to the left, and RN-D peeled back the dressing that was positioned on R41's right coccyx area. RN-D measured the	2 900		

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2 900	Continued From page 23 open area, which was described as peanut shaped with slough at the base, blanchable, with redness around it. The dressing had a small amount of serous drainage on it. RN-D placed the same dressing over the pressure ulcer. R41 was returned to her back. RN-D was asked about the ulcer on R41's right foot. RN-D stated he thought R41 did have an area on her foot, and proceeded to remove R41's heel protector. RN-D noted a scabbed area on the right distal right great toe. RN-D measured the scabbed area and stated it was 0.4 cm x 0.4 cm. RN-D replaced the heel protector to R41's right foot. RN-D stated R41 had a geofoam overlay on top of a regular mattress, and had a pressure-relief cushion on her wheelchair. Following the procedure, RN-D verified there was documentation on 9/7/16, indicating R41 had a pressure ulcer on the outside of her right foot. RN-D thought the nurse had mistakenly written right outer foot but meant the scabbed area on R41's right great toe. On 9/14/16, at 1:31 p.m. RN-D verified R41's pressure ulcers developed at the facility about 3 weeks ago. RN-D stated there was little to no drainage on the dressing, so he did not change the dressing. R41 had been seen by the wound care nurse practitioner the previous day, so had a new dressing put on at that time. RN-D stated R41's pain is managed with a Fentanyl (narcotic medication) patch and Tylenol. RN-D verified R41 is repositioned every 2 hours and as necessary, and stated R41 is compliant with that. RN-D denied seeing a pressure ulcer on the right outer foot. RN-D was unaware R41 had a pressure ulcer on the right foot. On 9/15/16, at 8:42 a.m. nursing assistant (NA)-E stated R41 had an open area on her bottom and a red area on her foot, which has improved since she got her new mattress. NA-E stated R41's mattress was put on her bed last week. NA-E	2 900		

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2 900	Continued From page 24 stated R41 had a regular mattress prior to receiving the new mattress. On 9/15/16, at 9:27 a.m. RN-D stated before R41 had skin breakdown, she was turned and repositioned every 2 hours and as necessary. Food and fluid intake was to be encouraged, R41 was to be promptly cleaned and dried after incontinence, linens were to be free from wrinkles, and staff were to monitor and report signs of breakdown. RN-D stated R41 had a pressure relieving cushion in the wheelchair, and got the new geofoam overlay on 9/9/16. RN-D stated initially after skin breakdown, an order for a Mepilex dressing was obtained. RN-D stated R41 had been on a multi-vitamin prior to skin breakdown and started receiving Mighty Shakes on 9/6/16. RN-D stated nursing starts interventions and if they don't work out, they notify dietary, and verified the dietary department was not notified until 9/6/16. RN-D verified R41 was noted to have a pressure ulcer of the right outer foot on 9/7/16. On 9/15/16, at 10:17 a.m. the director of nursing (DON) verified R41 had developed pressure ulcers and had risk factors prior to skin breakdown. The DON stated R41 had not received Mighty Shakes prior to skin breakdown, though had been on a multi-vitamin and had been repositioned every 2 to 3 hours. The DON stated a Mepilex dressing was initiated and a new mattress was put on her bed. The DON verified dietary should have been notified right away. The DON stated they had a new consultant dietician and the dietary tech was on vacation, though the nurse could have initiated the Mighty Shakes, and the dietician could have been called. The DON stated R41 was on a pressure reducing mattress previously and on 9/9/16, a geo-foam overlay was put on R41's bed. The DON stated R41 wears a heel protector and hadn't had any breakdown of	2 900		

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2 900	Continued From page 25 the heel. The DON verified R41 has not had occupational therapy assessments for positioning. On 9/15/16, at 1:33 p.m. RN-D went to do a wound check of R41's right foot upon surveyor's request. RN-D removed R41's right heel protector and stated R41's heel was normal and without bogginess. RN-D located the pressure ulcer on R41's right outer foot without a dressing on it and measured it. The pressure ulcer was dry and without drainage. RN-D measured the pressure ulcer and replaced R41's foot back in the heel protector. During an interview following the procedure, RN-D stated the open area was 0.7 cm x 0.8 cm with the blanchable redness around it measuring 1.0 cm x 1.0 cm. RN-D stated it was not warm to touch and had no drainage. RN-D stated it was a deep tissue injury and decided it was unstageable due to some eschar in the open area. RN-D verified the pressure ulcer could be caused by pressure from the boot. RN-D also verified he did not think the nurse practitioner had been notified of the pressure ulcer on R41's right foot. RN-D stated an acute care form would be filled out so the NP would look at the following day. Despite the increase in size of the pressure ulcer on the coccyx, the facility failed to reassess to promote the healing of the pressure ulcer, and failed to reassess to prevent the development of the pressure ulcer on the right foot. The facility policy and procedure for Skin Monitoring/Assessment/Documentation revised 9/10, directed the RN to assess reported signs of impaired skin and monitor weekly. The RN was to initiate a "Weekly Skin Monitor" and appropriate treatment. The policy directed the RN to notify the primary physician of skin integrity changes and implement the skin protocol. The policy further directed a tissue tolerance to be completed on all	2 900		

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2 900	Continued From page 26 residents upon admission and with any change in positioning and/or skin integrity. Nursing was to notify nutritional services, restorative services and discuss at the IDT (interdisciplinary team) meeting. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents do not develop a pressure ulcer unless it is clinically unavoidable, and residents who do have pressure ulcers are receiving the proper care and services needed to promote healing, prevent infection and prevent new pressure ulcers from developing. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21134	MN RULE 4658.0670 Supb. 2. Dishwashing; Sanitation, storage Sanitization; storage. All utensils and equipment must be thoroughly cleaned, and food-contact surfaces of utensils and equipment must be given sanitization treatment and must be stored in such a manner as to be protected from contamination. Cleaned and sanitized equipment and utensils must be handled in a way that protects them from contamination. This MN Requirement is not met as evidenced	21134		10/21/16

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21134	Continued From page 27 by: Based on observation, interview, and document review, the facility failed to ensure the meat slicer and the malt blender were appropriately cleaned to prevent food-borne illnesses. This had the potential to affect all 68 residents who received food served from the kitchen. Findings include: On 9/12/16, at 11:29 a.m. the meat slicer was observed to have greasy debris on the bottom edge of the blade, under the guide/guard. The dietary manager (DM) verified the meat slicer had just been cleaned and was ready for use. The DM ran her finger over the debris and verified it was greasy. In addition, the malt blender had a white debris at the top of the blending unit. DM verified, and stated it would be cleaned. On 9/15/16, at 1:05 p.m. the meat slicer had been cleaned of the greasy debris. The malt blender still had white debris at the top of the blending unit. DM verified the findings and removed the malt blender to be cleaned. The facility policy and procedure for Proper Cleaning and Sanitizing of Equipment dated 5/11/15, directed dietary staff to clean the meat slicer after each use and to clean the blade carefully. The policy directed the mixer was to be cleaned after each use. SUGGESTED METHOD OF CORRECTION: The Dietary Manager or designee could develop, review, and/or revise policies and procedures to ensure cleaning of kitchen equipment. The Dietary Manager or designee could educate all appropriate staff on the policies and procedures.	21134	corrected	

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21134	Continued From page 28 The Dietary Manager or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21134		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		10/21/16

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21390	Continued From page 29 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to administer recommended pneumococcal vaccinations for 9 of 11 residents (R95, R40, R1, R68, R23, R92, R99, R11, R137) reviewed for immunizations. Findings include: CDC recommendations: Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 [pneumococcal polysaccharide vaccine 23] should receive a dose of PCV13. The dose of PCV13 should be administered at least one year after the most recent PPSV23 dose. Immunization reports were reviewed for five residents chosen randomly from the facility census report. The reports indicted 5 of 5 residents had not received pneumococcal vaccinations per Center for Disease Control (CDC) recommendations (R95, R40, R1, R68, R23). R95's Face Sheet indicated R95 was admitted on 12/18/15, was 98 years old, and had diagnoses that included hypertension and atrial fibrillation. R95's annual Minimum Data Set (MDS) dated 6/10/16 indicated R95's pneumococcal vaccinations were up to date. R95's Minnesota Immunization Information Connection (MIIC) report, printed 9/14/16, indicated R95 received a Pneumo-PPSV23 on 1/8/2008. R40's Face Sheet indicated R40 was admitted on 9/23/15, was 84 years old, and had diagnoses that included dementia, hypertension, and weakness. R40's quarterly MDS dated 6/23/16,	21390	corrected	

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21390	Continued From page 30	21390		

lacked information regarding R40's pneumococcal vaccination status. R40's medical record lacked documentation of pneumococcal immunization status, and a MIIC report was not provided by the facility.

R1's face sheet indicated R1 was admitted on 12/9/14, was 86 years old, and had diagnoses that included chronic pain, atherosclerotic heart disease, and a history of bronchitis. R1's quarterly MDS dated 6/14/16, indicated R1's pneumococcal vaccinations were up to date. R1's Immunizations/Injection Summary Report indicted R1 had received the Pneumovax 23 on 10/7/97, and 3/6/3.

R68's face sheet indicated R68 was admitted on 4/1/16, was 98 years old, and had diagnoses that included diabetes, hypertension, and a history of a stroke. R68's quarterly MDS dated 7/7/16, indicated R68's pneumococcal vaccinations were up to date. R68's medical record lacked documentation of pneumococcal immunization status, however an undated handwritten note sheet received from the facility on 9/14/16, indicated R68 had received the Pneumovax 23 vaccination on 10/30/1996.

R23's face sheet indicated R23 was admitted on 2/8/16, was 87 years old, and had diagnoses that included congestive heart failure, chronic atrial fibrillation, chronic respiratory failure, and diabetes. R23's quarterly MDS dated 8/9/16, indicated R23's pneumococcal vaccinations were not up to date. R23's medical record lacked documentation of pneumococcal immunization status.

Four residents diagnosed with pneumonia in the last year (R92, R99, R11, R137) were reviewed.

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21390	Continued From page 31 R92's face sheet indicated R92 was admitted on 6/22/15, was 82 years old, and had diagnoses that included stomach cancer, congestive heart failure, chronic obstructive pulmonary disease and pneumonia. R92's quarterly MDS dated 3/22/16, indicated R92's pneumococcal immunizations were up to date. A Hospital Discharge Summary dated 6/24/16, indicated R92 had been hospitalized with acute respiratory failure with hypoxemia and pneumonia of right lower lobe. R92 was discharged back to the facility to receive oral and intravenous antibiotics. R92's medical record lacked documentation of pneumococcal immunization status however, the facility provided a handwritten list that indicated R92 had received Prevnar 13 (PCV13) on 3/6/15, and PPSV23 on 6/8/15. R99's face sheet indicated R99 was admitted on 9/17/15, was 75 years old, with diagnoses that included weakness, chronic obstructive pulmonary disease (COPD), dependence on supplemental oxygen, chronic respiratory failure, and pneumonia. R99's significant change MDS dated 7/29/16, indicated pneumococcal vaccinations were offered and declined, while the previous MDS, a quarterly on 6/16/16, indicated R99's pneumococcal vaccinations were up to date. R99's Emergency Department notes dated 2/18/16, diagnosed R99 with acute lower respiratory infection, and pneumonia to both lower lobes due to an infectious organism. R99's medical record lacked documentation of his pneumococcal immunization status however, the facility provided a handwritten list indicating R99 had received pneumococcal vaccine on 9/25/05, but it did not indicate what type of vaccination. R11's face sheet indicated R11 was admitted on	21390		

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21390	Continued From page 32 7/17/08, was 94 years old, with diagnoses that included atrial fibrillation and heart failure. R11's quarterly MDS dated 5/3/16, indicated that R11's pneumococcal vaccinations were up to date. On 4/21/16, a chest x-ray indicated "subtle bilateral lower lung field airspace opacities suggestive of pneumonia versus atelectasis." The physician's assistant progress note dated 4/26/16, indicated R11 had been hospitalized for pneumonia from 4/21/16, to 4/23/16. R11's medical record lacked documentation of the pneumococcal immunization status however, the facility provided a handwritten list indicating R11 had received the PPSV23 vaccination on 1/1/86, and 11/3/96. R137's face sheet indicated R137 was admitted 4/27/11, was 89 years old, and had diagnoses that included Parkinson's disease, asthma and pneumonia. An undated Resident vaccination and Mantoux record indicated R137 had received a pneumococcal vaccination in 2009, and the source was listed as "per admission assessment." A resident pneumococcal consent dated 10/30/15, indicated R137 had received a pneumococcal vaccination "4 years ago." R137's spouse also wrote on this form that she hoped R137 was eligible for another vaccination. A nurse practitioner's progress note dated 4/13/16, indicated influenza like illnesses and the provider was going to proceed with treatment for pneumonia. The progress note also indicated R137's chest x-ray was questionable for infiltrate. A death Record Worksheet dated 4/22/16, indicated R137 died on 4/20/16, with the immediate cause listed as pneumonia. CDC recommendations for pneumococcal vaccines include: one dose of PCV13 (also called Prevnar 13) is recommended for all adults aged	21390		

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21390	Continued From page 33 65 or older who've not previously received the vaccine. A dose of PPSV23 (also called Pneumovax 23) should be given at least one year later. For adults 65 years or older who have already received one or more doses of PPSV23, the dose of PCV13 should be given at least one year after receiving the most recent dose of PPSV23. On 9/15/16, at 9:19 a.m. registered nurse (RN)-B stated the old policy (revised 2004) was the one the facility was using. RN-B stated they were aware there were new CDC recommendations, but they were confusing and had not yet been implemented. On 9/15/16, at 9:25 a.m. the director of nursing (DON) stated the pneumococcal vaccinations were to be reviewed and offered if not up to date within the first 24 hours after admission. The DON stated it must have been overlooked and not enforced. The DON stated they knew they had to work on it [pneumococcal immunizations]. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure immunization guidelines are being met in the facility. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control	21426		10/21/16

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21426	Continued From page 34 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R40, R68, R1) had a baseline symptom screening for tuberculosis. Findings include: The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005, (MMWR) directed all residents must receive a baseline tuberculosis (TB) screening within 72 hours of admission or within 3 months prior to admission. The screening must include an assessment of the resident's risk	21426	corrected	

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21426	Continued From page 35 factors for TB, and any current TB symptoms. R40 was admitted to the facility on 9/23/15. R40's medical record lacked documentation of TB symptom screening upon admission. R68 was admitted to the facility on 4/1/16. R68's medical record lacked documentation of TB symptom screening upon admission. R1 was admitted to the facility on 12/9/14. R1's medical record lacked documentation of a first and second step Mantoux (a skin test to determine exposure to TB) readings/results upon admission. On 9/15/16, at 9:19 a.m., registered nurse (RN)-B verified she was unable to find documentation of R40 and R68's symptom screening and R1's first and second step Mantoux results. The facility nursing supervisor admission checklist revised 12/15, directed staff to ensure there is an order for a two step Mantoux test. A policy was not provided and the admission checklist lacks direction as to completion of a symptom screen. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents are properly screened for TB. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		

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21615	Continued From page 36	21615		
21615	MN Rule 4658.1340 Subp. 2 MedicineCabinet & Preparation Area;ScheduleII Subp. 2. Storage of Schedule II drugs. A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure storage and security of Fentanyl patches (which needed to be destroyed) was maintained on 2 of 2 units (3rd and 4th floor). Findings include: On 9/12/16, at 4:02 p.m. licensed practical nurse (LPN)-A completed a medication administration pass for resident (R16) which included removal and placement of a Fentanyl transdermal patch (a narcotic medicated adhesive patch placed on the skin to deliver a specific dose). LPN-A obtained R16's Fentanyl patch from a double locked narcotic drawer in the medication cart. LPN-A reconciled the number of Fentanyl patches left in the package for R16 and recorded this in the narcotic log book. LPN-A recorded under the "verified" section of the narcotic log book for R16's Fentanyl patch "disposed of old patch" and placed LPN-A's initials followed by a slash mark. LPN-A stated the disposal of the Fentanyl patches needed to be dual witnessed and because the other nurse wasn't close by, LPN-A would dispose of the Fentanyl patch later in a	21615	corrected	10/21/16

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21615	Continued From page 37	21615		

container in the medication room. LPN-A donned a pair of gloves and proceeded to remove R16's Fentanyl patch which was located on R16's left front shoulder and placed the new Fentanyl patch which LPN-A had dated 9/12/16, on R16's left shoulder. LPN-A removed the glove on her right hand, exited R16's room and went directly to the medication cart located in the doorway of R16's room. LPN-A placed the Fentanyl patch she had just removed in a clear unmarked medication cup, unlocked the medication cart and placed the unmarked clear medication cup in the top drawer of the medication cart. LPN-A removed the glove from her left hand and washed her hands. LPN-A again stated she would dispose of the used Fentanyl patch with another nurse later.

On 9/12/16, at 4:40 p.m. LPN-A confirmed the disposal of R16's removed Fentanyl patch wouldn't be destroyed until shift change around 10:30 p.m. LPN-A verified this was the routine practice for disposal of the Fentanyl patches. At this time, registered nurse (RN)-B and RN-C were observed seated at the nursing station directly down the hallway from where LPN-A had been passing medications.

On 9/13/16, at 4:31 p.m. LPN-B attempted to remove and apply a new Fentanyl patch on R95. LPN-B obtained the Fentanyl patch from the double locked narcotic drawer in the medication cart. LPN-B cut the very top of the Fentanyl packaging sleeve and wrote 9/13 on the Fentanyl patch. LPN-B entered R95's room and attempted to remove and place a new Fentanyl patch. R95 refused to have LPN-B remove the old Fentanyl patch or place the new Fentanyl patch. LPN-B stated she would re-approach R95 later and proceeded to place the new Fentanyl patch in the packaging sleeve and double locked it in the

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21615	Continued From page 38	21615		

medication cart narcotic drawer. LPN-B stated the used Fentanyl patches needed to be dual witnessed with another nurse and disposed of in the black box in the medication room.

On 9/13/16, at 6:02 p.m. LPN-B stated RN-F had been able to place the Fentanyl patch on R95 and they had saved it to demonstrate the disposal process. LPN-B obtained the R95's used Fentanyl patch from the double locked narcotic drawer in the medication cart. Both LPN-B and RN-F were present in the medication room. LPN-B opened an unlocked cupboard which had a wire holder that was secured to the inside cupboard door. There was a black biohazardous waste container secured in the wire holder. LPN-B placed the used Fentanyl patch in the black biohazardous container and LPN-B and RN-F co-signed in the narcotic book which indicated the disposal of R95's Fentanyl patch. LPN-B and RN-F confirmed the door to the cupboard had a lock on the outside of the cupboard, however the cupboard was not locked.

On 9/13/16, at 6:20 p.m. LPN-C confirmed the process for destroying Fentanyl patches included two nurses witnessed the disposal of the Fentanyl patch. This was completed at the end of the shift (around 10:30 p.m.) and usually completed with the two LPN's who were ending their shift. LPN-C stated she kept the Fentanyl patches which needed to be disposed of at the end of the shift in the top drawer of the medication cart. LPN-C confirmed this drawer was not double locked. LPN-C confirmed she had witnessed the disposal of R16's Fentanyl patch that had been removed on 9/12/16, around 4:00 p.m. with LPN-A at 10:30 p.m. on 9/12/16.

On 9/14/16, at 2:06 p.m. LPN-D stated the

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21615	Continued From page 39 Fentanyl patches were disposed of in the biohazard bins located in the unlocked cupboards in the medication rooms. LPN-D stated when the biohazard bins were filled they were removed from the wired casing and placed in the soiled utility room for the janitor to pick up. LPN-D confirmed the soiled utility room had a key pad access which all RN's, LPN's, housekeepers, janitors, and nursing assistants had access. LPN-D thought the janitors came and picked the containers up within two hours of it being requested. On 9/15/16, at 10:20 a.m. environmental services director (ESD) stated the janitors picked up the biohazard boxes which contained the Fentanyl patches from the soiled utility rooms on the units. On 9/15/16, at 12:14 p.m. LPN-E confirmed she placed the used Fentanyl patches into the top drawer of the medication cart, and at the end of the shift when the two nursing staff conduct a narcotic count, they dispose of the patch in the biohazard bin in the medication room. Each of the nurses sign the narcotic log. LPN-E confirmed the top drawer of the medication cart was not a double locked compartment. On 9/15/16, at 12:17 p.m. RN-D confirmed the usual schedule for removal and replacement of Fentanyl patches was between 3:00 p.m. and 5:00 p.m. The patch that was removed would be stored in the top drawer of the medication cart until the end of the shift and at that time would be destroyed with two nursing staff. On 9/15/16, at 12:25 p.m. janitor (J)-A confirmed there were times when she had picked up the full black box biohazard waste bins in the soiled utility rooms (which all RN's, LPN's, NA's,	21615		

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21615	Continued From page 40 housekeepers, and janitors had access). On 9/15/16, at 12:37 p.m. director of nursing (DON) confirmed the used Fentanyl patches were a transdermal medication and required the staff to wear gloves during placement and removal of the patches as if touched the staff had the potential to receive the effects of the narcotic. DON confirmed the used Fentanyl patches should be treated as a narcotic, and double locked if not immediately disposed. However, it was her expectation that the Fentanyl patches were disposed of immediately following removal of the patch and dual witnessed by an RN and/or LPN. If for some reason the Fentanyl patch could not be immediately disposed of, the used patch should be double locked in the narcotic drawer of the medication cart. DON confirmed there was the potential for diversion when the Fentanyl patches where not disposed of for five to six hours after they had been removed. DON verified the cupboard in the medication room which stored the black biohazard bins should be locked as the contents of the bins were considered to be narcotics and the facility policy was for all narcotics to be double locked. In addition, DON verified the filled black biohazard containers should not be left in the soiled utility room for pick up. On 9/15/16, at 2:38 p.m. the administrator confirmed the filled black biohazard containers should not be placed in the soiled utility room for pick up. In addition, the time from the removal of the Fentanyl patch to when it was witnessed to be destroyed should not be five to six hours. The facility Fentanyl Patch Procedure policy dated 4/15/13, directed staff to remove the patch, and two nurses must co-sign the destruction in	21615		

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21615	Continued From page 41 the narcotic book with the patch being placed in the black box in the medication room. Policy lacked a time frame of what was acceptable from removal of the patch to when it should be witnessed and placed in the black box. Narcotic Monitoring and Accountability policy dated 4/28/14, indicated all narcotics were kept locked in narcotic drawers of the medication carts or the medication room, and both must be double locked when not supervised. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and pharmacist or their designee, could develop and implement policies/procedures and staff training related to medication storage/ disposal of medications. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21615		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21685	corrected	10/21/16

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21685	Continued From page 42 review, the facility failed to maintain a safe, clean and homelike environment in 6 of 35 resident room (Rooms 307, 314, 317, 323, 326, 402). Findings include: On 9/15/16, 9:45 a.m. during an environmental tour, the manager of facilities and environmental services (FM) verified the following environmental findings: Room 307: the bathroom floor was dirty and the wall at the entrance to the bathroom had a gouged area that was approximately 1 foot x 2 inches in size. Room 314: the siderail on the side of the bed by the window was soiled with a dark colored sticky substance. Room 317: the door frame to the bathroom had deep gouges. The lower outer corner of the bathroom door was chipped and missing approximately 3 inches x 3 inches making it a rough and uncleanable surface. Room 323: had a build up of dirt around the non-skid strips on the bathroom floor in front of the toilet and the tiles under sink were stained a brown color. The doorway to the bathroom was badly gouged approximately 2 feet up from the floor. Room 326: a storage cupboard over the toilet had brown rust along the bottom lower edge. Room 402: in the bathroom the caulking around the base of the toilet was missing and the open space had dirt in it. The toilet riser had feces on back of the seat and down the back of the inside	21685		

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21685	Continued From page 43 of the riser. During the tour the FM stated siderails should be washed when the beds were washed but did not know how often the beds were washed or when done last. When rooms were remodeled, the bathroom cabinets were replaced with shelves. There was not a plan for any further remodeling. The FM stated the facility has a computer system that any staff could use to inform maintenance of needed cleaning or repairs. The facility also had a routine maintenance computer system with scheduled equipment and facility areas to check . The facility's Maintenance Work Orders policy dated 2/15, indicated all work requests must be requested using the intranet work order system. Only tenants that do not have the intranet work order system were allowed to use the written work order form. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop a maintenance program to ensure the facility was in good repaired to maintain a safe, clean, homelike environment. The DON or designee could educate all appropriate staff on the program, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21685		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual	21810		10/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00603	A. BUILDING: _____ B. WING _____	09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21810	Continued From page 44 needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the call light was within reach for 1 of 35 residents (R27) reviewed for call lights. Findings include: R27's Face Sheet indicated R27's diagnoses included weakness, adult failure to thrive and anxiety. The quarterly Minimum Data Set (MDS) dated 8/12/16, indicated R27 was cognitively intact. R27 required limited assist of one staff with bed mobility, transfers, walking in her room and toilet use. R27 had occasional incontinence of bowel and bladder. R27 had shortness of breath, used oxygen and had a prognosis which may result in a life expectancy of six months or less. R27 received a diuretic (a medication that increases the production of urine) seven of seven days during the assessment period. R37's care plan dated 9/14/16, indicated R27 had a potential for falls due to decreased mobility and weakness. The care plan directed staff to have the call light within reach at all times, and to remind R27 to ask for assistance with activities of daily living (ADL) as needed.	21810	corrected	

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21810	Continued From page 45 On 9/13/16, at 2:05 p.m. R27's call light was observed hanging on the bed post at the foot of the bed. The call light and bed post were covered with a white fleece jacket. R27 was sitting in the recliner. When asked about the call light, R27 was unable to find the call light, and then unable to reach the call light. R27 stated she used the call light when she needed something and did not know what she would do if she did not have it. R27's room was located at the end of the hall. On 9/14/16, at 10:00 a.m. R27 stated she used the call light for everything; when she needed to go to the bathroom, if she wanted a drink of water, dropped something on the floor and, "Sometimes the over bed table gets stuck and I can't reach something." R27 further stated, "Sometimes I have to apologize to the staff because I put the light on so much. I feel safe with my call light because I know they will come when I put the call light on." On 9/14/16, at 10:55 a.m. nursing assistant (NA)-A stated sometimes R27 put her call light on often, usually to go to the bathroom, for a pain pill or transfer into the wheelchair. NA-A further stated sometimes R27's friend would put the call light on if he felt she needed something. On 9/15/16, at 8:00 a.m. the administrator stated R27 should be able to use the call light and would expect staff to make sure every resident's call light was within reach as directed by the care plan. On 9/15/15, at 12:15 p.m. registered nurse (RN)-A stated R27 was able to use the call light. RN-A stated she would expect staff to make sure the call light was within reach. RN-A stated all resident's care plans directed staff to have the	21810		

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21810	Continued From page 46 call light within reach at all times. RN-A further stated R27 has not had a fall since coming to the facility, and R27 knows to put the call light on and ask for assist. The facility's Call Light policy dated 9/15/16, indicated call lights would be used in all resident rooms. Call lights would be within reach the resident's reach. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure call lights are kept within resident reach. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		