DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: AQ8U Facility ID: 00603

| | IAKI I- | TO BE COMIT | DETED DI 1 | HE SIAI | E SURVET AGENCI | racinty ib. 00003 | | |
|--|---------------------|---|---|------------|---|--|--|--|
| MEDICARE/MEDICAID PROVID (L1) 245458 | ER NO. | 3. NAME AND AI (L3) ESSENTIA | | | RE CENT | 4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification | | |
| 2.STATE VENDOR OR MEDICAID | NO. | (L4) 901 9TH ST | REET NORT | H | | 3. Termination 4. CHOW | | |
| (L2) 936325400 | | (L5) VIRGINIA, | MN | | (L6) 55792 | 5. Validation 6. Complaint 7. On-Site Visit 9. Other | | |
| 5. EFFECTIVE DATE CHANGE OF | OWNERSHIP | 7. PROVIDER/SU | | | <u>02</u> (L7) | 8. Full Survey After Complaint | | |
| (L9) 01/01/2013 | 2/004 | 01 Hospital | 05 HHA | 09 ESRD | 13 PTIP 22 CLIA | | | |
| o. Bill of Soliver | 9/2016 (L34) | 02 SNF/NF/Dual | 06 PRTF | 10 NF | 14 CORF | FISCAL YEAR ENDING DATE: (L35) | | |
| 8. ACCREDITATION STATUS: | (L10) | 03 SNF/NF/Distinct | 07 X-Ray | 11 ICF/IID | | ` ' | | |
| 0 Unaccredited 1 TJC 2 AOA 3 Other | | 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | 12/31 | | |
| 11LTC PERIOD OF CERTIFICATIO | N | 10.THE FACILITY | IS CERTIFIED | AS: | | | | |
| From (a): | | A. In Complia | ance With | | And/Or Approved Waivers Of | The Following Requirements: | | |
| To (b): | | _ | equirements e Based On: | | 2. Technical Personnel 3. 24 Hour RN | 6. Scope of Services Limit7. Medical Director | | |
| | | 1 A | cceptable POC | | 4. 7-Day RN (Rural SN | | | |
| 12.Total Facility Beds | 90 (L18) | | ecceptuote 1 oc | | 5. Life Safety Code | 9. Beds/Room | | |
| 13.Total Certified Beds | 90 (L17) | X B. Not in Cor | mpliance with Programs and/or Applied V | _ | * Code: A | (L12) | | |
| 14. LTC CERTIFIED BED BREAKDO |)WN | requirements | and or rippined | 1 | 15. FACILITY MEETS | (2.2) | | |
| 18 SNF 18/19 SNF | 19 SNF | ICF | IID | | 1861 (e) (1) or 1861 (j) (1): | (L15) | | |
| 90 | 19 SMF | ICI | Ш | | 1801 (e) (1) 01 1801 (j) (1). | (113) | | |
| (L37) (L38) | (L39) | (L42) | (L43) | | | | | |
| 16. STATE SURVEY AGENCY REM | ARKS (IF APPLICA | ABLE SHOW LTC CA | ANCELLATION : | DATE): | | | | |
| See Attached Remarks | | | | | | | | |
| 17. SURVEYOR SIGNATURE | | Date : | | | 18. STATE SURVEY AGENCY | APPROVAL Date: | | |
| Kimberly Settergren | , HFE NEII | 1 | 1/21/2016 | (L19) | Mark Weath | , Enforcement Specialist | | |
| PA | RT II - TO BE | COMPLETED 1 | BY HCFA RI | EGIONAI | OFFICE OR SINGLE S | TATE AGENCY | | |
| 19. DETERMINATION OF ELIGIBI | LITY | | MPLIANCE WITI | H CIVIL | | ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) | | |
| X 1. Facility is Eligible to | Participate | RIGHTS ACT: | | | 3. Both of the Above : | | | |
| 2. Facility is not Eligible | | | | | | | | |
| | (L21) | | | | | | | |
| 22. ORIGINAL DATE | 23. LTC AGREE | MENT 2 | 4. LTC AGREEN | MENT | 26. TERMINATION ACTION: | (L30) | | |
| OF PARTICIPATION | BEGINNING | G DATE | ENDING DA | ГЕ | VOLUNTARY 00 | INVOLUNTARY | | |
| 04/01/1987 | | | | | 01-Merger, Closure | 05-Fail to Meet Health/Safety | | |
| (L24) | (L41) | | (L25) | | 02-Dissatisfaction W/ Reimburs | · · | | |
| 25. LTC EXTENSION DATE: | 27. ALTERNATI | VE SANCTIONS | | | 03-Risk of Involuntary Termination | on <u>OTHER</u> | | |
| | | n of Admissions: | | | 04-Other Reason for Withdrawal | 07-Provider Status Change | | |
| | A. Suspension | | | | | | | |
| (1.27) | | | (L44) | | | 00-Active | | |
| (L27) | | uspension Date: | (L44) | | | 00-Active | | |
| (L27) | | | (L44) (L45) | | | 00-Active | | |
| (L27) 28. TERMINATION DATE: | B. Rescind S | | (L45) | | 30. REMARKS | 00-Active | | |
| | B. Rescind S | uspension Date: | (L45) | | 30. REMARKS | 00-Active | | |
| | B. Rescind S | uspension Date: | (L45) | (L31) | 30. REMARKS | 00-Active | | |
| 28. TERMINATION DATE: | B. Rescind S | uspension Date: O. INTERMEDIARY 03001 | (L45) /CARRIER NO. | | 30. REMARKS | 00-Active | | |
| | B. Rescind S | uspension Date: 0. INTERMEDIARY, 03001 2. DETERMINATION | (L45) /CARRIER NO. | | 30. REMARKS | 00-Active | | |
| 28. TERMINATION DATE: | B. Rescind S | uspension Date: O. INTERMEDIARY 03001 | (L45) /CARRIER NO. | | 30. REMARKS DETERMINATION APP | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00603

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 pursuant 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.



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 Weath

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



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: 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

Essentia Health Virginia Care Center November 21 2016 Page 2

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 Weath

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

POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION A. Building | | | DATE OF REV | /ISIT |
|--|------------------------------------|---------------------------------------|----|-------------|-------|
| | 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).

| ITE Y4 | | DATE Y5 | ITEM Y4 | | DATE Y5 | ITEM Y4 | | | DATE Y5 |
|---|---------------|---|-------------------|-------------|-------------------|------------|---------------------|--------------|-------------------|
| ID Prefix | | Correction | ID Prefix F | | Correction | ID Prefix | | | Correction |
| Reg. # | 483.10(b)(11) | Completed | Reg. # | 33.15(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 F | 0314 | Correction | ID Prefix | F0323 | | Correction |
| Reg. # | 483.25 | Completed | Reg. # | 33.25(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 F | 0371 | Correction | ID Prefix | F0431 | | Correction |
| Reg. # | 483.25(n) | Completed | Reg. # | 33.35(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 | | | |
| REVIEWI STATE A | | REVIEWED BY (INITIALS) LB/mm | DATE 11/21/201 | | JRE OF SURVEYOR | 34089 | | DATE 11/0 |)9/2016 |
| REVIEWI CMS RO | ED BY | 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 | | | | | s 🗆 NO | | |

POST-CERTIFICATION REVISIT REPORT

| | MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 | | | DATE OF REV | ISIT |
|--------------------------|--|---------------------------------------|----|-------------|------|
| | 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).

| ITE 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. # | 101 Complete | d 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. # | Complete | d Reg.# | Completed |
| LSC | K0104 | 10/21/2016 | LSC | | LSC | |
| ID Prefix | | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | | Completed | Reg. # | Complete | d Reg. # | Completed |
| LSC | | | LSC | | LSC | |
| ID Prefix | | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | | Completed | Reg. # | Complete | d Reg. # | Completed |
| LSC | | | LSC | | LSC | |
| ID Prefix | | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | | Completed | Reg. # | Complete | d Reg. # | Completed |
| LSC | | | LSC | | LSC | |
| REVIEW STATE A | | REVIEWED BY (INITIALS) TA/mm | DATE 11/21/2016 | SIGNATURE OF SURVEYOR | 27200 | DATE 10/27/2016 |
| REVIEW 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? | | | |



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 / | MULTIPLE CONSTRUCTION | | DATE | E OF REVIS | SIT |
|------------------------------|-----------------------|---------------------------------------|-------|------------|-----|
| IDENTIFICATION NUMBER | A. Building | | | | |
| 00603 _{Y1} | 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).

| ITE | М | | DATE | ITEM | | | DATE | ITEM | | | DATE |
|------------------------|--------------------------------|--------------------|------------|---|------------------|---------------------|------------|-----------|--------------------------------|--------------|--------------|
| Y4 | | | Y5 | Y4 | | | Y5 | Y4 | | | Y5 |
| ID Prefix | 20265 | | Correction | ID Prefix | 20565 | | Correction | ID Prefix | 20830 | | Correction |
| Reg. # | MN Rule 4658.0 | 0085 | Completed | Reg. # | MN Ru Subp. 3 | le 4658.0405 | Completed | Reg. # | MN Rule 4658.09 Subp. 1 | 520 | 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 4658.0 Subp. 3 |)525 | Completed | Reg. # | MN RU Supb. 2 | JLE 4658.0670 2. | Completed | Reg. # | MN Rule 4658.08 Subp. 4 A-I | 800 | 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 | Completed | Reg. # | MN Ru | le 4658.1340 | Completed | Reg. # | MN Rule 4658.14 | 415 | Completed |
| LSC | Subd. 3 | | 10/21/2016 | LSC | Subp. 2 | 2 | 10/21/2016 | LSC | Subp. 2 | | 10/21/2016 |
| ID Prefix | 21210 | | Correction | ID Prefix | | | Correction | ID Prefix | | | Correction |
| ID FIEIIX | MN St. Statute | 144 651 | Correction | ID FIEIIX | - | | Correction | ID FIEIIX | | | Correction |
| Reg. # | Subd. 6 | 144.031 | 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 | | | - |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| REVIEWS | | REVIEW (INITIAL | | DATE 11/21/2 | 016 | SIGNATURE O | | 34089 | | DATE 11/0 | 09/2016 |
| REVIEWI CMS RO | | REVIEW (INITIAL | /ED BY | DATE | | TITLE | | | | DATE | |
| FOLLOW 9/15/201 | OLLOWUP TO SURVEY COMPLETED ON | | | CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO | | | | | | | |

Page 1 of 1 EVENT ID: AQ8U12

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| | MEDICARE/MEDICAID CERTIFICATIO PART I - TO BE COMPLETED BY THE S | | | | | | | | |
|---|---|--|---|-------------------------|--|--|--|-----------------------------------|--|
| 1. MEDICARE/MEDICAID PROVID (L1) 245458 2.STATE VENDOR OR MEDICAID (L2) 936325400 | NO. | 3. NAME AND AI (L3) ESSENTIA (L4) 901 9TH ST (L5) VIRGINIA, | HEALTH VIR REET NORTH | GINIA CA | (L6) 55792 | 4. TYPE OI 1. Initial 3. Termina 5. Validati 7. On-Site | 2. Reation 4. Cl | (L8) eccertification HOW omplaint | |
| 5. EFFECTIVE DATE CHANGE OF (L9) 01/01/2013 6. DATE OF SURVEY 09/1 | OWNERSHIP 5/2016 (L34) | 7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual | PPLIER CATEG 05 HHA 06 PRTF | ORY 09 ESRD 10 NF | 02 (L7) 13 PTIP 22 CLIA 14 CORF | | n ENDRIG DATE | | |
| 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other | (L10) | 03 SNF/NF/Distinct 04 SNF | 07 X-Ray 08 OPT/SP | 11 ICF/III 12 RHC | D 15 ASC 16 HOSPICE | 12/ | R ENDING DATE | E: (L35) | |
| 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds | 90 (L18) 90 (L17) | Compliance1. A X B. Not in Con | equirements e Based On: cceptable POC | gram | And/Or Approved Waivers Or 2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural S) 5. Life Safety Code * Code: B * 15. FACILITY MEETS | el 6. Sco 7. Me | ope of Services Li edical Director tient Room Size | mit | |
| 18 SNF 18/19 SNF 90 (L37) (L38) | 19 SNF (L39) | ICF (L42) | IID (L43) | | 1861 (e) (1) or 1861 (j) (1): | (L1 | 15) | | |
| 16. STATE SURVEY AGENCY REM See Attached Remarks 17. SURVEYOR SIGNATURE | MARKS (IF APPLICA | BLE SHOW LTC CA | NCELLATION I | DATE): | 18. STATE SURVEY AGENC | Y APPROVAL | Dat | e: | |
| Kathie Killoran, HFE | NEII | 1 | 0/21/2016 | (L19) | Mark Weath | , Enforcemen | t Specialist | 11/07/2016 (L20 | |
| PA | RT II - TO BE | COMPLETED I | BY HCFA RE | GIONAL | L OFFICE OR SINGLE S | STATE AGEN | NCY | | |
| 19. DETERMINATION OF ELIGIBI _X 1. Facility is Eligible to 2. Facility is not Eligible | Participate | | IPLIANCE WITH HTS ACT: | I CIVIL | 21. 1. Statement of Fine2. Ownership/Contr3. Both of the Abov | rol Interest Disclos | | 513) | |
| 22. ORIGINAL DATE OF PARTICIPATION 04/01/1987 | 23. LTC AGREEN BEGINNING | | 4. LTC AGREEM ENDING DAT | | 26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure | <u>0</u> <u>I</u> | (L30) NVOLUNTARY 5-Fail to Meet Hea | lth/Safety | |
| (L24) | (L41) | TE CANCETONS | (L25) | | 02-Dissatisfaction W/ Reimburg 03-Risk of Involuntary Terminati | rsement 06 | 6-Fail to Meet Agre | - | |
| 25. LTC EXTENSION DATE: (L27) | _ | n of Admissions: | (L44) (L45) | | 04-Other Reason for Withdrawal | 1 07 | THER 7-Provider Status (0-Active | Change | |
| 28. TERMINATION DATE: | 29 | . INTERMEDIARY/ | | | 30. REMARKS | | | | |
| 20. 15.00.00.00.00.00.00.00.00.00.00.00.00.00 | (L28) | 03001 | CHRISTIAN. | (L31) | 50. REMINICO | | | | |
| 31. RO RECEIPT OF CMS-1539 | 32 | . DETERMINATION | OF APPROVAL | DATE | Posted 11/07/2016 Co |) | | | |

(L33)

DETERMINATION APPROVAL

(L32)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

VEY AGENCY Facility ID: 00603

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 unsubstantiated. 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.



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Teresa Ament@state.mn.us

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

PRINTED: 11/06/2016 FORM APPROVED OMB NO. 0938-0391

| 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. | - | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
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| 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 157 483.10(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 (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); or a decision to transfer or discharge the resident from the facility as specified in | PRÉFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF | D BE | COMPLÉTION | |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE | | existing form of treat consequences, or to treatment); or a decent the resident from the §483.12(a). | atment due to adverse to commence a new form of sision to transfer or discharge the facility as specified in | | | | | |

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(X6) DATE

Electronically Signed 10/07/2016

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: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION () G | (X3) DATE SURVEY COMPLETED | | |
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| F 157 | and, if known, the ror interested family change in room or specified in §483.1 resident rights under regulations as specified in §483.1 resident rights under regulations and phase and phase regulations and phase regulations are resident rights under regulations and interest rights under regulations and interest rights under regulations and interest rights under r | so promptly notify the resident esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of cord and periodically update one number of the resident's er or interested family member. NT is not met as evidenced tion, interview, and document ailed to ensure the physician development of a new of 3 residents (R41) reviewed of 3 residents (R41) reviewed except allow open ulcer with a red thout slough. May also present noruptured serum-filled blister, hickness tissue loss in which er is covered by slough (yellow, brown) and/or eschar (tan, | F 15 | 1 R 41 MD has been notified of development of new pressure ulcer. 2 All residents could be affected by the 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 pressure sore were reviewed and restaff educated on the importance of reporting to MD any changes in condand the policy and procedures implemented. 4 Observational monitoring of the restrect will be completed on a minimal 5 residents a week for a period of the months. Results will be reviewed with as needed. Review of results will be reviewed at the quarterly QAPI meet Ongoing monitoring will be at recommendation of QAPI team. | of a vised. dition sident um of ree h staff | | |

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| F 157 | adjacent tissue. R41's face sheet p diagnoses that incl vascular disease (kextremities), anemin chronic kidney dinsufficiency (decrethe extremities), arregion (triangular-sspine). R41's quarterly Minassessment dated moderate cognitive further indicated Rataff for bed mobility. The MDS also idenincontinent of bower indicated R41 was pressure ulcers, hapressure ulcers, and evice for chair and R41's care plan da an unstageable preand right outer foot interventions incluprotein drinks) three practitioner, physic the area worsened hours, wound nurse changes as ordere | rinted 9/15/16, indicated uded diabetes, peripheral blood circulation disorder of the ia (low iron levels in the blood) isease, peripheral venous eased circulation in the veins of ad pressure ulcer of the sacral haped bone at the base of the nimum Data Set (MDS) 7/25/16, indicated R41 had a impairment. R41's MDS 41 required assistance of 2 by, toilet use, and transfers. Intified R41 was frequently all and bladder. R41's MDS at risk for the development of ad no unhealed or unhealed and had a pressure reducing | F 157 | , | | | |
| | assist of one staff f had a geo-mattress mattress) on the be foot at all times (sta | ther indicated R41 required for turning and repositioning, is (a pressure reduction ed, a special boot on the right eart date of 12/3/11), and a cushion in the wheelchair. The | | | | | |

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| F 157 | from wrinkles as poimmediately regard discoloration of the R41's Care Area As 4/27/16, indicated I integrity, required e activities of daily livincontinent of bowerepositioned every toileted or changed requested, and lotic to keep R41's skin warm and dry. R41's Skin Risk As dated 7/17/16, indicrisk of skin breakdon ocurrent pressure On 8/30/16, a prog foot was cool to touthe foot pulses, cap within normal limits On 9/7/16, a Skin In Report indicated Funstageable pressures 1.1 cm, and was condeep tissue injury. a heel Medix boot (on the heel) on the was not notified. On 9/11/16, a Skin Scale (an assessment determining a residindicated R41 was breakdown. R41's sidentified risk factorissues and history indicated R41 had | staff to keep linens as free possible and notify the nurse ling any redness or skin. Sesessments (CAAs) dated R41 was at risk for altered skin extensive to total assistance for ring, and was frequently all and bladder. R41 was to be 2 hours and as necessary, I every 2 hours and as oned with cares. The goal was free of pressure ulcers, clean, sessment with Braden Scale cated R41 was at moderate own and indicated there were a ulcers. The goal was free or pressure ulcers at moderate own and indicated there were a ulcers. The sessment with Braden Scale cated R41 was at moderate own and indicated there were a ulcers. The sessment with Braden Scale cated R41 was at moderate own and indicated there were a ulcers. The sessment with Braden Scale cated R41 was at moderate own and indicated there were a ulcers. The sessment with Braden Scale cated R41 was at moderate own and indicated there were a ulcers. The sessment with Braden Scale cated R41 was at moderate own and indicated there were a ulcers. The sessment with Braden Scale cated R41 was at moderate own and indicated there were a ulcers. The sessment with Braden Scale cated R41 was at moderate own and indicated there were a ulcers. The sessment with Braden Scale cated R41 was at moderate own and indicated there were a ulcers. | F 15 | 7 | | | |

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| F 157 | on the right heel, a right foot. The ass the pressure ulcer On 9/12/16, a nurs note lacked documulcer on the right of On 9/13/16, an off indicated R41 was practitioner (NP) fouttock. The NP dwas painful to R41 taking protein sup documented the wollow on the right of the wollow on the right of the wollow on the right of the wollow on the | passible deep tissue breakdown) and wore a heel protector on the essment lacked identification of on the right foot. Sing home physician's progress nentation of R41's pressure oot. Sice visit progress note, seen by surgical nurse or wound care of an ulcer of the ocumented the pressure ulcer 1, and R41 recently began plements. The NP further yound measured 2 cm x 1 cm x mented plan was to treat the the Mepilex AG (silver in-exuding chronic or acute timicrobial action is indicated), ressings every 7 days or as to be turned or repositioned is "this wound will not heal and do (sic) if pressure is not kept off. The NP note lacked garding the right foot pressure in Integrity Pressure Sore Event it indicated R41's coccyx dincreased in size to 2.7 cm x arrounding redness measuring. The documentation indicated was a Stage 2, though it which would indicate the ulcer. The report indicated the da scant amount of clear arrountions remained the same. documentation of the pressure | F 1 | 57 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| F 157 | right foot. RN-D sta an area on her foot R41's heel protecto on the right distal ri the scabbed area a cm. RN-D replaced right foot. RN-D sta overlay on top of a pressure-relief cusl Following the proce documentation on s pressure ulcer on the RN-D thought the right outer foot but R41's right great to On 9/14/16, at 1:31 pressure ulcers deveks ago. RN-D on the right outer for had a pressure ulcer On 9/15/16, at 9:27 noted to have a pre- foot on 9/7/16. On 9/15/16, at 1:33 wound check of R4 request. RN-D rem and stated R41's he bogginess. RN-D lo R41's right outer for measured it. The p without drainage. Fulcer and replaced protector. During an procedure, RN-D si cm x 0.8 cm with the it measuring 1.0 cm not warm to touch a | asked about the ulcer on R41's ated he thought R41 did have a, and proceeded to remove or. RN-D noted a scabbed area ght great toe. RN-D measured and stated it was 0.4 cm x 0.4 the heel protector to R41's ated R41 had a geofoam regular mattress, and had a mion on her wheelchair. Edure, RN-D verified there was 9/7/16, indicating R41 had a he outside of her right foot. The nurse had mistakenly written meant the scabbed area on e. p.m. RN-D verified R41's veloped at the facility about 3 denied seeing a pressure ulcer out. RN-D was unaware R41 | F 1 | 57 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER A HEALTH VIRGINIA | CARE CENT | STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792 | | | |
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| F 157 F 246 SS=D | area. RN-D verified caused by pressure verified he did not the been notified of the foot. RN-D stated a filled out so the NP day. The facility policy as Monitoring/Assessment of skin into the skin protocol. In the skin | the to some eschar in the open the pressure ulcer could be from the boot. RN-D also hink the nurse practitioner had pressure ulcer on R41's right in acute care form would be would look at the following and procedure for Skin nent/Documentation revised RN to notify the primary regrity changes and implement dursing was to notify nutritional eservices and discuss at the ty team) meeting. ONABLE ACCOMMODATION ERENCES right to reside and receive ity with reasonable individual needs and the when the health or safety of er residents would be | F 15 | 6 | | 10/21/16 |
| | review, the facility fa was within reach fo reviewed for call lig Findings include: R27's Face Sheet in | ion, interview, and document ailed to ensure the call light r 1 of 35 residents (R27) hts. Indicated R27's diagnoses adult failure to thrive and | | Resident 27 call light was put in to enable proper usage is ensured. Plan was reviewed and revised as needed. All residents have plans of care was be followed by staff caring for resident. All residents have been refor their call light usage and proper placement. Their care plans, profile. | Care which the eviewed | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION NG | ` ' | E SURVEY PLETED |
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| | | 245458 | B. WING _ | | 09/· | 15/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH | | |
| | | | | VIRGINIA, MN 55792 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF CROSS-REFERENCED TO THE APPR DEFICIENCY) | ILD BE | (X5) COMPLETION DATE |
| F 246 | 8/12/16, indicated I required limited ass mobility, transfers, use. R27 had occa and bladder. R27 hoxygen and had a pa life expectancy of received a diuretic the production of unduring the assessmant R37's care plan data a potential for falls weakness. The carthe call light within remind R27 to ask daily living (ADL) as On 9/13/16, at 2:05 observed hanging of the bed. The call ligwith a white fleece recliner. When ask was unable to find to reach the call ligicall light when she know what she wor R27's room was low On 9/14/16, at 10:00 the call light for every go to the bathroom water, dropped son "Sometimes the ovicant reach someth | num Data Set (MDS) dated R27 was cognitively intact. R27 sist of one staff with bed walking in her room and toilet sional incontinence of bowel ad shortness of breath, used prognosis which may result in a six months or less. R27 (a medication that increases rine) seven of seven days ment period. Ited 9/14/16, indicated R27 had due to decreased mobility and e plan directed staff to have reach at all times, and to for assistance with activities of | F 24 | NAR group lists will be updated needed. Also all residents are renursing during their MDS assess period to ensure care plans, pro NAR group lists are updated with changes. All residents who are a call light or other adaptive devistaff to their needs have the potential be affected by not having device their reach. 3 Call Light policy and procedure reviewed and revised as necess were educated on the policy and procedure related to call light us 4 Observational audits will be consured to ensure call lights are within refersidents per their plan of care. It minimum of three audits will be weekly at random times to ensure ongoing compliance for three means of the audits. The monitoring result reported to the quarterly QAPI to QAPI team will make recommental for ongoing monitoring. 5 Completion date is October 21 6 Persons responsible: DON, Not Managers, Nurse Supervisors | viewed by ment iles and a any ble to use ce to alert ential for within were ary. Staff age. mpleted ach of all a done e onths. Ingoing esults of s will be am. The dations | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | } | 24 | 58 | B. WING | | | 09/ | 15/2016 |
| NAME OF F | | CARE CENT | | | 9 | STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792 | | |
| (X4) ID PREFIX TAG | 3Y F | TEMENT OF DEFIC Y MUST BE PRECEI SC IDENTIFYING IN | D BY FULL | ID PREFI TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD | | BE | (X5) COMPLETION DATE |
| F 246 | ista cal cal cal cal cal cal cal cal cal ca | ge 8 ght on so much ecause I know to light on." 55 a.m. nursing etimes R27 put to the bathroom wheelchair. NAR27's friend wo eneeded some a.m. the admite to use the call to use the call esure every rech as directed 5 p.m. register was able to use the call times. In the admite to use the call times and a fall since the at all times. In the admite that a fall since the at all times. In the admite that a fall since the at all times. In the admite that all times. In the admite that a fall since the admites | ey will come essistant er call light on for a pain pill a further d put the call ning. estrator stated ght and would dent's call the care d nurse the call light. to make sure estated all to have the N-A further coming to the | F 2 | 246 | | | |
| F 282 SS=D | 15/1 all rech tl FIE the | ight policy date would be used vould be within RVICES BY QU ARE PLAN ded or arranged by qualified pers ach resident's w | 9/15/16, n all resident ach the LIFIED by the facility | F 2 | :82 | | | 10/21/16 |
| | all rech the the | would be used vould be within RVICES BY QUARE PLAN ded or arranged by qualified pers | n all resident each the LIFIED by the facility ons in | F 2 | :82 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
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| | | 245458 | B. WING _ | | 06 | /15/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT | | STREET ADDRESS, CITY, STATE, ZIP 901 9TH STREET NORTH VIRGINIA, MN 55792 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 282 | Continued From pa | | F 28 | 32 | | |
| | by: Based on observat review, the facility for the second of the second | ed 9/14/16, indicated R27 had due to decreased mobility and e plan directed staff to have reach at all times, and to for assistance with activities of | | 1 Resident 27 call light was and staff ensured she was properly. Care Plan was rerevised as needed. 2 All residents have plans of must be followed by staff coresident. All residents will be call light usage and proper. Their care plans, profiles a lists will be updated as needed residents are reviewed by a their MDS assessment per care plans, profiles and NA are updated with any chang 3. The Care Plan Implement was reviewed and revised. Care Plans are readily avas staff providing direct care to Staff re educated on the Care plan intervent within reach for residents. 4 Observational Audits will to ensure the plans of care followed. A minimum of the becompleted weekly at valensure ongoing compliance months. Staff will be released ongoing basis on the result audits. The monitoring result reviewed at the Quarterly Care the team will make recommongoing monitoring. 5 Completion date is Octob 6 Persons responsible DOM Managers, Nurse Supervis | able to use it eviewed and of care which caring for the pereviewed for placement. Ind NAR group eded. Also all nursing during riod to ensure AR group lists ges. Intation Policy as necessary. Itable for all to the residents are Plan policy tion of call light be completed are being ree audits will prious times to the for three for three cated on an ants of these calls will be gap and the perevisions for t | |

| ` ' | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245458 | B. WING | | | 09/ ⁻ | 15/2016 |
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| F 282 | recliner. When ask was unable to find to reach the call light call light when she know what she wou R27's room was loo On 9/14/16, at 10:0 the call light for every go to the bathroom water, dropped son "Sometimes the ovican't reach someth "Sometimes I have because I put the light may call light be when I put the call I On 9/14/16, at 10:5 (NA)-A stated some often, usually to go or transfer into the stated sometimes Flight on if he felt she On 9/15/16, at 8:00 R27 should be able expect staff to mak light was within reach light within reac | the call light, R27 the call light, and then unable ht. R27 stated she used the needed something and did not all do if she did not have it. Cated at the end of the hall. 10 a.m. R27 stated she used erything; when she needed to if she wanted a drink of nething on the floor and, her bed table gets stuck and I ling." R27 further stated, to apologize to the staff ght on so much. I feel safe ecause I know they will come | F 2 | 282 | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION IG | | SURVEY PLETED |
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| | | 245458 | B. WING _ | | 09/1 | 15/2016 |
| | PROVIDER OR SUPPLIER A HEALTH VIRGINIA | CARE CENT | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 282 | | ge 11 vas requested and not | F 28 | 32 | | |
| F 309 SS=D | Each resident must provide the necessior maintain the high mental, and psychological accordance with the and plan of care. This REQUIREMENT by: Based on observative, the facility for positioning was proof 1 (R53) resident. Findings include: R53's Face Sheet is include cerebrovaschemiparesis (sever (paralysis on one signispecified abnormalication). | CARE/SERVICES FOR EING Treceive and the facility must ary care and services to attain nest practicable physical, isocial well-being, in a comprehensive assessment Output O | F 30 | 1 Resident 53 has had an OT eval to w/c positioning during meals and need for any adaptive equipment. Restorative Services has supplied a tray table that is the appropriate for him to have the proper position meals. 2 All residents will be reviewed to appropriate positioning during meal and when in their wheel chairs. All residents require w/c positioning assessments upon admit, quarterly annually, with any significant change condition and with the use of a new | I related d the 53 with height ing at ensure altimes y, ge in | 10/21/16 |
| | required supervisio lower extremity rangone side; and utilize | R53's cognition was intact; in with eating; had upper and ge of motion impairment on ed a wheelchair for mobility. | | and prn. 3 The policies and procedures wer reviewed and revised as appropria were reeducated on the policies ar procedures, including monitoring of appropriate positioning during meaning me | ite. Staff nd of | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION IG | | E SURVEY IPLETED |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 309 | 2/15/16, indicated of one staff for all with R53's meals a dated 2/15/16, inditransportation was R53's care plan daset up R53's meal independently. In a with his electric whextensive transfer R53's Device Asset indicated R53 utilizes mobility. This asset for positioning duri R53's Wheelchair for mobility. This asset for positioning duri R53's Wheelchair for mobility and the chair to the chair to the comparate the chair to the comparate the chair to the dining protector, the dining room. Reparallel to the circum (unaffected side) of distance from the to wheelchair was above the comparate with the comparate with the comparate with the comparate the chair was above the comparate the | and then R53 was able to eat addition, R53 was independent electric mobility after from staff. | F 30 | 4 At a minimum three observe will be completed weekly at recommendations for ongoin 5 Compliance date is Octobe 6 Responsible: DON, Nurse Nursing Supervisors | andom times appropriate s of audits QAPI team. g monitoring.er 21 2016 | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | NG | | MPLETED |
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| | | 245458 | B. WING | | 09 | 9/15/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 309 | setting. R53 took h watermelon pieces mouth. R53's cloth shoulder due to his right while eating. Follothing protector be shoulder. Each time his plate; he neede neck to the right. R pieces of red gelati bringing the spoone utilized the weighte which had spilled of then placed the gel p.m. R53's wheeler red gelatin and whir right outside side be wheel hub casing. On 9/14/16, at 8:35 motorized wheelch at the same circular position as noted at R53 was observed and neck to the right breakfast meal. R5 noted as he utilized watermelon pieces sandwich to his mobrought the egg sat the scrambled egg side of the sandwich protector or fell to the wheelchair and the and picked up the ponto his clothing protection. | ge 13 Jalize and reach his place his fork and stabbed the her then brought them to his ing protector fell off of his right having to twist and lean to the R53 was able to reposition his ack into place onto his right a R53 took items of food off of d to twist his upper torso and rought to the R53 was observed twice to spill an with whipped topping while ad gelatin to his mouth. R53 d spoon to pick up the gelatin into his clothing protector and atin into his mouth. At 5:30 hair was noted to have spots of oped topping spilled down the ear and onto the top of the right. Tam. R53 was seated in his air with a clothing protector on table and in the same bove on 9/12/16, at 5:16 p.m. having to twist his upper torso at to visualize and reach his 3's right hand had a tremor his fingers more to bring the and scrambled egg breakfast uth. Several times when R53 andwich to his mouth, pieces of spilled out of the back and h landing on his clothing he floor between his table. R53 utilized his fingers bieces of egg which had fallen rotector and put them into his oletion of breakfast, chunks of | F 3 | 09 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | | OMPLETED |
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| | PROVIDER OR SUPPLIER | CARE CENT | | STREET ADDRESS, CITY, STATE, ZIP COI 901 9TH STREET NORTH VIRGINIA, MN 55792 | DE . | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 309 | the table and where positioned. On 9/14/16, at 12:2 motorized wheelcha at the same circula position as noted at and 9/14/16, 8:35 a observations. Again twist his upper torso visualize and reach feed himself indeped (NA)-B set up his positioned onto his clothing protector. food onto his clothing before the bites of the completion of Repeaches, cottage of were noted on the finder where R53's wheeled on 9/12/16, at 5:30 way he did at the did table was too short the table. On 9/14/16, at 12:3 (RN)-D confirmed in positioned at an andid not allow R53 to alignment with his to R53's motorized with the dining room table of the tables they converted the table. RN and the table in R53 under the table. | e noted on the floor between e R53's wheelchair had been 5 p.m. R53 was seated in his air with a clothing protector on table and in the same pove on 9/12/16, 5:16 p.m. | F 3 | 09 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD E | 3E | (X5) COMPLETION DATE |
| F 309 | had tried other thing and that should be record. RN-D was a evaluated by occup wheelchair position confirmed R53 nee and neck to the right on 9/14/16, at 12:5 medical record lack attempts tried to act at the dining room to R53 had not been a positioning while earn of the rapy staff in the worked with physical therapy staff in the worked with him reddining room table. The tried other things sure R53 think any of the raised high enough under. R53 stated hate. R53's wheelch sauce and the sam and hub casing of and hub casing of and hub casing of the confirmed the staff thursday night. On 9/14/16, at 1:43 (OT)-A confirmed the staff thursday night. On 9/14/16, at 1:43 (OT)-A confirmed the diwith her clinical judg appropriate for R53 on and aligned with | ber. RN-D stated the facility gs like a TV tray type table, documented in R53's medical unsure if R53 had ever been ational therapy (OT) for ing while eating. RN-D ded to twist his upper torso at to reach his food. 5 p.m. RN-D confirmed R53's red documentation of any commodate R53's positioning able. RN-D also confirmed assessed for wheelchair | F3 | 09 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| 245458 | | B. WING | | 09/15/2016 | | |
| NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH VIRGINIA CARE CENT | | | 9 | STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH /IRGINIA, 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | OULD BE COMPLÉTION | |
| F 309 | (DON) stated she was high | ege 16 8 p.m. director of nursing was unsure if the facility had a gh enough to place R53's but a table could be obtained | F 309 | | | |
| F 314 SS=G | 9/15/16, indicated r positioning concern Referrals for wheel made to the physic needed. In addition | IENT/SVCS TO | F 314 | | 10/21/16 | |
| | resident, the facility who enters the faci does not develop p individual's clinical they were unavoida pressure sores received. | orehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection and from developing. | | | | |
| | by: Based on observative review, the facility for services were providevelopment of, an ulcers for 1 of 3 res | NT is not met as evidenced tion, interview, and document ailed to ensure care and ided to prevent the d worsening of pressure sidents (R41) reviewed for his resulted in actual harm for | | 1 R41 MD has been notified of pre sores and has evaluated her, Surgi has also seen her and has changed orders. No direct pressure to ulcer coccyx, assure silver Mepilex to ulc all times, F/U apt in two weeks. We | ical NP d on cer at | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245458 | B. WING | | | 09/15/2016 | |
| NAME OF PROVIDER OR SUPPLIER | | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| ESSENTIA HEALTH VIRGINIA CARE CENT | | | | | 01 9TH STREET NORTH 'IRGINIA, MN 55792 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRODEFICIENCY) | | BE | (X5) COMPLETION DATE |
| F 314 | pressure ulcers. Findings include: Pressure Ulcer State Pressure Ulcer Adv Stage II: Partial thic presenting as a sha pink wound bed, wi as an intact or oper Unstageable: Full the the base of the ulce tan, gray, green or brown or black) in t Suspected Deep Ti localized area of dis blood-filled blister of soft tissue from pre may be preceded b mushy, boggy, warra adjacent tissue. R41's face sheet pr diagnoses that incluvascular disease (be extremities), anemi in chronic kidney di insufficiency (decre the extremities), an region (triangular-si spine). R41's quarterly Min assessment dated moderate cognitive further indicated R4 staff for bed mobilit The MDS also iden incontinent of bowe indicated R41 was | ges according to the National risory Panel ckness loss of dermis allow open ulcer with a red thout slough. May also present n/ruptured serum-filled blister. hickness tissue loss in which er is covered by slough (yellow, brown) and/or eschar (tan, | F3 | 314 | update her sooner if needed. Heels now free floated, special boot on rig discontinued. Turning and reposition schedule has been reviewed and reduction in the cushion has been provided to help pressure and decrease pain. A signification change MDS has been scheduled. In plan has been reviewed and revise 2 All residents who currently have a pressure ulcer and/or are at a high pressure ulcers have the potential that affected by this deficient practice. A residents with pressure ulcers have reviewed to ensure implementation interventions, follow up and monitionare in place. 3 Policy and procedures related to pressure ulcer care and prevention been reviewed and revised. Key Nustaff are being sent for further eductional that the potential systems implemented in the EMR. educated on new systems. Weekly meetings scheduled with IDT. 4. Audits of all residents with currer pressure ulcers will be completed which are ulcers will be completed which are included and revised, reviewed with staff as needed, reviewed with staff as needed. 5 Completion date October 21 2016 Responsible person DON. Nurse | ght foot ning evised. ew w/c relieve nificant Care d. a risk for so be all e been of oring have arising sation. licies 6, oring Staff Skin evekly. re veek for will be ew with ill | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | ` ' | (X3) DATE SURVEY COMPLETED | |
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| | | 245458 | B. WING | | 90 | 09/15/2016 | |
| NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH VIRGINIA CARE CENT | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | (X5) COMPLETION DATE | | |
| F 314 | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | F 3 | Manager, Nurse Supervisor | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245458 | B. WING | | 09/ | 15/2016 | |
| NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH VIRGINIA CARE CENT | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLÉTION | | |
| F 314 | moist, granular applinterventions include for bed and chair, parents and the progressings to the progressings to the progress note date open area measuri coccyx had been in Event Report. The had received orders for a Mepilex dress days and as necessing on 8/21/16, a Physical nursing to apply a Nacral/coccyx ulcer and as necessary. nursing to refer R4 practitioner for a wounstageable presson 8/29/16, a Skin Report indicated R4 (area incorrectly ide increased in size to unstageable, 100% or white tissue that Interventions remains turning and reposition 8/30/16, a progression orders law the foot pulses, cap within normal limits | n) x 0.5 cm, with a shiny, rearrance of pink or red tissue. Ided a pressure reducing device pressure ulcer, along with pain related progress note ex (foam) dressing was ree practitioner was notified. A d 8/20/16, indicated a new ng 0.5 cm x 0.5 cm on the lentified, as noted on the Skin progress notes indicated R41 is from the nurse practitioner ing to be changed every 3 sary. ician Order Report directed Mepilex (foam) dressing to and change it every 3 days An order of 9/6/16, directed 1 to a wound care nurse ound consult of the ure ulcer to the buttock. The coked orders for treatment to ure ulcer. Integrity Pressure Sore Event 41's left buttock pressure ulcer entified by the facility) had 1.4 cm x 0.6 cm and was a covered with slough (yellow adheres to the ulcer bed). In the same in addition to a oning program. The same in addition to a oning program. The same in addition to a oning program. | F 314 | 4 | | | |
| | buttock pressure ul | cer (area incorrectly identified larger and measured 3 cm x | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTII A. BUILDIN | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 245458 | B. WING | | 09 | /15/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT | | STREET ADDRESS, CITY, STATE, ZIP C 901 9TH STREET NORTH VIRGINIA, MN 55792 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 314 | the center. Yellowis was noted. The ph notified on that Tue On 9/6/16, a nutriti dietary tech was not pressure ulcer on tidentified by the fact and decreased into notified that the reginitiated Mighty Shanote indicated R41 and would be moniprogress note indicated R41 and would be moniprogress note indicated R41 month and had be supplements. The documentation of tright outer foot. A r 9/13/16, indicated without identifying fulcer. On 9/7/16, a Skin I Report indicated Funstageable press 1.1 cm, and was condeptissue injury. a heel Medix boot on the heel) on the was not notified. On 9/7/16, a Skin I Report indicated Rulcer (area incorrect increased in size to surrounding redness The pressure ulcer covered with sloug | m x 1.5 cm slough/eschar in sh drainage with a foul odor ysician's assistant was to be | F 31 | 4 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245458 | B. WING | | | 09/1 | 5/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT | | STREET ADDRESS, CITY 901 9TH STREET NOR' VIRGINIA, MN 55792 | тн | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH CORREC | PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 314 | with the addition of intervention to man indicated a geo ma an appointment wa nurse practitioner. On 9/11/16, a Tissutest which helps de resident's skin toler area) indicated R41 coccyx (tail bone) a immediately with of to an area) in bed a On 9/11/16, a Skin Scale (an assessm determining a residindicated R41 was breakdown. R41's sidentified risk factor issues and history cindicated R41 had a coccyx, and had sli which indicates poson the right heel, arright foot. On 9/12/16, a nursinote lacked documulcers. On 9/13/16, an officindicated R41 was practitioner (NP) fo buttock. The NP do was painful to R41, taking protein supp documented the woold of t | a nutrition or hydration age skin problems. Measures t was applied to the bed and s made with a wound care Te Tolerance Assessment (a termine time period the ates continued pressure to an had an initial redness of the and buttocks which dissipated floading (relieveing pressure | F 3 | 14 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | TIPLE CONSTRUCTION ING | | ATE SURVEY OMPLETED |
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| | | 245458 | B. WING | | 0 | 9/15/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT | | STREET ADDRESS, CITY, STATE, ZIP 901 9TH STREET NORTH VIRGINIA, MN 55792 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE |
| F 314 | needed. R41 was to every 1-2 hours as will likely worsened the wound area." To documentation regarder. On 9/14/16, a Skin Sore Event Report pressure ulcer had 1.4 cm with the surface with the surface with the pressure sore word to the pressure ulcer had drainage. The intermediate the contained slough, was unstageable. The pressure ulcer had drainage. The intermediate the contained slough, was unstageable. The report lacked of ulcer on the right of On 9/14/16, at 9:25 and RN-C entered check. R41 was lying and RN-C turned R41's right coccyx appendict of serous documents around it. The report lacked with slough redness around it. The amount of serous documents around it. The serous documents around the scabbed area on the RN-D measured the was 0.4 cm x 0.4 cm protector to R41's right and a geofoam over | "this wound will not heal and (sic) if pressure is not kept off the NP note lacked arding the right foot pressure. Integrity Pressure Sore Event indicated R41's coccyx increased in size to 2.7 cm x rounding redness measuring the documentation indicated was a Stage 2, though it which would indicate the ulcer the report indicated the a scant amount of clear ventions remained the same. | F 3 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245458 | B. WING | | - 09 | /15/2016 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STAT 901 9TH STREET NORTH VIRGINIA, MN 55792 | · | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | X (EACH CORRECTIVE CROSS-REFERENCED | N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE LIENCY) | (X5) COMPLETION DATE | |
| F 314 | verified there was indicating R41 had outside of her right had mistakenly with escabbed area On 9/14/16, at 1:3 pressure ulcers doweeks ago. RN-D drainage on the dithe dressing. R41 care nurse practitinew dressing put R41's pain is man medication) patch is repositioned evand stated R41 is denied seeing a pfoot. RN-D was urulcer on the right on 9/15/16, at 8:4 stated R41 had ar ared area on her she got her new nmattress was put stated R41 had a receiving the new On 9/15/16, at 9:2 had skin breakdorepositioned every Food and fluid into was to be promptly incontinence, line wrinkles, and staff signs of breakdow pressure relieving got the new geofo stated initially after | Following the procedure, RN-D documentation on 9/7/16, d a pressure ulcer on the t foot. RN-D thought the nurse itten right outer foot but meant on R41's right great toe. 1 p.m. RN-D verified R41's eveloped at the facility about 3 stated there was little to no ressing, so he did not change had been seen by the wound oner the previous day, so had a on at that time. RN-D stated aged with a Fentanyl (narcotic and Tylenol. RN-D verified R41 ery 2 hours and as necessary, compliant with that. RN-D ressure ulcer on the right outer naware R41 had a pressure foot. 2 a.m. nursing assistant (NA)-E n open area on her bottom and foot, which has improved since nattress. NA-E stated R41's on her bed last week. NA-E regular mattress prior to | F3 | 314 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245458 | B. WING | | | 09/ ⁻ | 15/2016 |
| | PROVIDER OR SUPPLIER | | | 901 | REET ADDRESS, CITY, STATE, ZIP CODE 9TH STREET NORTH RGINIA, MN 55792 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 314 | breakdown and sta on 9/6/16. RN-D st interventions and it dietary, and verifier not notified until 9/1 noted to have a profession on 9/7/16. On 9/15/16, at 10: (DON) verified R4-ulcers and had risk breakdown. The D received Mighty St though had been or repositioned every a Mepilex dressing mattress was put of dietary should have DON stated they hand the dietary technical the dietician could stated R41 was on previously and on put on R41's bed. heel protector and the heel. The DON occupational thera positioning. On 9/15/16, at 1:33 wound check of R4 request. RN-D remand stated R41's hogginess. RN-D le R41's right outer for measured it. The pwithout drainage. Fulcer and replaced | age 24 Iti-vitamin prior to skin arted receiving Mighty Shakes rated nursing starts f they don't work out, they notify d the dietary department was 6/16. RN-D verified R41 was ressure ulcer of the right outer a.m. the director of nursing a had developed pressure a factors prior to skin ON stated R41 had not makes prior to skin breakdown, on a multi-vitamin and had been a to 3 hours. The DON stated a was initiated and a new on her bed. The DON verified re been notified right away. The ad a new consultant dietician h was on vacation, though the mitiated the Mighty Shakes, and have been called. The DON a pressure reducing mattress 9/9/16, a geo-foam overlay was The DON stated R41 wears a hadn't had any breakdown of a verified R41 has not had py assessments for a p.m. RN-D went to do a 41's right foot upon surveyor's noved R41's right heel protector leel was normal and without ocated the pressure ulcer on not without a dressing on it and one survey following the pressure R41's foot back in the heel in interview following the | F3 | 14 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER A HEALTH VIRGINIA | CARE CENT | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY) | D BE | (X5) COMPLETION DATE |
| F 314 | cm x 0.8 cm with the it measuring 1.0 cm not warm to touch a stated it was a deep was unstageable du area. RN-D verified caused by pressure verified he did not the been notified of the foot. RN-D stated a filled out so the NP day. Despite the increas on the coccyx, the fipromote the healing failed to reassess to the pressure ulcer of the facility policy at Monitoring/Assessing/10, directed the Rimpaired skin and minitiate a "Weekly Streatment. The policy primary physician of implement the skin directed a tissue told residents upon admitted positioning and/or signotify nutritional services." | atted the open area was 0.7 e blanchable redness around a x 1.0 cm. RN-D stated it was and had no drainage. RN-D tissue injury and decided it use to some eschar in the open the pressure ulcer could be from the boot. RN-D also hink the nurse practitioner had pressure ulcer on R41's right in acute care form would be would look at the following e in size of the pressure ulcer acility failed to reassess to go fithe pressure ulcer, and prevent the development of on the right foot. In a procedure for Skin ment/Documentation revised and procedure for Skin nent/Documentation revised and protocol. The RN was to kin Monitor and appropriate by directed the RN to notify the f skin integrity changes and protocol. The policy further erance to be completed on all hission and with any change in the integrity. Nursing was to vices, restorative services and interdisciplinary team) | F 3 | | | 10/21/16 |
| SS=D | HAZARDS/SUPER The facility must en environment remain | | Γ 32 | | | 10/21/10 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | LE CONSTRUCTION (| (X3) DATE SURVEY COMPLETED | | |
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| | | 245458 | B. WING | | 09/1 | 5/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT | 9 | STREET ADDRESS, CITY, STATE, ZIP CODE 101 9TH STREET NORTH /IRGINIA, MN 55792 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| | adequate supervisi prevent accidents. This REQUIREMED by: Based on observareview, the facility for mattress to decreate of 3 residents (R78) Findings include: R78's face sheet prevents and supervised the supervised for t | on and assistance devices to NT is not met as evidenced tion, interview, and document ailed to provide an appropriate se the risk for entrapment for 1) reviewed for accidents. | F 323 | 1 Resident 78 had been provided a new appropriate mattress to decrease risk for entrapment. R 78 discharged from facilit on 10/3. 2 All residents could be at risk of entrapment if mattress is not appropriate length. All residents currently in the facilit have had their beds evaluated to ensure the mattress was appropriate length to | | |
| | 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 | | | decrease risk of entrapment. 3 All residents will have mattress assessed upon admit and with any change of mattress or bed to ensure appropriate. 4 The device policy was revised and new procedure put into place to ensure resident safety. Staff were reeducate the policies and procedures. New equipment was obtained. 5 At a minimum three observational per week will completed for a minim 3 months to ensure compliance. Resof audits will be reviewed at quarterly QAPI meeting and ongoing monitori be at the recommendation of the QA team. 5 Completion October 21 2016 6 Responsible persons: DON, Nurse Managers, Nurse Supervisors | e it is I a ure ed on audits um of sults y ng will | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION NG | _ | (X3) DATE SURVEY COMPLETED | |
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| | | 245458 | B. WING | | | 09/ | 15/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT | | STREET ADDRESS, CITY, ST 901 9TH STREET NORTH VIRGINIA, MN 55792 | FATE, ZIP CODE | | |
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| F 323 | revised 7/8/16, indichad a history of fallinon-weight-bearing and received high-rected to keep he times, keep frequer keep room free from the bathroom and to R78 to ask for assist and to ensure she care plan indicated regular height so Richard he | cated R78 was at risk for falls, s with a left hip fracture, was a had episodes of confusion, risk medications. Staff were r call light within reach at all ntly used items within reach, m clutter and a clear path to o closet. Staff were to remind stance with ADLs as needed wore nonskid footwear. R78's R78's bed was to be kept at a 78 could rise from the bed with r, and indicated R78 required one for bed mobility, and R78 In addition, R78 required total ff for transfers with a lift. 19 p.m. the space between the top of the mattress on R78's e greater than 4 3/4 inches. 19 p.m. registered nurse (RN)-E that it was the wrong mattress 78's bed. RN-E verified the entrapment risk for R78, as nobile and needed assistance 10 p.m. RN-E measured the ne mattress and the large. DON verified the facility sessment process in place for nis time. DON stated they remainder of the beds in the the mattress if needed. | | 23 | | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245458 | B. WING | | 09/ | 15/2016 | |
| | PROVIDER OR SUPPLIER A HEALTH VIRGINIA | CARE CENT | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792 | | | |
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| F 323 | | a.m. RN-D verified there no e fit of the mattress on the bed | F 3 | 23 | | | |
| F 334 SS=E | The facility policy ardated 9/8/14, direct restorative to evaluate were the appropriate not be at risk for en mattress, mattress worked on the bed. | and procedure for Bed Safety ed nursing staff and ate mattresses to ensure they e length so the resident would trapment with any changes in type or after maintenance has | F 3 | 34 | | 10/21/16 | |
| | that ensure that (i) Before offering the each resident, or the representative recebenefits and potential immunization; (ii) Each resident is immunization October annually, unless the contraindicated or t | offered an influenza per 1 through March 31 immunization is medically he resident has already been his time period; | | | | | |

| - | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION ING | (XS | B) DATE SURVEY COMPLETED |
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| | | 245458 | B. WING | | | 09/15/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT | • | STREET ADDRESS, CITY, STATE, ZI 901 9TH STREET NORTH VIRGINIA, MN 55792 | P CODE | 2 2 2 2 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFII TAG | | ION SHOULD BE HE APPROPRIAT | |
| F 334 | influenza immuniza influenza immuniza influenza immuniza contraindications or The facility must de that ensure that (i) Before offering the immunization, each legal representative the benefits and poimmunization; (ii) Each resident is immunization, unless medically contraind already been immu (iii) The resident or representative has immunization; and (iv) The resident's redocumentation that following: (A) That the resident representative was the benefits and popneumococcal immunication or (v) As an alternative and practitioner reconneumococcal immunication, unless following the immunization, unless immunization, unless immunization. | tion or did not receive the tion due to medical refusal. velop policies and procedures me pneumococcal resident, or the resident's receives education regarding tential side effects of the offered a pneumococcal state immunization is icated or the resident has nized; the resident's legal the opportunity to refuse medical record includes indicated, at a minimum, the ent or resident's legal provided education regarding tential side effects of munization; and ent either received the munization or did not receive mmunization due to medical refusal. e, based on an assessment ommendation, a second munization may be given after 5 first pneumococcal is medically contraindicated or resident's legal representative | | 334 | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | . , | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 334 | Continued From pa | ge 30 | F 334 | ı | | |
| | by: Based on interview facility failed to adm pneumococcal vace (R95, R40, R1, R68 reviewed for immure Findings include: CDC recommendator or older who have mand who have previous of PPSV23 [vaccine 23] should dose of PCV13 should dose of P | tions: Adults 65 years of age not previously received PCV13 iously received one or more pneumococcal polysaccharide receive a dose of PCV13. The buld be administered at least most recent PPSV23 dose. Its were reviewed for five andomly from the facility reports indicted 5 of 5 eccived pneumococcal enter for Disease Control ations (R95, R40, R1, R68, andicated R95 was admitted on ears old, and had diagnoses tension and atrial fibrillation. The product of the product o | | 1 R 95,40,1, 68, 23, 92 Education potential risks and benefits of vacc (VIS) was provided to representati consent obtained and Pneumovax been administered. R 99,11,137 and deceased. 2 All residents have the potential from area. All residents or their Representatives have been sent of informational letters with VIS and offorms included. Consents or refusible documented in the residents reduced to the process of the Influenza and Pneumococca vaccination policy was reviewed and revised as necessary. All nursing severe reeducated on the process of offering the Pneumococcal and infivaccines and providing information the potential risks and benefits of the vaccine. Informational flyers and a consent form are a part of the Administration of the process of the Administration of the process of the Administration of Pneumococcal and Influenza Vaccine per CDC recommendations. Three Random audits will be completed each were ensure ongoing compliance. The monitoring results will be reviewed the quarterly QAPI team, the QAPI team team team team team team team team | cine ves and have re or be or this ut consent als will cord. I nd staff f luenza n about he nission or that is nas ne / to nd chart k to with | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245458 | B. WING | | | 09/ | 15/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT | | 90 | TREET ADDRESS, CITY, STATE, ZIP CODE 01 9TH STREET NORTH (IRGINIA, MN 55792 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | X | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 334 | 9/23/15, was 84 yethat included demeweakness. R40's qlacked information pneumococcal vacrecord lacked docuimmunization status provided by the factoriological status provided chronical disease, and a historiological status provided chronical status provided that the factoriological status provided that the factoriological status provided status provided status, however and sheet received from the factoriological status provided status provide | ars old, and had diagnoses ntia, hypertension, and uarterly MDS dated 6/23/16, regarding R40's cination status. R40's medical mentation of pneumococcal s, and a MIIC report was not ility. icated R1 was admitted on ars old, and had diagnoses ic pain, atherosclerotic heart ory of bronchitis. R1's quarterly s, indicated R1's cinations were up to date. R1's cinations were up to date. R1's ction Summary Report indicted e Pneumovax 23 on 10/7/97, dicated R68 was admitted on rs old, and had diagnoses that hypertension, and a history of arterly MDS dated 7/7/16, eumococcal vaccinations were nedical record lacked oneumococcal immunization undated handwritten note in the facility on 9/14/16, received the Pneumovax 23 | F3 | 34 | will make recommendations for one monitoring. 5 Completion date October 21 201 6 Persons responsible DON, Infect Nurse, Nurse Mangers, Nurse Supervisors | 6 | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION NG | | E SURVEY MPLETED |
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| | | 245458 | B. WING | | 09 | /15/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINTED DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| F 334 | last year (R92, R99 R92's face sheet in 6/22/15, was 82 year that included stomar failure, chronic obstand pneumonia. R93/22/16, indicated Fimmunizations were Discharge Summar R92 had been hosp failure with hypoxer lower lobe. R92 was facility to receive or R92's medical record pneumococcal imm facility provided a h R92 had received Fand PPSV23 on 6/8 R99's face sheet in 9/17/15, was 75 year included weakness pulmonary disease supplemental oxyge and pneumonia. R9 dated 7/29/16, indic vaccinations were coprevious MDS, a quency R99's pneumococci date. R99's Emerge 2/18/16, diagnosed respiratory infection lower lobes due to a medical record lack | nosed with pneumonia in the , R11, R137) were reviewed. dicated R92 was admitted on ars old, and had diagnoses uch cancer, congestive heart tructive pulmonary disease 02's quarterly MDS dated R92's pneumococcal e up to date. A Hospital ry dated 6/24/16, indicated bitalized with acute respiratory mia and pneumonia of right is discharged back to the all and intravenous antibiotics. It is discharged to the and written list that indicated Prevnar 13 (PCV13) on 3/6/15, | F 3 | 34 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDII | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 245458 | B. WING _ | | 09 | /15/2016 |
| | PROVIDER OR SUPPLIER IA HEALTH VIRGINIA | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792 | | , 10, 2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRESTIVE ACTION SHOUTH CORRESTIVE ACTION SHOUTH CORRESTIVE ACTION SHOUTH CORRECTIVE ACTION OF THE APPORT OF TH | OULD BE | (X5) COMPLETION DATE |
| F 334 | facility provided a had received pneubut it did not indicated provided at received pneubut it did not indicated provider was going pneumonia. An unMantoux record indicated pneumococcal vaciations assessment." A redated 10/30/15, indicated provider was going pneumonia. The pneumonia. | mandwritten list indicating R99 mococcal vaccine on 9/25/05, ate what type of vaccination. Indicated R11 was admitted on ears old, with diagnoses that llation and heart failure. R11's ed 5/3/16, indicated that R11's coinations were up to date. On ray indicated "subtle bilateral space opacities suggestive of atelectasis." The physician's note dated 4/26/16, indicated pitalized for pneumonia from 5. R11's medical record lacked the pneumococcal is however, the facility provided andicating R11 had received the on on 1/1/86, and 11/3/96. Indicated R137 was admitted ears old, and had diagnoses nson's disease, asthma and dated Resident vaccination and dicated R137 had received a coination in 2009, and the | F 3: | 34 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION IG | | E SURVEY IPLETED | |
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| | | 245458 | B. WING _ | | 09/ | 15/2016 | |
| | PROVIDER OR SUPPLIER | CARE CENT | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792 | O9/15/201 ATE, ZIP CODE AN OF CORRECTION OF ACTION SHOULD BE COMPLED TO THE APPROPRIATE OAT | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE | |
| F 334 | immediate cause list CDC recommendate vaccines include: o Prevnar 13) is reco 65 or older who've vaccine. A dose of Pneumovax 23) she later. For adults 65 already received or the dose of PCV13 year after receiving PPSV23. | ge 34 d on 4/20/16, with the sted as pneumonia. iions for pneumococcal ne dose of PCV13 (also called mmended for all adults aged not previously received the PPSV23 (also called ould be given at least one year years or older who have ne or more doses of PPSV23, should be given at least one the most recent dose of a.m. registered nurse (RN)-B | F 33 | 34 | | | |
| F 371 SS=F | stated the old policy the facility was usin aware there were no but they were confusion and they were confusion but they were confusion but they were confusion but they were confusion by the facility of the facility must of the facility mus | y (revised 2004) was the one g. RN-B stated they were ew CDC recommendations, using and had not yet been a.m. the director of nursing neumococcal vaccinations d and offered if not up to date ours after admission. The have been overlooked and DON stated they knew they neumococcal immunizations]. ROCURE, //SERVE - SANITARY om sources approved or tory by Federal, State or local distribute and serve food | F 37 | 1 | | 10/21/16 | |

| | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (XD) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUC | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245458 | B. WING | | 09/1 | 5/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT | 9 | STREET ADDRESS, CITY, STATE, ZIP CODE 101 9TH STREET NORTH /IRGINIA, MN 55792 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 371 | Continued From pa | ge 35 | F 371 | | | |
| | by: Based on observate review, the facility fare and the malt blender to prevent food-bore potential to affect a food served from the Findings include: On 9/12/16, at 11:2 observed to have greated to have | 9 a.m. the meat slicer was reasy debris on the bottom under the guide/guard. The M) verified the meat slicer had and was ready for use. The DM the debris and verified it was the malt blender had a white the blending unit. DM verified, be cleaned. p.m. the meat slicer had been sy debris. The malt blender at the top of the blending e findings and removed the cleaned. and procedure for Proper tring of Equipment dated etary staff to clean the meat e and to clean the blade of directed the mixer was to be | | 1. Meat slicer was cleaned properl malt blender was taken out of use. 2. All residents have the potential to placed at risk by deficient practice. 3. All Kitchen staff were reeducated proper cleaning of equipment. Polic and procedures were reviewed and revised. 4. Observational audits will be comat a minimum of 3 times a week on random shifts by Dietary Superviso ensure food prep equipment is cleas anitary for 3 months. Results of the audits will be reviewed at the quarted QAPI meeting. The QAPI Team will recommendations for ongoing mon 5. Completion date is October 21 2 6. Persons responsible Dietary Man Dietary Supervisors | b be don cies pleted rs to un and e erly make itoring. | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | MPLETED |
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| | | 245458 | B. WING | | 09 | 9/15/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 431 F 431 SS=E | 483.60(b), (d), (e) ILABEL/STORE DR The facility must en a licensed pharmacof records of receip controlled drugs in accurate reconciliar records are in orde controlled drugs is reconciled. Drugs and biological labeled in accordar professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartment controls, and perminance access to the The facility must professional princip controls, and perminance access to the The facility must professional princip appropriate access to the control of the facility must store a locked compartment controls, and perminance access to the The facility must professional princip acceptance access to the Control of the facility must professional principal drugs list comprehensive Drugontrol Act of 1976 abuse, except when package drug districts. | DRUG RECORDS, UGS & BIOLOGICALS Inploy or obtain the services of cist who establishes a system and disposition of all sufficient detail to enable and tion; and determines that drug and that an account of all maintained and periodically als used in the facility must be not with currently accepted oles, and include the ory and cautionary expiration date when State and Federal laws, the all drugs and biologicals in the sunder proper temperature to only authorized personnel to keys. Ovide separately locked, a compartments for storage of the died in Schedule II of the ug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the linimal and a missing dose can | F4 F4 | | | 10/21/16 |
| | This REQUIREMENT by: | NT is not met as evidenced | | | | |

| | | | (X3) DATE COMF | SURVEY PLETED | | |
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| | | 245458 | B. WING | | 09/1 | 5/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT | 9 | STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 431 | review, the facility | age 37 tion, interview, and document failed to ensure storage and of patches (which needed to be | F 431 | 1 There were no residents affecte deficient action | | |
| | | intained on 2 of 2 units (3rd | | 2 The policy and procedure was reand revised to ensure storage and security of Fentanyl patches is main the facility. 3 The policy and procedure for ren | ntained | |
| | On 9/12/16, at 4:02 (LPN)-A completed pass for resident (I and placement of a narcotic medicated skin to deliver a sp R16's Fentanyl pat narcotic drawer in reconciled the num the package for R1 narcotic log book. "verified" section o R16's Fentanyl pat placed LPN-A's init LPN-A stated the copatches needed to because the other would dispose of the container in the medical pass of the container in the medical pass of the container in the pass o | 2 p.m. licensed practical nurse I a medication administration R16) which included removal a Fentanyl transdermal patch (a ladhesive patch placed on the ecific dose). LPN-A obtained ch from a double locked the medication cart. LPN-A obtained che from a double locked the medication cart. LPN-A obtained che recorded this in the LPN-A recorded under the find the narcotic log book for che "disposed of old patch" and the filliage of the Fentanyl be dual witnessed and nurse wasn't close by, LPN-A ne Fentanyl patch later in a edication room. LPN-A donned | | storage and security was reviewed staff. Upon removal of a Fentanyl from a resident it is to be placed in narcotic drawer of the medication of until it can be properly disposed of black box in the medication room. soon as the second nurse is availated within 2 hours at the latest) the patch be placed in the black box and the nurses will cosign of its disposal in narcotic record for that individual rooms. The black box is kept in a locked of in the medication room and the black is in a locked cage. Once it is almost the nurse will notify the EV Superventhis designee that it needs to be rear the nurse will then press the yellow down, so it is tamper resistant. The janitor will then come up to the medication room, both the janitor as | with patch in the part in the As able (ch will 2 the esident. abinet above to the patch with the esident. The patch box patch | |
| | a pair of gloves and Fentanyl patch whith front shoulder and which LPN-A had constructed shoulder. LPN-A resulted R16's medication cart location cart location. LPN-A place just removed in a cart location cart location cart location. | d proceeded to remove R16's ch was located on R16's left placed the new Fentanyl patch lated 9/12/16, on R16's left emoved the glove on her right room and went directly to the lated in the doorway of R16's left the Fentanyl patch she had elear unmarked medication medication cart and placed the ledication cup in the top drawer last. LPN-A removed the glove | | nurse will cosign that the black box exchanged hands and the janitor wit for proper disposal. 4 Observational audits will be com to ensure Fentanyl patches are restored and kept secured. A minimula audit will be done weekly for three months, the results will be reviewe staff on an ongoing basis. The rest these audits will be reported to the quarterly QAPI team. The QAPI teams and the properties of the properties of the part of the pa | c has vill take pleted moved, um of 3 d with ults of | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245458 | B. WING | | | 09/ ⁻ | 15/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT | | 9 | TREET ADDRESS, CITY, STATE, ZIP CODE 01 9TH STREET NORTH VIRGINIA, MN 55792 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 431 | again stated she w Fentanyl patch with On 9/12/16, at 4:40 disposal of R16's rewouldn't be destroy 10:30 p.m. LPN-A practice for disposathis time, registered were observed seadirectly down the homeon passing medion on 9/13/16, at 4:31 remove and apply LPN-B obtained the double locked narrocart. LPN-B cut the packaging sleeve a patch. LPN-B enter to remove and place refused to have LP patch or place the stated she would reproceeded to place packaging sleeve a medication cart natused Fentanyl patch witnessed with anothe black box in the On 9/13/16, at 6:02 been able to place they had saved it to process. LPN-B ob Fentanyl patch from drawer in the media | and washed her hands. LPN-A ould dispose of the used an another nurse later. D. p.m. LPN-A confirmed the emoved Fentanyl patch yed until shift change around verified this was the routine all of the Fentanyl patches. At did nurse (RN)-B and RN-C atted at the nursing station allway from where LPN-A had ideations. D. p.m. LPN-B attempted to a new Fentanyl patch on R95. The Fentanyl patch from the exitic drawer in the medication are very top of the Fentanyl and wrote 9/13 on the Fentanyl are a new Fentanyl patch. LPN-B e-approach R95 later and the new Fentanyl patch in the and double locked it in the rectic drawer. LPN-B stated the thes needed to be dual other nurse and disposed of in | F 4 | 31 | monitoring. 5 Completion date. October 21 201 6 Responsible persons: DON, Nurse Managers, Nurse Supervisors | 6 | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | ONSTRUCTION | ` ' | E SURVEY IPLETED |
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| | | 245458 | B. WING | | | 09/· | 15/2016 |
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| F 431 | a wire holder that we cupboard door. The waste container set LPN-B placed the ublack biohazardous RN-F co-signed in indicated the disposance LPN-B and RN-F co-cupboard had a loc cupboard, however On 9/13/16, at 6:20 process for destroy two nurses witness patch. This was con (around 10:30 p.m. the two LPN's who stated she kept the needed to be disposance the top drawer of the confirmed this draw LPN-C confirmed so of R16's Fentanyl pon 9/12/16, around p.m. on 9/12/16. On 9/14/16, at 2:06 Fentanyl patches which all R1 is access which all R1 is anitors, and nursin LPN-D thought the | unlocked cupboard which had vas secured to the inside ere was a black biohazardous cured in the wire holder. used Fentanyl patch in the container and LPN-B and the narcotic book which sal of R95's Fentanyl patch. onfirmed the door to the k on the outside of the the cupboard was not locked. I. p.m. LPN-C confirmed the ing Fentanyl patches included ed the disposal of the Fentanyl mpleted at the end of the shift and usually completed with were ending their shift. LPN-C Fentanyl patches which sed of at the end of the shift in the medication cart. LPN-C ver was not double locked. The had witnessed the disposal match that had been removed 4:00 p.m. with LPN-A at 10:30 | F 4 | 31 | | | |

| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE | | COMPLETED | | | |
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| | | 245458 | B. WING _ | | 09 | /15/2016 |
| | ESSENTIA HEALTH VIRGINIA CARE CENT (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 431 Continued From page 40 requested. On 9/15/16, at 10:20 a.m. environmental service 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 | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792 | · | |
| PRÉFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 431 | requested. On 9/15/16, at 10:2 director (ESD) state biohazard boxes wipatches from the second of the used Fedrawer of the mediathe shift when the transcotic count, they biohazard bin in the nurses sign the nartop drawer of the mediathe shift when the transcotic count, they biohazard bin in the nurses sign the nartop drawer of the mediathe shift when the transcotic count, they biohazard bin in the nurses sign the nartop drawer of the mediathe sign that the sign that the sign that the sign that the patches with the patches as if to potential to receive DON confirmed that the sign that the sign that the patches as if to potential to receive DON confirmed that the sign | 20 a.m. environmental services and the janitors picked up the hich contained the Fentanyl colled utility rooms on the units. 4 p.m. LPN-E confirmed she entanyl patches into the top cation cart, and at the end of two nursing staff conduct a dispose of the patch in the emedication room. Each of the rootic log. LPN-E confirmed the redication cart was not a partment. 7 p.m. RN-D confirmed the removal and replacement of the removal and replacement of the removal and that was removed would be awer of the medication cart shift and at that time would be nursing staff. | | 1 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | IPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
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| | PROVIDER OR SUPPLIER | CARE CENT | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792 | | , |
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| F 431 | was her expectatio were disposed of ir of the patch and du LPN. If for some renot be immediately should be double to the medication cart the potential for divpatches where not hours after they had the cupboard in the stored the black bid as the contents of the narcotics and the fanarcotics to be douverified the filled black bid. | diately disposed. However, it in that the Fentanyl patches inmediately following removal all witnessed by an RN and/or ason the Fentanyl patch could disposed of, the used patch ocked in the narcotic drawer of an DON confirmed there was tersion when the Fentanyl disposed of for five to six in disposed of for five to six in disposed of the bear removed. DON verified is medication room which chazard bins should be locked the bins were considered to be accility policy was for all ble locked. In addition, DON ack biohazard containers in the soiled utility room for pick | F 43 | 31 | | |
| | confirmed the filled should not be place pick up. In addition the Fentanyl patch destroyed should not be facility Fentanyl dated 4/15/13, directly and two nurses must he narcotic book with black box in the lacked a time frame removal of the patch witnessed and place. Narcotic Monitoring dated 4/28/14, indicated should be placed to the patch witnessed and placed to the patch witnessed to the patch witnes | B p.m. the administrator black biohazard containers ed in the soiled utility room for the time from the removal of to when it was witnessed to be ot be five to six hours. If Patch Procedure policy cated staff to remove the patch, est co-sign the destruction in with the patch being placed in the medication room. Policy the of what was acceptable from the to when it should be the din the black box. If and Accountability policy cated all narcotics were kept drawers of the medication carts | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | ` ' | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 245458 | B. WING | | 09/15/2016 | |
| | PROVIDER OR SUPPLIER | CARE CENT | 9 | STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLÉTION | |
| F 431 F 465 SS=E | or the medication rollocked when not su 483.70(h) | oom, and both must be double | F 431 | | 10/21/16 | |
| | The facility must pro | ovide a safe, functional, ortable environment for the public. | | | | |
| | by: Based on observat review, the facility fand homelike envirom (Rooms 307, Findings include: On 9/15/16, 9:45 a. tour, the manager of services (FM) verififindings: Room 307: the bath wall at the entrance gouged area that we inches in size. Room 314: the side the window was so substance. Room 317: the dood deep gouges. The labathroom door was | ion, interview and document ailed to maintain a safe, clean onment in 6 of 35 resident 314, 317, 323, 326, 402). m. during an environmental of facilities and environmental ed the following environmental ed the bathroom had a as approximately 1 foot x 2 erail on the side of the bed by led with a dark colored sticky r frame to the bathroom had ower outer corner of the chipped and missing hes x 3 inches making it a | | 1 Rooms, 307, 314, 317, 323, 326 402. Have been cleaned, repaired a painted. Work orders were complete all rooms that needed repair. 2 All residents have the potential to affected by the deficient practice. The Housekeeping Supervisor or designed a walk through of each resident to audit other areas for cleanliness repair prior to 10/21/16. Work order be completed on all areas with the rof cleaning or repair. 3 Housekeepers do a daily checklis areas that are in need of repair in the areas. When a need is noted, they a place an online work order. The Maintenance Dept. gets the work or and completes repairs based on pri All staff are to report if there is a maintenance concern. Staff have be educated on the online process for completing work. 4 Observational audits will be comp weekly on at a minimum 3 random to by EVS Supervisor or designee to entered the | and ed in be ne nee will room and s will need t of neir are to der orities. een | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245458 | B. WING | | | 09/ | 15/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT | | 9 | TREET ADDRESS, CITY, STATE, ZIP CODE 01 9TH STREET NORTH 'IRGINIA, MN 55792 | , 00, | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 465 | rough and uncleana Room 323: had a b non-skid strips on the toilet and the tile brown color. The do badly gouged approfiloor. Room 326: a storage brown rust along the Room 402: in the be the base of the toile space had dirt in it. back of the seat and of the riser. During the tour the washed when the be know how often the done last. When roo bathroom cabinets There was not a pla The FM stated the filth that any staff could needed cleaning or routine maintenanc scheduled equipme The facility's Mainte dated 2/15, indicate requested using the Only tenants that do | _ | F 4 | 165 | rooms are clean and well maintaine Results will be reviewed by the quexistry QAPI team and recommendations made for ongoing audits. Policy an Procedure for maintenance and cleof rooms is in place. 5 Completion date October 21 201 6 Persons Responsible: EVS Supermaintenance Supervisor, ES Management of the procedure for maintenance for maintenance and cleof rooms is in place. | arterly will be d eaning 6 ervisor, | |

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PRINTED: 10/17/2016 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' | CONSTRUCTION - MAIN BUILDING 01 | | TE SURVEY MPLETED |
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| | | 245458 | B. WING | | 09 | /14/2016 |
| | PROVIDER OR SUPPLIER A HEALTH VIRGINIA | CARE CENT | 901 | REET ADDRESS, CITY, STATE, ZIP O 9TH STREET NORTH RGINIA, MN 55792 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE |
| K 000 | INITIAL COMMEN | TS | K 000 | | | |
| | FIRE SAFETY | | | | | |
| | ALLEGATION OF DEPARTMENT'S A SIGNATURE AT TI | POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST 1S-2567 WILL BE USED AS F COMPLIANCE. | | | | |
| | ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA | OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN VITH YOUR VERIFICATION. | | | | |
| | Minnesota Departr Fire Marshal Divisi | Survey was conducted by the ment of Public Safety, State on. At the time of this survey, rginia Convalescent Center | | | | |
| | was found not in surequirements for p Medicare/Medicaid 483.70(a), Life Saf edition of National | ubstantial compliance with the articipation in I at 42 CFR, Subpart Fety from Fire, and the 2000 Fire Protection Association 101, Life Safety Code (LSC), | | | | |
| | PLEASE RETURN CORRECTION FO DEFICIENCIES (K | OR THE FIRE SAFETY | | EPO | | |
| | STATE FIRE MAR | RE INSPECTIONS SHAL DIVISION STREET, SUITE 145 | | | | |

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.

If continuation sheet Page 1 of 6

10/10/2016

Electronically Signed

PRINTED: 10/17/2016 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | CONSTRUCTION - MAIN BUILDING 01 | | TE SURVEY MPLETED |
|--------------------------|--|--|---------------------|--|-----------|----------------------------|
| | | 245458 | B. WING | | 09 | /14/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT | 901 | EET ADDRESS, CITY, STATE, ZIP CO 9TH STREET NORTH GINIA, MN 55792 | DDE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| K 000 | ST. PAUL, MN 551 By e-mail to both: Marian.Whitney@s and Angela.Kappenma THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defice 2. The actual, or p 3. The name and/oresponsible for corprevent a reoccurr | state.mn,us n@state.mn.us PRRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done siency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency | K 000 | | | |
| | building with full b was constructed in 197 The nursing home floors. A 3 story he type adjoins the nuby a 2 hour fire rated self closing of home was inspect The building is full facility has a compande detection in open to the corridor. | Medical Center is a 4-story asement. The original building a 1936 and additions and 1999, all of Type II(222). occupies the 3rd and 4th ospital of the same construction ursing home, and is separated ed barrier, with 1&1/2 hour doors. Therefore, the nursing ed as one building. The system with the corridors and spaces or, that is monitored for artment notification. | | | | |

Facility ID: 00603

FORM CMS-2567(02-99) Previous Versions Obsolete

| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | E CONSTRUCTION 01 - Main Building 01 | | SURVEY PLETED |
|--------------------------|--|--|---------------------|---|----------|----------------------------|
| | | 245458 | B. WING | | 09/ | 14/2016 |
| | ROVIDER OR SUPPLIER A HEALTH VIRGINIA | CARE CENT | 9 | TREET ADDRESS, CITY, STATE, ZIP CO 01 9TH STREET NORTH 'IRGINIA, MN 55792 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| K 000 | | age 2 censed capacity of 90 beds of 68 at the time of the survey. | K 000 | | | |
| K 018 SS=E | NOT MET. NFPA 101 LIFE SA Doors protecting or required enclosure hazardous areas s as those construct core wood, or capa 20 minutes. Cleara and floor covering in fully sprinklered required to resist th no impediment to t open devices that pushed or pulled a | t 42 CFR Subpart 483.70(a) is AFETY CODE STANDARD orridor openings in other than s of vertical openings, exits, or hall be substantial doors, such ed of 13/4 inch solid-bonded able of resisting fire for at least ance between bottom of door is not exceeding 1 inch. Doors smoke compartments are only ne passage of smoke. There is he closing of the doors. Hold release when the door is re permitted. Doors shall be eans suitable for keeping the | K 018 | | | 10/21/16 |
| | door closed. Dutch permitted. Door fra made of steel or of with 8.2.3.2.1. Roll CMS regulations in 19.3.6.3 This STANDARD Based on observa | doors meeting 19.3.6.3.6 are times shall be labeled and ther materials in compliance er latches are prohibited by a all health care facilities. is not met as evidenced by: tition and interview, the facility | | 1 Door latch and strike plate | | |
| | the requirements of Code" 2000 edition deficient practice of as well as an under visitors if smoke fr | prridor doors that did not meet of NFPA 101 "The Life Safety in (LSC) section 19.3.6.3.2. This could affect 20 of 68 residents, stermined number of staff, and om a fire were allowed to enterridors making it untenable. | | the door that did not meet co 2 This was completed on 9/1 3 3 Person responsible EV M designee | 15/2016 | |
| | | ween 11:00 a.m. to 3:30 p.m. | | | | |

| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ` ′ | | (X3) DATE | SURVEY PLETED |
|--------------------------|--|---|---------------------|--|--|---------------------------|
| | | 245458 | B. WING | | 09/1 | 4/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT | 90 | TREET ADDRESS, CITY, STATE, ZIP CODE D1 9TH STREET NORTH IRGINIA, MN 55792 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETIO DATE |
| K 018 | revealed that the c on the 4th floor wa latching hardware | age 3 servations and staff interviews orridor door to staff office 4503 is not equipped with door and would not positively latch in tested during the facility tour. | K 018 | | | |
| K 052 SS=F | Maintenance Super NFPA 101 LIFE SATE A fire alarm system be, tested, and man NFPA 70 National National Fire Alarm available. The syst maintenance and trapplicable requirer 9.6.1.4, 9.6.1.7, This STANDARD Based on observation of the system o | required for life safety shall intained in accordance with Electric Code and NFPA 72 to Code and records kept readily em shall have an approved esting program complying with ment of NFPA 70 and 72. The code is not met as evidenced by: tion and staff interview, the stall and maintain the fire alarm | K 052 | 1 Process has been reviewed. Sm Detector Sensitivity testing is done | | 10/21/16 |
| | 2000 NFPA 101, S 19.3.6.3.3, and 9.6 Sections 7.1. The adversely affect th system that could emergency actions affecting 68 of 68 | nce with the requirements of ections 19.3.4., 19.3.6.3.2, as well as 1999 NFPA 72, se deficient practices could be functioning of the fire alarm delay the timely notification and a for the facility thus negatively residents as well as an aber of staff, and visitors to the | | automatically by the main fire pane will be manually tested and logged vendor during the annual testing of alarm system components. The artesting log has been amended to verthe annual sensitivity testing. 2 Completion date by October 21 2 3 Person responsible EV Manager designee | by the the fire nual erify 016 | |
| | on 09/14/2016, du alarm maintenance last 12 months and | ween 11:00 a.m. to 3:30 p.m. ring a review of all available fire e/testing documentation for the d an interview with the ervisor, it was revealed that the | | | | |

| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ′ | | CONSTRUCTION 1 - MAIN BUILDING 01 | | E SURVEY IPLETED |
|--------------------------|---|---|--------------------|-----|--|----------|----------------------------|
| | | 245458 | B, WING | | | 09/ | 14/2016 |
| | PROVIDER OR SUPPLIER IA HEALTH VIRGINIA | CARE CENT | | 90 | REET ADDRESS, CITY, STATE, ZIP CODE 1 9TH STREET NORTH RGINIA, MN 55792 | ·. | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| K 052 | monthly tests of the transmitter (DACT) | sument and/or verify 6 of 12 e digital alarm communicator b. | ΚC | 52 | | | |
| K 054 SS=F | This deficient condition was verified by a Maintenance Supervisor. 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 | | K | 054 | 1 Process has been changed who notification will be to the Fire Dept monthly instead of quarterly. 2 Completion date October 21 20:3 Responsible person EV Manage designee | t. 16 | 10/21/16 |
| | on 09/14/2016, du alarm maintenance the last 12 months Maintenance Staff inspection the facil current documents the required sensit | ween 11:00 a.m. to 3:30 p.m. ring a review of all available fire and testing documentation for , and an interview with the revealed that at the time of the lity could not provide any ation verifying the completion of civity testing of each smoke proughout the facility. | | | a E | | |
| | This deficient cond | dition was verified by a ervisor. | | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION 11 - MAIN BUILDING 01 | 4 | E SURVEY IPLETED |
|--------------------------|--|---|--------------------|-----|--|------------------------------------|----------------------------|
| | | 245458 | B. WING | | | 09/ | 14/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT | | 90 | REET ADDRESS, CITY, STATE, ZIP CODE 11 9TH STREET NORTH RGINIA, MN 55792 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| K 104 SS=F | Penetrations of sm protected in accord not required in ductor barriers in fully ductor sprinkler system in provided for adjace 18.3.7.3, 19.3.7.3. damper testing into NFPA 105. All other maintain a 4-year of 8.3.5. This STANDARD Based on docume interview, the fire/speen maintained in requirements of NF 5.2. This deficient proper operation of could allow smoke 68 of 68 residents | arkety CODE STANDARD soke barriers by ducts are clance with 8.3.5. Dampers are it penetrations of smoke sted HVAC systems where a accordance with 18/19.3.5 is ent smoke compartments. Hospitals may apply a 6-year erval conforming to NFPA 80 & er health care facilities must clamper maintenance interval. is not met as evidenced by: entation review and staff smoke damper system has not accordance with the FPA 90(99) section 5-1.2 and practice does not ensure the f the fire/smoke dampers and migration to negatively affect as well as an undetermined and visitors to the facility. | K | 104 | 1 Maintenance Staff is in the protesting all fire and smoke dampe Preventative Maintenance Schedbeen revised to testing and inspervery 4 years. 2 Completion date will be Octobe 2016 3 Responsible person EV Manag designee | rs. lule has ecting er 21 | 10/21/16 |
| | on 09/14/2016, it was of the facility's fire test/inspection does an interview with that the facility coutesting documenta smoke dampers havithin the last 4 years. | dition was verified by a | | | | | |



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 <u>only a suggestion</u> 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

Essentia Health Virginia Care Center September 30, 2016 Page 2

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

(X6) DATE

Minnesota Department of Health

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|--|---|-------------------------------|--------------------------|
| | | 00603 | B. WING | | 09/15/2 | 2016 |
| | PROVIDER OR SUPPLIER | CARE CENT 901 9TH | DDRESS, CITY, S STREET NOR A, MN 55792 | RTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE C | (X5) COMPLETE DATE |
| 2 000 | Initial Comments | | 2 000 | | | |
| | ****ATTEN | NTION***** | | | | |
| | NH LICENSING | CORRECTION ORDER | | | | |
| | 144A.10, this correct pursuant to a surver found that the deficit herein are not corrected shall I with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Ruwhen a rule contain comply with any of tack of compliance. re-inspection with a result in the assess | hether a violation has been | | | | |
| | that may result from orders provided tha the Department with | hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance. | | | | |
| | receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st | participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are | | | | |

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 10/07/16

TITLE

09/15/2016

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING: COMPLETED

> B. WING ____ 00603

| | PROVIDER OR SUPPLIER A HEALTH VIRGINIA CARE CENT | STREET ADDRESS, CITY 901 9TH STREET NO VIRGINIA, MN 5579 | ORTH | |
|--------------------------|---|--|---|--------------------------|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA | FULL PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| 2 000 | Continued From page 1 Department of Health orders being subryou electronically. Although no plan of is necessary for State Statutes/Rules, penter the word "corrected" in the box avext. You must then indicate in the electrostate licensure process, under the head completion date, the date your orders we corrected prior to electronically submitting Minnesota Department of Health. On 9/12/16 through 9/15/16, surveyors of Department's staff visited the above protothe following correction orders are issued Please indicate in your electronic plan of correction that you have reviewed these and identify the date when they will be of H Complaint H5458014 was investigated substantiated. Minnesota Department of Health is doctor the State Licensing Correction Orders of federal software. Tag numbers have been assigned to Minnesota state statutes/run Nursing Homes. The assigned tag number appears in the column entitled "ID Prefix Tag." The statute/rule out of compliance is listed in "Summary Statement of Deficiencies" of and replaces the "To Comply" portion of correction order. This column also inclused findings which are in violation of the status after the statement, "This Rule is not me evidence by." Following the surveyors find are the Suggested Method of Correction Time period for Correction. | correction blease vailable for ronic ding vill be ng to the of this byider and ed. of e orders, completed, ed and not umenting using en les for les fo | DEPICIENCY) | |
| | PLEASE DISREGARD THE HEADING FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION | | | |

6899

Minnesota Department of Health STATE FORM

AQ8U11 If continuation sheet 2 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|--|--|--|--|
| | 00603 | B. WING | | 09/ | 15/2016 | |
| PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, | STATE, ZIP CODE | | | |
| IA HEALTH VIRGINIA | CARE CENT | _ | RTH | | | |
| (EACH DEFICIENCY | / MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | ON SHOULD BE LE APPROPRIATE | (X5) COMPLETE DATE | |
| APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC | ERAL DEFICIENCIES ONLY. R ON EACH PAGE. QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF | 2 000 | | | | |
| A nursing home mupolicies to guide staphysicians, physicians, physician practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the have criteria which appropriate notifica. A. an accident results in injury and physician intervention. B. a significant physician intervention becample, a deterior psychosocial status conditions or clinical example, a need to of treatment due to begin a new form or conditions | atus ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious. At a minimum, the director of and the medical director or an must be involved in the se policies. The policies mus address at least the tion times for: involving the resident which I has the potential for requiring on; change in the resident's resychosocial status, for eation in health, mental, or in either life-threatening all complications; ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment; | t d | | | 10/21/16 | |
| D. a decision t | o transfer or discharge the | | | | | |
| | PROVIDER OR SUPPLIER IA HEALTH VIRGINIA SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa APPLIES TO FEDE THIS WILL APPEA THERE IS NO RECURENCY PLAN OF CORRECUMINNESOTA STAT MN Rule 4658.0088 Resident Health State A nursing home muture policies to guide state physicians, physician practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the have criteria which appropriate notifical A. an accident results in injury and physician interventi B. a significant physician interventi B. a significant physician interventi C. a need to all example, a deterior psychosocial status conditions or clinical conditions or clinical example, a need to of treatment due to begin a new form or conditions. | PROVIDER OR SUPPLIER IA HEALTH VIRGINIA CARE CENT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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 mus 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 CORRECTION IDENTIFICATION NUMBER: 00603 B. WING B. WING B. WING B. WING B. WING STREET ADDRESS, CITY, SOI 9TH STREET NOI VIRGINIA, MN 55792 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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 which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident which results in injury and has the potential for requiring physician intervention; C. a need to alter treatment significantly, 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; | OF CORRECTION DENTIFICATION NUMBER: A BUILDING: B. WING | OF CORRECTION DENTIFICATION NUMBER: A BUILDING: COM O99/ | |

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

| AND DIAN OF CODDECTION INDENTIFICATION NUMBER | | (X2) MULTIPL A. BUILDING: | | X3) DATE SURVEY COMPLETED | | | |
|--|---|--|---|------------------------------|---|--------|--------------------------|
| | | 00603 | | B. WING | | 09/1 | 15/2016 |
| NAME OF PROVIDER OR S | SUPPLIER | | STREET AD | DRESS, CITY, | STATE, ZIP CODE | | |
| ESSENTIA HEALTH V | IRGINIA | CARE CENT | | STREET NOI , MN 55792 | RTH | | |
| PREFIX (EACH D | EFICIENCY | TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INF | ED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETE DATE |
| This MN Reby: Based on creview, the was notified pressure ut for pressure. Findings in Pressure Ustage II: Papresenting pink wound as an intacunstageab the base of tan, gray, gorown or blessured localized at blood-filled soft tissue may be premushy, bog adjacent tis R41's face diagnoses vascular diextremities in chronic less and the service of the s | equirement observation facility for the color for 1 to color standard thick as a shall bed, with the ulce for ack) in the ulce from presence of district of the color for presence of the color from the | ursing home; or d unexpected re ent is not met a on, interview, ar ailed to ensure t development of of 3 residents (| s evidenced and document the physician a new (R41) reviewed to the National ermis with a red ay also present an-filled blister. loss in which slough (yellow, schar (tan, ple or maroon kin or af underlying ear. The area bainful, firm, a compared to andicated beripheral disorder of the s in the blood) al venous | | Corrected | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 4 of 47

Minnesota Department of Health

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 00603 | B. WING | · · · · · · · · · · · · · · · · · · · | 09/1 | 5/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH VIRGINIA | CARE CENT | STREET NOF , MN 55792 | RTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 2 265 | region (triangular-s spine). R41's quarterly Min assessment dated moderate cognitive further indicated R4 staff for bed mobilit The MDS also iden incontinent of bowe indicated R41 was pressure ulcers, hap ressure ulcers, and device for chair and R41's care plan daran unstageable preand right outer foot interventions incluprotein drinks) thre practitioner, physic the area worsened hours, wound nurse changes as orderereferral to the surgi R41's care plan fur assist of one staff fhad a geo-mattress mattress) on the befoot at all times (stapressure relieving care plan directed sfrom wrinkles as point integrity, required eactivities of daily livincontinent of bowerepositioned every | haped bone at the base of the simum Data Set (MDS) 7/25/16, indicated R41 had impairment. R41's MDS 41 required assistance of 2 by, toilet use, and transfers. Itified R41 was frequently and bladder. R41's MDS at risk for the development of a no unhealed or unhealed and had a pressure reducing a bed. Ited 9/6/16, indicated R41 had assure ulcer to the right buttock. R41's care plan indicated and Mighty Shakes (increased at times daily, notify the nurse ian assistant, or physician if a turn and reposition every 2 at to follow weekly, dressing and by the physician, and a cal certified nurse practitioner. Ither indicated R41 required for turning and repositioning, a (a pressure reduction and a special boot on the right art date of 12/3/11), and a cushion in the wheelchair. The staff to keep linens as free possible and notify the nurse ling any redness or | 2 265 | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 5 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
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| | | 00603 | | B. WING | | 09/ | 15/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT | 901 9TH 9 | DRESS, CITY, S STREET NOF , MN 55792 | STATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCI / MUST BE PRECEDED B SC IDENTIFYING INFORM | Y FULL | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| 2 265 | requested, and lotic to keep R41's skin warm and dry. R41's Skin Risk Asdated 7/17/16, indicrisk of skin breakdon current pressure On 8/30/16, a progression of the foot pulses, cap within normal limits On 9/7/16, a Skin In Report indicated Runstageable pressured the foot pulses of deep tissue injury. In a heel Medix boot (on the heel) on the was not notified. On 9/11/16, a Skin Scale (an assessmed determining a residindicated R41 was breakdown. R41's sidentified risk factor issues and history of indicated R41 had a coccyx, and had sliwhich indicates poson the right heel, arright foot. The asset the pressure ulcer of On 9/12/16, a nursinote lacked documulcer on the right foon 9/13/16, an officindicated R41 was practitioner (NP) for buttock. The NP dowas painful to R41, | oned with cares. The free of pressure ulcosessment with Brade ated R41 was at mown and indicated the ulcers. The ress note indicated atch, nurse was unabilitary refill and skin the report indicated are ulcer measuring onsidered to be a sufficient of the report indicated designed to relieve right foot, and the pressure ulcer on a pressure ulcer on ght bogginess (soft as pressure ulcer on ght bogginess (s | len Scale oderate here were R41's right ole to feel color were one Event right foot 0.5 cm x spected I R41 wore pressure ohysician with Braden heakdown) is skin ent note the tissue reakdown) ector on the utification of s progress essure of the sure ulcer of the sure ulcer | 2 265 | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 6 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE | SURVEY LETED |
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| AND FLAN OF CONNECTION | IDENTIFICATION NOMBER. | A. BUILDING: | | COM | LLTLD |
| | 00603 | B. WING | | 09/1 | 5/2016 |
| NAME OF PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| ESSENTIA HEALTH VIRGINIA | CARE CENT 901 9TH S | STREET NOF | RTH | | |
| ESSENTIA TIEALITI VINGINIA | VIRGINIA | , MN 55792 | | | |
| PREFIX (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 265 Continued From pa | ge 6 | 2 265 | | | |
| taking protein supple documented the wo 0.1 cm. The docum coccyx ulcer with the sulfate-for mediumwounds where antire and change the dreneded. R41 was the every 1-2 hours as will likely worsened the wound area." The documentation regardler. On 9/14/16, a Skin Sore Event Report pressure ulcer had 1.4 cm with the surface the pressure sore work to contained slough, which was unstageable. The pressure ulcer had drainage. The internormal the report lacked dulcer on the right of the contained slough, which was unstageable. The internormal the report lacked dulcer on the right of the contained slough, which is the season of the right of the scale of the contained slough. The internormal slough is the scale of the right distal right foot. RN-D states an area on her foot. R41's heel protector on the right distal right foot. RN-D states overlay on top of a pressure-relief cush following the proced documentation on states. | ements. The NP further and measured 2 cm x 1 cm x ented plan was to treat the e Mepilex AG (silver exuding chronic or acute microbial action is indicated), ssings every 7 days or as to be turned or repositioned "this wound will not heal and (sic) if pressure is not kept off the NP note lacked arding the right foot pressure. Integrity Pressure Sore Event andicated R41's coccyx increased in size to 2.7 cm x rounding redness measuring the documentation indicated as a Stage 2, though it which would indicated the a scant amount of clear ventions remained the same. ocumentation of the pressure | | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 7 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---------------------|---|-------------------------------|--------------------------|
| | | 00603 | B. WING | | 09/ | 15/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, S | TATE. ZIP CODE | | |
| | | 901 9TH | STREET NOR | | | |
| ESSENT | IA HEALTH VIRGINIA | CARE CENT VIRGINIA | , MN 55792 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE |
| 2 265 | RN-D thought the nright outer foot but it R41's right great too On 9/14/16, at 1:31 pressure ulcers deviweeks ago. RN-D on the right outer for had a pressure ulce On 9/15/16, at 9:27 noted to have a prefoot on 9/7/16. On 9/15/16, at 1:33 wound check of R4 request. RN-D remand stated R41's he bogginess. RN-D lo R41's right outer for measured it. The provided the replaced protector. During an procedure, RN-D stated it was a deep was unstageable duarea. RN-D verified caused by pressure verified he did not to been notified of the foot. RN-D stated a filled out so the NP day. The facility policy and Monitoring/Assessing/10, directed the Rephysician of skin into the skin protocol. | urse had mistakenly written meant the scabbed area on e. p.m. RN-D verified R41's veloped at the facility about 3 lenied seeing a pressure ulcer oot. RN-D was unaware R41 | | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 8 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| | | 00603 | B. WING | | 09/1 | 5/2016 |
| _ | PROVIDER OR SUPPLIER | CARE CENT 901 9TH | ADDRESS, CITY, I STREET NO I A, MN 55792 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 265 | IDT (interdisciplinar SUGGESTED MET The Director of Nur develop, review, an procedures to phys resident has a char The Director of Nur educate all appropr procedures. The Director of Nur develop monitoring compliance. | ry team) meeting. HOD OF CORRECTION: sing or designee could d/or revise policies and ician's are notified when a | 2 265 e | | | |
| 2 565 | Plan of Care; Use Subp. 3. Use. A comust be used by all care of the resident | 5 Subp. 3 Comprehensive omprehensive plan of care personnel involved in the care in the ca | 2 565 | | | 10/21/16 |
| | by: Based on observati review, the facility for was in place as direct | on, interview and document ailed to ensure the call light ected by the care plan for 1 of eviewed for call lights not in | | Corrected | | |
| | | ndicated R27's diagnoses , adult failure to thrive and | | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 9 of 47

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00603 09/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH **ESSENTIA HEALTH VIRGINIA CARE CENT** VIRGINIA, MN 55792 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 565 Continued From page 9 2 565 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

Minnesota Department of Health STATE FORM

6899 AQ8U11 If continuation sheet 10 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| | | 00603 | B. WING | | 09/1 | 5/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| ESSENTIA HEALTH VIRGINIA CARE CENT | | | STREET NOF MN 55792 | RTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 565 | Continued From page 10 | | 2 565 | | | |
| | when I put the call I | ight on." | | | | |
| | (NA)-A stated some often, usually to go or transfer into the stated sometimes F | 5 a.m. nursing assistant etimes R27 put her call light on to the bathroom, for a pain pill wheelchair. NA-A further R27's friend would put the call e needed something. | | | | |
| | R27 should be able expect staff to make | a.m. the administrator stated to use the call light and would e sure every resident's call ch as directed by the care | | | | |
| | 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 w provided. | vas requested and not | | | | |
| | The Director of Nur develop, review, an procedures to ensu The Director of Nur educate all appropr procedures. The Director of Nur develop monitoring compliance. | THOD OF CORRECTION: sing or designee could d/or revise policies and re care plans are followed. sing or designee could riate staff on the policies and resigner could systems to ensure ongoing | | | | |

Minnesota Department of Health

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | | A. BOILDING. | | | |
| | | 00603 | B. WING | ····· | 09/1 | 5/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH VIRGINIA | CARE CENT | STREET NOF , MN 55792 | RTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 2 565 | Continued From pa | ige 11 | 2 565 | | | |
| | (21) days. | | | | | |
| 2 830 | Proper Nursing Car Subpart 1. Care in | general. A resident must | 2 830 | | | 10/21/16 |
| | 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. | | | Corrected | | |
| | Findings include: | | | | | |
| | include cerebrovas hemiparesis (sever (paralysis on one si | dentified R53's diagnoses to cular disease (stroke) with the weakness) and hemiplegia dide), depression, and nal involuntary movements. | | | | |
| | 8/11/16, indicated F required supervisio | nimum Data Set (MDS) dated R53's cognition was intact; n with eating; had upper and ge of motion impairment on | | | | |

6899

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| | | 00603 | B. WING | | 09/1 | 5/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH VIRGINIA | CARE CENT | TREET NOF MN 55792 | RTH | | |
| (X4) ID PREFIX TAG | PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| 2 830 | one side; and utilized R53's Care Area As of daily living (ADL) 2/15/16, indicated for one staff for all A with R53's meals a dated 2/15/16, indicated ransportation was R53's care plan dated set up R53's meal at independently. In a with his electric whe extensive transfer for R53's Device Asset indicated R53 utilized mobility. This asset for positioning during R53's Wheelchair for mobility. This asset indicated for wheelchair for mobility and proper at the chair the list lacked an asset meal time. On 9/12/16, at 5:16 seated in his motor clothing protector, at the dining room. R5 parallel to the circuity (unaffected side) clothing composition of the dining room in the d | ed a wheelchair for mobility. ssessment (CAA) on activities - functional status dated R53 required extensive assist DL's which included set up nd beverages. R53's fall CAA cated R53's primary mode of his motorized wheelchair. ted 5/15/16, directed staff to and then R53 was able to eat ddition, R53 was independent eelchair mobility after rom staff. ssment dated 8/10/16, ed an electric wheelchair for ssment lacked an assessment | 2 830 | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 13 of 47

Minnesota Department of Health

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| | | 00603 | B. WING | | 09/1 | 5/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH VIRGINIA | CARE CENT | TREET NOF MN 55792 | RTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 830 | independently feed having to twist his uright in order to visis setting. R53 took havatermelon pieces mouth. R53's cloth shoulder due to his right while eating. For clothing protector be shoulder. Each time his plate; he needed neck to the right. Repieces of red gelation bringing the spoone utilized the weighte which had spilled of then placed the gel p.m. R53's wheeled red gelatin and whir right side of his whor right outside side bowheel hub casing. On 9/14/16, at 8:35 motorized wheelch at the same circular position as noted a R53 was observed and neck to the right breakfast meal. R5 noted as he utilized watermelon pieces sandwich to his mobrought the egg sat the scrambled egg side of the sandwich protector or fell to the wheelchair and the and picked up the grant strength of the sandwich to his mobrought the egg sat the scrambled egg side of the sandwich to his mobrought the egg sat the scrambled egg side of the sandwich to his mobrought the egg sat the scrambled egg side of the sandwich to his mobrought the egg sat the scrambled egg side of the sandwich to his mobrought the egg sat the scrambled egg side of the sandwich egg side egg side of the sandwich egg side egg s | himself. R53 was observed apper torso and neck to the palize and reach his place his fork and stabbed the having to twist and lean to the R53 was able to reposition his ack into place onto his right e R53 took items of food off of d to twist his upper torso and 53 was observed twice to spill n with whipped topping while ed gelatin to his mouth. R53 d spoon to pick up the gelatin nto his clothing protector and atin into his mouth. At 5:30 hair was noted to have spots of pped topping spilled down the eelchair and adhered to the ar and onto the top of the right family and in the same bove on 9/12/16, at 5:16 p.m. having to twist his upper torso and scrambled egg breakfast buth. Several times when R53 ndwich to his mouth, pieces of spilled out of the back and the landing on his clothing he floor between his table. R53 utilized his fingers protector and put them into his rotector and put them into his | 2 830 | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 14 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|--|--|-------------------------------|--------------------------|
| İ | | 00603 | B. WING | | 09/ | 15/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT 901 9TH S | DRESS, CITY, S STREET NOR , MN 55792 | TATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETE DATE |
| 2 830 | mouth. At the compscrambled egg wer the table and where positioned. On 9/14/16, at 12:2 motorized wheelchat the same circular position as noted and 9/14/16, 8:35 and observations. Againt twist his upper torso visualize and reach feed himself indeper (NA)-B set up his positioned onto his clothing protector. If food onto his clothing before the bites of the completion of the table was too short the table. On 9/14/16, at 12:3 (RN)-D confirmed for positioned at an and did not allow R53 to alignment with his the R53's motorized with the dining room table of the tables they complete the table. RN under the table. | oletion of breakfast, chunks of e noted on the floor between e R53's wheelchair had been 5 p.m. R53 was seated in his air with a clothing protector on r table and in the same bove on 9/12/16, 5:16 p.m. | 2 830 | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 15 of 47

(X3) DATE SURVEY

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING | A. BUILDING: | | COMPLETED | | | |
|---|---|--|---|---|-----------|--------------------------|--|--|
| | | 00603 | B. WING | | 09/1 | 5/2016 | | |
| | PROVIDER OR SUPPLIER | CARE CENT 901 | | ADDRESS, CITY, STATE, ZIP CODE H STREET NORTH | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETE DATE | | |
| 2 830 | had tried other thing and that should be record. RN-D was a evaluated by occup wheelchair positionic confirmed R53 need and neck to the right on 9/14/16, at 12:5 medical record lack attempts tried to act at the dining room to R53 had not been a positioning while ease. On 9/14/16, at 1:13 worked with physical therapy staff in the worked with him recommenders where the same and the same and hub casing of Figure 2 and the same and hub casing of Figure 2 and the staff Thursday night. On 9/14/16, at 1:43 (OT)-A confirmed the staff Thursday night. On 9/14/16, at 1:43 (OT)-A confirmed the diwith her clinical judg appropriate for R53 on and aligned with | ber. RN-D stated the facings like a TV tray type table documented in R53's meansure if R53 had ever be ational therapy (OT) for sing while eating. RN-D ded to twist his upper torset to reach his food. 5 p.m. RN-D confirmed Fixed documentation of any commodate R53's positionable. RN-D also confirmed assessed for wheelchair | e, dical sen so | | | | | |

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | | | SURVEY LETED |
|--|---|--|-----------------------|--|------|--------------------------|
| | | | | | | |
| | | 00603 | B. WING | | 09/1 | 5/2016 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH VIRGINIA | CARE CENT | TREET NOF MN 55792 | RTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 830 | Continued From pa | ge 16 | 2 830 | | | |
| | (DON) stated she was high wheelchair under, before 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. | | | | | |
| | The Director of Nur develop, review, an procedures to ensu during meals is pro The Director of Nur educate all appropr procedures. The Director of Nur | THOD OF CORRECTION: sing or designee could d/or revise policies and re appropriate positioning vided. sing or designee could iate staff on the policies and sing or designee could systems to ensure ongoing | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | |
| 2 900 | MN Rule 4658.0529 Ulcers | 5 Subp. 3 Rehab - Pressure | 2 900 | | | 10/21/16 |
| | comprehensive res of nursing services | sores. Based on the ident assessment, the director must coordinate the ursing care plan which | | | | |

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 17 of 47 AQ8U11

Minnesota Department of Health

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | |
|--------------------------|--|---|---------------------|---|-------------------|--------------------------|
| | | 00603 | B. WING 0 | | 09/1 | 5/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| ECCENT | IA HEALTH VIRGINIA | CARE CENT 901 9TH S | TREET NOF | RTH | | |
| ESSENT | IA HEALITI VINGINIA | VIRGINIA, | MN 55792 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 900 | Continued From pa | ge 17 | 2 900 | | | |
| | without pressure s pressure sores unle condition demonstr authenticates, that B. a resident w receives necessary | o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and tho has pressure sores by treatment and services to revent infection, and prevent veloping. | | | | |
| | by: Based on observation review, the facility of services were providevelopment of, an ulcers for 1 of 3 respressure ulcers. The R41 who developed pressure ulcers. Findings include: Pressure Ulcer State Pressure Ulcer Adv. Stage II: Partial thic presenting as a shapink wound bed, with as an intact or oper Unstageable: Full the base of the ulcetan, gray, green or brown or black) in the Suspected Deep Tillocalized area of disblood-filled blister of soft tissue from preserving the services of the services of the ulcetan of th | d worsening of pressure sidents (R41) reviewed for his resulted in actual harm for dimultiple unstageable ges according to the National risory Panel ckness loss of dermis fallow open ulcer with a red thout slough. May also present horuptured serum-filled blister, hickness tissue loss in which fer is covered by slough (yellow, brown) and/or eschar (tan, | | Corrected | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 18 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ' | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|---|--------------------------|---|--------|--------------------------|
| | | | | A. BUILDING: | | | |
| | | 00603 | | B. WING | | 09/1 | 15/2016 |
| NAME OF | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH VIRGINIA | CARE CENT | | STREET NOF , MN 55792 | RTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCY Y MUST BE PRECEDED SC IDENTIFYING INFOR | BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETE DATE |
| 2 900 | Continued From pa | age 18 | | 2 900 | | | |
| | - | | | | | | |
| | R41's face sheet p diagnoses that incl vascular disease (to extremities), anemin chronic kidney dinsufficiency (decrethe extremities), arregion (triangular-sspine). R41's quarterly Mir assessment dated moderate cognitive further indicated R4staff for bed mobility The MDS also idenincontinent of bowe indicated R41 was pressure ulcers, ardevice for chair and R41's care plan da an unstageable preand right outer foot interventions incluprotein drinks) thre practitioner, physic the area worsened hours, wound nurse changes as ordere referral to the surgical R41's care plan fur assist of one staff foot at all times (stapressure relieving care plan directed afrom wrinkles as possible foot at all times (stapressure relieving care plan directed afrom wrinkles as possible foot at all times (stapressure relieving care plan directed afrom wrinkles as possible foot at all times (stapressure relieving care plan directed afrom wrinkles as possible foot at all times (stapressure relieving care plan directed afrom wrinkles as possible foot at all times (stapressure relieving care plan directed afrom wrinkles as possible foot at all times (stapressure relieving care plan directed afrom wrinkles as possible foot at all times (stapressure relieving care plan directed afrom wrinkles as possible foot at all times (stapressure relieving care plan directed afrom wrinkles as possible foot at all times (stapressure relieving care plan directed afrom wrinkles as possible foot at all times (stapressure relieving care plan directed afrom wrinkles as possible foot at all times (stapressure relieving care plan directed afrom wrinkles as possible foot at all times (stapressure plan directed afrom wrinkles as possible foot at all times (stapressure plan directed afrom wrinkles as possible foot at all times (stapressure plan directed afrom wrinkles as possible foot at all times (stapressure plan directed afrom wrinkles as possible foot at all times (stapressure plan directed afrom wrinkles as possible foot at all times (stapressure plan directed | uded diabetes, per plood circulation distinction and pressure ulcer of haped bone at the nimum Data Set (M. 7/25/16, indicated a impairment. R41's 41 required assistant, to tiffied R41 was free and had a pressure ulcer of had a pressure ulcer of had a pressure ulcer of had a pressure ulcer to the at risk for the development of had a pressure ulcer to the act at risk for the development of had a pressure ulcer to the act at risk for the development of had a pressure ulcer to the act at risk for the development of had a pressure ulcer to the act at risk for the development under the ded Mighty Shakes the times daily, notifying an assistant, or proposition and reposition at the rindicated R41 or turning and reposition and reposition and the rindicated R41 or turning and reposition and the result of the physician, and the rindicated R41 or turning and reposition and the physician, as a special boot of art date of 12/3/11) cushion in the whe staff to keep linens | ipheral sorder of the n the blood) venous the veins of the sacral base of the IDS) R41 had s MDS ance of 2 cansfers. Quently 1's MDS elopment of unhealed reducing and R41 had right buttock ndicated s (increased y the nurse hysician if an every 2 dressing and a practitioner. required ositioning, ction on the right, and a elchair. The sas free | | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 19 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|--|--|-------|--------------------------|
| | | 00603 | B. WING | | 09/1 | 5/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT 901 9TH S | DRESS, CITY, S STREET NOF , MN 55792 | STATE, ZIP CODE RTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 900 | immediately regard discoloration of the R41's Care Area As 4/27/16, indicated F integrity, required e activities of daily livincontinent of bowe repositioned every toileted or changed requested, and lotic to keep R41's skin warm and dry. R41's Skin Risk As dated 7/17/16, indicrisk of skin breakdon ocurrent pressure On 8/20/16, a Skin Report indicated R4 Stage II pressure u 0.5 centimeters (cm moist, granular app Interventions includ for bed and chair, p dressings to the premanagement. The indicated the Mepile initiated and the nur progress note dated open area measuric coccyx had been id Event Report. The had received orders for a Mepilex dress days and as necess On 8/21/16, a Phys nursing to apply a N sacral/coccyx ulcer and as necessary. | ing any redness or skin. sessments (CAAs) dated R41 was at risk for altered skin xtensive to total assistance for ing, and was frequently I and bladder. R41 was to be 2 hours and as necessary, every 2 hours and as oned with cares. The goal was free of pressure ulcers, clean, sessment with Braden Scale cated R41 was at moderate own and indicated there were culcers. Integrity Pressure Sore Event I had a new occurrence of a licer on the coccyx measuring (a) x 0.5 cm, with a shiny, earance of pink or red tissue. He a pressure ulcer care and essure ulcer, along with pain related progress note ex (foam) dressing was rese practitioner was notified. A did 8/20/16, indicated a new and 0.5 cm x 0.5 cm on the entified, as noted on the Skin progress notes indicated R41 from the nurse practitioner ing to be changed every 3 sary. I ician Order Report directed Mepilex (foam) dressing to and change it every 3 days An order of 9/6/16, directed I to a wound care nurse | 2 900 | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 20 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|---|--------------------------|--|-------|--------------------------|
| | | | | | | | |
| | | 00603 | | B. WING | | 09/1 | 5/2016 |
| NAME OF PROVIDE | R OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| ESSENTIA HEA | LTH VIRGINIA | CARE CENT | | STREET NOF , MN 55792 | RTH | | |
| | ACH DEFICIENC | ATEMENT OF DEFIC Y MUST BE PRECE SC IDENTIFYING II | DED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| unsta physic the ric On 8/Report (area increa unstate or when Interviturnin On 8/foot wither for within On 9/buttoo by the 2.5 crithe call was motified on 9/dietar pressidential and dietar pressidential and dietar pressidential and within onto it is an and within onto it is an analysis of its analysis. | cian orders land that foot press 29/16, a Skin at indicated R incorrectly ideased in size to geable, 100% te tissue that entions remains and reposit 30/16, a progras cool to too to pulses, can normal limits 4/16, a progras cool to too to pulses, can normal limits 4/16, a progras cool to too to pulses, can normal limits 4/16, a progras cool to too to pulses, can normal limits 4/16, a progras cool to too to pulses, can normal limits 4/16, a progras cool to too to pulses, can normal limits 4/16, a progras cool to too to pulses, can normal limits and that Tue foot was not enter and bear and had bear and had bear entation of too too too to pulses. The nentation of too tender foot. A note, indicated limits and had bear entation of too too too too too too too too too | ure ulcer to the cked orders foure ulcer. Integrity Press 41's left buttocentified by the covered with adheres to the ined the same ioning programmes note indicated, nurse was billary refill and cer (area incordarger and means at 1.5 cm slows the drainage with sician's assisted and the buttocks (and the buttocks (and the buttocks), with recent in the complete of t | r treatment to sure Sore Event k pressure ulcer facility) had cm and was slough (yellow e ulcer bed). in addition to a n. sated R41's right runable to feel l skin color were ted R41's right rectly identified asured 3 cm x ough/eschar in th a foul odor tant was to be ote indicated the late, of R41's rea incorrectly ent weight loss y tech was (RN) had outs. The nutrition a multivitamin 16, a nutrition a significant s. The progress ght loss over a dighty shake s lacked cer on R41's | 2 900 | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 21 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|--------------------------|---|-------|--------------------------|
| | | | | | | |
| | | 00603 | B. WING | | 09/1 | 5/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH VIRGINIA | CARE CENT | STREET NOF , MN 55792 | RTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 900 | Report indicated Runstageable pressondated Runstageable pressondated Runstageable pressondated Runstageable pressondated Runstageable pressondated Runstageable processondated Runstageable | Integrity Pressure Sore Event (41 had a new outer right foot cure ulcer measuring 0.5 cm x considered to be a suspected. The report indicated R41 wore (designed to relieve pressure right foot, and the physician on tegrity Pressure Sore Event (41's right buttock pressure city identified by the facility) of 1.1 cm x 2.1 cm with the cas measuring 3.3 cm x 3.1 cm. was unstageable, was the and had a scant amount of the erventions remained the same a nutrition or hydration that a special continued pressure to an another time period the cates continued pressure | 2 900 | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 22 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA | ` , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---------------------|---|-------------------------------|--------------------------|
| | | 00603 | B. WING | | 09/1 | 5/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| FSSENT | IA HEALTH VIRGINIA | CARE CENT 901 9TH S | TREET NOF | RTH | | |
| LOOLINI | TATIEAETH VIIIOINIA | VIRGINIA, | MN 55792 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 900 | Continued From pa | ge 22 | 2 900 | | ļ | |
| 2 900 | right foot. On 9/12/16, a nursi note lacked docume ulcers. On 9/13/16, an officindicated R41 was a practitioner (NP) for buttock. The NP do was painful to R41, taking protein supp documented the would of the woll of the wo | ng home physician's progress entation of R41's pressure se visit progress note, seen by surgical nurse recommended the pressure ulcer and R41 recently began ements. The NP further and measured 2 cm x 1 cm x ented plan was to treat the e Mepilex AG (silver exuding chronic or acute microbial action is indicated), ssings every 7 days or as to be turned or repositioned "this wound will not heal and (sic) if pressure is not kept off the NP note lacked arding the right foot pressure Integrity Pressure Sore Event indicated R41's coccyx increased in size to 2.7 cm x rounding redness measuring the documentation indicated ras a Stage 2, though it which would indicated the a scant amount of clear ventions remained the same. ocumentation of the pressure | 2 900 | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 23 of 47

Minnesota Department of Health

| STATEMEN | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | |
|--------------------------|---|--|--|--|-----------|--------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMP | LETED |
| | | 00603 | B. WING | B. WING | | 5/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH VIRGINIA | CARE CENT 901 9TH | STREET NO | RTH | | |
| LOOLINI | IATILALITI VINGINIA | VIRGINI | A, MN 55792 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF | D BE | (X5) COMPLETE DATE |
| 2 900 | Continued From pa | ge 23 | 2 900 | | | |
| | open area, which we shaped with slough redness around it. amount of serous decreased area on R41's right R41 did have an arto remove R41's he scabbed area on the RN-D measured the was 0.4 cm x 0.4 cm protector to R41's right was 0.4 cm x 0.4 cm protector to R41's right was 0.4 cm x 0.4 cm protector to R41's right had a geofoam over mattress, and had a her wheelchair. For verified there was dindicating R41 had outside of her right had mistakenly write the scabbed area on On 9/14/16, at 1:31 pressure ulcers device weeks ago. RN-D section of R41's pain is manamedication) patch a is repositioned ever and stated R41 is condenied seeing a prefoot. RN-D was unaulcer on the right for On 9/15/16, at 8:42 stated R41 had an extending the section of the right for the right | vas described as peanut at the base, blanchable, with The dressing had a small brainage on it. RN-D placed the ressure ulcer. R41 was k. RN-D was asked about the tet foot. RN-D stated he thought ea on her foot, and proceede eel protector. RN-D noted a ter right distal right great toe. te scabbed area and stated it m. RN-D replaced the heel ight foot. RN-D stated R41 trlay on top of a regular ta pressure-relief cushion on following the procedure, RN-D documentation on 9/7/16, a pressure ulcer on the foot. RN-D thought the nurse ten right outer foot but meant on R41's right great toe. p.m. RN-D verified R41's veloped at the facility about 3 stated there was little to no tessing, so he did not change had been seen by the wound oner the previous day, so had on at that time. RN-D stated ged with a Fentanyl (narcotic and Tylenol. RN-D verified R4 ry 2 hours and as necessary, compliant with that. RN-D tessure ulcer on the right outer aware R41 had a pressure tot. a.m. nursing assistant (NA)-lopen area on her bottom and | e di | | | |
| | she got her new ma | oot, which has improved since attress. NA-E stated R41's n her bed last week. NA-E | | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 24 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|-----------------------|--|-------|--------------------------|
| | | 00603 | B. WING | ····· | 09/1 | 5/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | ORESS, CITY, S | STATE, ZIP CODE | | |
| ESSEN ⁻ | ΓΙΑ HEALTH VIRGINIA | CARE CENT | TREET NOF MN 55792 | RTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| 2 900 | stated R41 had a re receiving the new in On 9/15/16, at 9:27 had skin breakdow repositioned every Food and fluid intak was to be promptly incontinence, lines wrinkles, and staff signs of breakdowr pressure relieving og the new geofoa stated initially after Mepilex dressing whad been on a multibreakdown and stated initially after Mepilex dressing whad been on a multibreakdown and stated initially after Mepilex dressing whad been on a multibreakdown and stated initially after Mepilex dressing whad been on a multibreakdown and stated to have a prefoot on 9/6/16. RN-D stainterventions and if dietary, and verified not notified until 9/6 noted to have a prefoot on 9/7/16. On 9/15/16, at 10:1 (DON) verified R41 ulcers and had risk breakdown. The DO received Mighty Sh though had been or repositioned every a Mepilex dressing mattress was put of dietary should have in the dietician could be stated R41 was on previously and on sput on R41's bed. The state of R41' | egular mattress prior to nattress. 7 a.m. RN-D stated before R41 n, she was turned and 2 hours and as necessary. The was to be encouraged, R41 cleaned and dried after so were to be free from were to monitor and report note. RN-D stated R41 had a cushion in the wheelchair, and the moverlay on 9/9/16. RN-D skin breakdown, an order for a reas obtained. RN-D stated R41 ti-vitamin prior to skin rted receiving Mighty Shakes | 2 900 | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 25 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--|---|--------------------------|--|-------------------|--------------------------|
| | | A. DOILDING. | | | |
| | 00603 | B. WING | | 09/1 | 5/2016 |
| NAME OF PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| ESSENTIA HEALTH VIRGINIA | CARE CENT | STREET NOF , MN 55792 | RTH | | |
| PREFIX (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| occupational therappositioning. On 9/15/16, at 1:33 wound check of R4 request. RN-D rem and stated R41's his bogginess. RN-D lo R41's right outer for measured it. The pwithout drainage. Fulcer and replaced protector. During all procedure, RN-D scm x 0.8 cm with the it measuring 1.0 cm not warm to touch a stated it was a deel was unstageable dranged by pressure verified he did not to been notified of the foot. RN-D stated a filled out so the NP day. Despite the increase on the coccyx, the promote the healing failed to reassess to the pressure ulcer of the facility policy a Monitoring/Assessing/10, directed the Filling indicated a "Weekly Streatment. The poliprimary physician of the state of the poliprimary physician of the properties of the prop | verified R41 has not had by assessments for 8 p.m. RN-D went to do a and single foot upon surveyor's oved R41's right heel protector eel was normal and without boated the pressure ulcer on ot without a dressing on it and ressure ulcer was dry and RN-D measured the pressure R41's foot back in the heel in interview following the stated the open area was 0.7 he blanchable redness around in x 1.0 cm. RN-D stated it was and had no drainage. RN-D population to some eschar in the open the pressure ulcer could be a from the boot. RN-D also hink the nurse practitioner had a pressure ulcer on R41's right an acute care form would be would look at the following see in size of the pressure ulcer, and oprevent the development of | 2 900 | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 26 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COM | | | SURVEY LETED |
|--------------------------|--|---|--|--|------|--------------------------|
| | | | A. BOILDING. | | | |
| | | 00603 | B. WING | | 09/1 | 5/2016 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH VIRGINIA | CARE CENT | TREET NOF MN 55792 | RIH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 900 | positioning and/or somotify nutritional set discuss at the IDT immeeting. SUGGESTED MET The Director of Nur develop, review, and procedures to ensure pressure ulcer unleand residents who receiving the proper promote healing, procedures and residents who receiving the proper promote healing, procedured all appropring procedures. The Director of Nur develop monitoring compliance. | nission and with any change in skin integrity. Nursing was to rvices, restorative services and (interdisciplinary team) THOD OF CORRECTION: rsing or designee could ad/or revise policies and are residents do not develop a residents do not develop a designee could and are residents do not develop a residents are uncare and services needed to revent infection and prevent | 2 900 | | | |
| 21134 | MN RULE 4658.06 Sanitation, storage | 70 Supb. 2. Dishwashing; | 21134 | | | 10/21/16 |
| | must be thoroughly surfaces of utensil given sanitization tr in such a manner a contamination. Cle and utensils must protects them from | e. All utensils and equipment or cleaned, and food-contact is and equipment must be reatment and must be stored as to be protected from eaned and sanitized equipment be handled in a way that contamination. | | | | |

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| 901 9T | | DDRESS, CITY, STATE, ZIP CODE STREET NORTH | | | | |
|--------------------------|--|---|---|--------------------------|--|--|
| ESSENTI | A HEALTH VIRGINIA CARE CENT VIRGINIA | A, 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) COMPLETE DATE | | |
| 21134 | Continued From page 27 by: | 21134 | | | | |
| | 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. | | corrected | | | |
| | 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 DN 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. | 1 | | | | |
| | On 9/15/16, at 1:05 p.m. the meat slicer had beer 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. | | | | | |

Minnesota Department of Health STATE FORM

E FORM 6899 AQ8U11 If continuation sheet 28 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (3) DATE SURVEY COMPLETED | |
|--|--|--|---------------------|--|------------------------------|--------------------------|
| | | 00603 | B. WING | | 09/1 | 5/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH VIRGINIA | RTH | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 21134 | Continued From pa | ge 28 | 21134 | | | |
| | The Dietary Managmonitoring systems compliance. | er or designee could develop to ensure ongoing | | | | |
| | TIME PERIOD FOF (21) days. | R CORRECTION: Twenty-one | | | | |
| 21390 | MN Rule 4658.0800 Subp. 4 A-I Infection Control | | 21390 | | | 10/21/16 |
| | control program muprocedures which pare A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service exprevention and con E. a resident he immunization progrationed in part 465 procedures of resid the prevention and F. the development of the prevention and F. the development of the products, including defined in part 4656 G. a system for the products which affed disinfectants, antised incontinence products. In methods for the survey of the products of the pro | ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; ment and implementation of slicies and infection control a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of ct infection control, such as eptics, gloves, and | | | | |

6899

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|---|--|-------|--------------------------|
| | | 00603 | B. WING | | 09/1 | 5/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT 901 9TH | DDRESS, CITY, STREET NO A, MN 55792 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 21390 | This MN Requirements: Based on interview facility failed to adm pneumococcal vaco (R95, R40, R1, R66 reviewed for immure Findings include: CDC recommendation or older who have mand who have previdoses of PPSV23 [Invaccine 23] should dose of PCV13 should dose o | ent is not met as evidenced and document review, the ninister recommended cinations for 9 of 11 residents B, R23, R92, R99, R11, R137) nizations. tions: Adults 65 years of age not previously received PCV13 tiously received one or more pneumococcal polysaccharide receive a dose of PCV13. The nuld be administered at least nost recent PPSV23 dose. Its were reviewed for five andomly from the facility reports indicted 5 of 5 eccived pneumococcal enter for Disease Control ations (R95, R40, R1, R68, Indicated R95 was admitted or ears old, and had diagnoses tension and atrial fibrillation. Inum Data Set (MDS) dated 195's pneumococcal up to date. R95's Minnesota mation Connection (MIIC) 16, indicated R95 received a | | corrected | | |
| | 9/23/15, was 84 year that included demen | ars old, and had diagnoses ntia, hypertension, and uarterly MDS dated 6/23/16. | | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 30 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING: | E CONSTRUCTION | | E SURVEY PLETED | |
|--|---|---|---|--|--------------------|--------------------------|
| | | 00603 | B. WING | | 09/ | 15/2016 |
| | PROVIDER OR SUPPLIER | CARE CENT 901 9TH S | DRESS, CITY, S' STREET NOR , MN 55792 | TATE, ZIP CODE TH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETE DATE |
| 21390 | lacked information pneumococcal vaccinecord lacked docu immunization status provided by the factor R1's face sheet ind 12/9/14, was 86 year that included chron disease, and a histed MDS dated 6/14/16 pneumococcal vaccil immunizations/Injer R1 had received the and 3/6/3. R68's face sheet in 4/1/16, was 98 year included diabetes, It a stroke. R68's qualindicated R68's pneup to date. R68's modocumentation of pstatus, however an sheet received from indicated R68 had invaccination on 10/3 R23's face sheet in 2/8/16, was 87 year included congestive fibrillation, chronic indicated R23's pneup to date. R23's qualindicated R23's pneup to date. R23's qualindicated R23's pneup to date. R23's qualindicated R23's pneup to date. R23 documentation of pstatus. | regarding R40's cination status. R40's medical mentation of pneumococcal s, and a MIIC report was not slity. icated R1 was admitted on ears old, and had diagnoses ic pain, atherosclerotic heart bry of bronchitis. R1's quarterly s, indicated R1's cinations were up to date. R1's ction Summary Report indicted to Pneumovax 23 on 10/7/97, dicated R68 was admitted on rs old, and had diagnoses that the hypertension, and a history of arterly MDS dated 7/7/16, received the Pneumovax 23 on 10/16, received the Pneumovax 23 | 21390 | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 31 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|--|-----------------------|--|--------|--------------------------|
| | | | | | | | |
| | | 00603 | | B. WING | | 09/1 | 5/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH VIRGINIA | CARE CENT | | TREET NOF MN 55792 | RIH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| 21390 | 0 Continued From page 31 | | | 21390 | | | |
| | 6/22/15, was 82 ye that included stoma failure, chronic obs and pneumonia. RS 3/22/16, indicated I immunizations were Discharge Summal R92 had been hosp failure with hypoxel lower lobe. R92 was facility to receive or R92's medical recopneumococcal imm facility provided a hR92 had received I and PPSV23 on 6/8 | idicated R92 was admit ars old, and had diagnous ach cancer, congestive tructive pulmonary disectly are quarterly MDS datectly are up to date. A Hospital ry dated 6/24/16, indicated and pneumonia of as discharged back to the ral and intravenous antifered lacked documentation and prevnar 13 (PCV13) on 18/15. | bses heart ease ed lited biratory right ne biotics. on of ver, the cated 3/6/15, | | | | |
| | 9/17/15, was 75 ye included weakness pulmonary disease supplemental oxyg and pneumonia. Rs dated 7/29/16, indic vaccinations were oprevious MDS, a qu R99's pneumococci date. R99's Emergi 2/18/16, diagnosed respiratory infection lower lobes due to medical record lack pneumococcal immifacility provided a had received pneumotical tractional indications and the second | idicated H99 was admit ars old, with diagnoses chronic obstructive (COPD), dependence en, chronic respiratory 99's significant change cated pneumococcal offered and declined, what was a vaccinations were upency Department notes 1 R99 with acute lowern, and pneumonia to be an infectious organism and precious organism and was a documentation of hounization status however and was a dicated R11 was admit dicated R11 was admit | on failure, MDS while the icated to to a dated of the icated of the icat | | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--|---------------------|--|--------------------------------|--------------------------|
| | | 00603 | | B. WING | | 09/ | 15/2016 |
| ESSENTIA HEALTH VIRGINIA CARE CENT 901 9TH S | | DRESS, CITY, S STREET NOF , MN 55792 | STATE, ZIP CODE | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCI MUST BE PRECEDED B SC IDENTIFYING INFORM | Y FULL | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE LE APPROPRIATE | (X5) COMPLETE DATE |
| 21390 | Continued From particles of the previous assistant progress R11 had been hosp 4/21/16, to 4/23/16, documentation of the immunization status a handwritten list in PPSV23 vaccination PPSV23 vaccination of the preumococcal vaccious assistant progress R11 had been hosp 4/21/16, to 4/23/16, documentation of the immunization status a handwritten list in PPSV23 vaccination PPSV23 vaccination R137's face sheet in 4/27/11, was 89 year that included Parking pneumonia. An uncompreumococcal vaccious assessment." A rest dated 10/30/15, independence also wrote of R137 was eligible for A nurse practitioner 4/13/16, indicated in provider was going pneumonia. The provider was going pneumonia. | ars old, with diagno ation and heart failured 5/3/16, indicated cinations were up to ay indicated "subtle pace opacities suggatelectasis." The prote dated 4/26/16, oitalized for pneumo. R11's medical recome pneumococcal is however, the facilidicating R11 had ren on 1/1/86, and 11 andicated R137 was ars old, and had dianson's disease, astrolated Resident vaccination in 2009, and is "per admission ident pneumococcal icated R137 had reconation "4 years agon this form that short another vaccination "5 progress note dan fluenza like illness to proceed with treations on the disease of PCV13 in the corresponding to th | tre. R11's that R11's o date. On a bilateral gestive of hysician's indicated on a from ord lacked deceived the /3/96. admitted gnoses had and cination and ceived a district on a distr | | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 33 of 47

Minnesota Department of Health

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COM | | | SURVEY LETED |
|--------------------------|---|--|---|---|------|--------------------------|
| | | | A. Boilbing. | | | |
| | | 00603 | B. WING | | 09/1 | 5/2016 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH VIRGINIA | CARE CENT | STREET NOF , MN 55792 | RTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETE DATE |
| 21390 | vaccine. A dose of I Pneumovax 23) shalater. For adults 65 already received on the dose of PCV13 year after receiving PPSV23. On 9/15/16, at 9:19 stated the old policy the facility was usin aware there were nout they were confusinglemented. On 9/15/16, at 9:25 (DON) stated the properties of Nursing or designed staff on the policies | ge 33 not previously received the PPSV23 (also called ould be given at least one year years or older who have le or more doses of PPSV23, should be given at least one the most recent dose of a.m. registered nurse (RN)-By (revised 2004) was the one g. RN-B stated they were lew CDC recommendations, using and had not yet been a.m. the director of nursing neumococcal vaccinations dand offered if not up to date ours after admission. The have been overlooked and DON stated they knew they neumococcal immunizations]. THOD OF CORRECTION: sing or designee could d/or revise policies and re immunization guidelines are facility. The Director of ecould educate all appropriate and procedures. The Director nee could develop monitoring ongoing compliance. | 21390 | DEFICIENCY) | | |
| | TIME PERIOD FOR (21) Days | R CORRECTION: Twenty One | | | | |
| 21426 | MN St. Statute 144 Prevention And Cor | A.04 Subd. 3 Tuberculosis ntrol | 21426 | | | 10/21/16 |

6899

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

| NAME OF | PROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, S | STATE, ZIP CODE | |
|--------------------------|--|---|-----------------------|--|--------------------------|
| ESSENT | IA HEALTH VIRGINIA CARE CENT | | TREET NOF MN 55792 | RTH | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| 21426 | Continued From page 34 | | 21426 | | |
| | (a) A nursing home provider must estab maintain a comprehensive tuberculosis infection control program according to the current tuberculosis infection control guid issued by the United States Centers for I Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in Morbidity and Mortality Weekly Report (Northis program must include a tuberculosis infection control plan that covers all paid unpaid employees, contractors, students residents, and volunteers. The Department Health shall provide technical assistance regarding implementation of the guideline (b) Written compliance with this subdivisible maintained by the nursing home. | e most delines Disease of CDC's MMWR). s and ent of | | | |
| | This MN Requirement is not met as evid by: Based on interview and document review facility failed to ensure 3 of 5 residents (FR68, R1) had a baseline symptom scree tuberculosis. Findings include: The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis Health-Care Settings, 2005, (MMWR) diresidents must receive a baseline tuberculosis creening within 72 hours of admission. The significant substitution of the resident and several contents of the resident substitution. | v, the R40, ning for llosis in rected all ulosis sion or screening | | corrected | |

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 35 of 47 AQ8U11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER:

O0603

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

B. WING

O9/15/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| (7.1) 15 | ER'S PLAN OF CORRECTION (X5) |
|---|---|
| () | |
| | RRECTIVE ACTION SHOULD BE COMPLET DATE DATE |
| 21426 Continued From page 35 21426 | |
| 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. | |

Minnesota Department of Health STATE FORM

AQ8U11 If continuation sheet 36 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|-----------------------|---|------|--------------------------|
| | | 00603 | B. WING | | 09/1 | 5/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | ORESS, CITY, S | STATE, ZIP CODE | | |
| ESSENTIA HEALTH VIRGINIA CARE CENT | | | TREET NOF MN 55792 | RTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21615 | Continued From page 36 | | 21615 | | | |
| 21615 | MN Rule 4658.1340 Preparation Area;S | O Subp. 2 MedicineCabinet & cheduleII | 21615 | | | 10/21/16 |
| | nursing home must compartments, per physical plant or me controlled drugs lis section 152.02, sul | | | | | |
| | 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). | | | corrected | | |
| | Findings include: | | | | | |
| | (LPN)-A completed pass for resident (F and placement of a narcotic medicated skin to deliver a spe R16's Fentanyl pate narcotic drawer in t reconciled the num the package for R1 narcotic log book. L "verified" section of R16's Fentanyl pate placed LPN-A's init LPN-A stated the dipatches needed to because the other resident (F) and placed to be a section (F) and | p.m. licensed practical nurse a medication administration R16) which included removal Fentanyl transdermal patch (a adhesive patch placed on the ecific dose). LPN-A obtained the from a double locked the medication cart. LPN-A ber of Fentanyl patches left in 6 and recorded this in the LPN-A recorded under the the narcotic log book for the "disposed of old patch" and tals followed by a slash mark. Is sposal of the Fentanyl be dual witnessed and the patch later in a | | | | |

6899

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLI A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|--------------------------|--|--------|--------------------------|
| | | 00603 | B. WING | | 09/1 | 15/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH VIRGINIA | CARE CENT | STREET NOF , MN 55792 | RTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE | (X5) COMPLETE DATE |
| 21615 | container in the me a pair of gloves and Fentanyl patch which LPN-A had d shoulder. LPN-A rehand, exited R16's medication cart locaroom. LPN-A placed just removed in a croup, unlocked the nunmarked clear me of the medication cartom her left hand a again stated she we Fentanyl patch with On 9/12/16, at 4:40 disposal of R16's rewouldn't be destroy 10:30 p.m. LPN-A with practice for disposations time, registered were observed sear directly down the habeen passing medical which is the content of the medication of t | dication room. LPN-A donned of proceeded to remove R16's on was located on R16's left placed the new Fentanyl patch ated 9/12/16, on R16's left moved the glove on her right room and went directly to the ated in the doorway of R16's of the Fentanyl patch she had lear unmarked medication nedication cart and placed the edication cup in the top drawer art. LPN-A removed the glove and washed her hands. LPN-A build dispose of the used another nurse later. p.m. LPN-A confirmed the emoved Fentanyl patch red until shift change around rerified this was the routine all of the Fentanyl patches. At dinurse (RN)-B and RN-C ted at the nursing station allway from where LPN-A had cations. | 21615 | | | |
| | remove and apply a LPN-B obtained the double locked narco cart. LPN-B cut the packaging sleeve a patch. LPN-B enter | p.m. LPN-B attempted to a new Fentanyl patch on R95. Fentanyl patch from the otic drawer in the medication very top of the Fentanyl nd wrote 9/13 on the Fentanyl ed R95's room and attempted e a new Fentanyl patch. R95 | | | | |
| | refused to have LPI patch or place the r stated she would re proceeded to place | N-B remove the old Fentanyl new Fentanyl patch. LPN-B approach R95 later and the new Fentanyl patch in the and double locked it in the | | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 38 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE COMP | SURVEY LETED | |
|--|---|--|--------------------------|--|-----------------|--------------------------|
| | | 00603 | B. WING | ···· | 09/1 | 5/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH VIRGINIA | CARE CENT | STREET NOF , MN 55792 | RTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 21615 | medication cart narused Fentanyl patch witnessed with anothe black box in the On 9/13/16, at 6:02 been able to place they had saved it to process. LPN-B obtentanyl patch from drawer in the medicant RN-F were present LPN-B opened and a wire holder that woupboard door. The waste container secuploard the ublack biohazardous RN-F co-signed in the indicated the disposance LPN-B and RN-F coupboard had a loc cupboard, however On 9/13/16, at 6:20 process for destroy two nurses witness patch. This was cor (around 10:30 p.m.) the two LPN's who stated she kept the needed to be disposance the confirmed this draw LPN-C confirmed sof R16's Fentanyl pon 9/12/16, around p.m. on 9/12/16. | cotic drawer. LPN-B stated the nes needed to be dual ther nurse and disposed of in | 21615 | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 39 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

| | 00000 | | 03/ | 13/2010 |
|--------------------------|---|---------------------|--|--------------------------|
| NAME OF F | PROVIDER OR SUPPLIER STREET AD | DRESS, CITY, S | STATE, ZIP CODE | |
| FSSENT | IA HEALTH VIRGINIA CARE CENT | STREET NOF | RTH | |
| LOOLIVII | 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) COMPLETE DATE |
| 21615 | Continued From page 39 | 21615 | | |
| | 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. | | | |
| Minnocoto | 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, epartment of Health | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 40 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|---|--------------------------|--|--------------------------------|--------------------------|
| | | | | | | | |
| | | 00603 | | B. WING | | 09/ | 15/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | STATE, ZIP CODE | | |
| ESSENT | IA HEALTH VIRGINIA | CARE CENT | | STREET NOF , MN 55792 | RTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT | ULL | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC' | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| 21615 | housekeepers, and On 9/15/16, at 12:3 (DON) confirmed the a transdermal med to wear gloves durithe patches as if to potential to receive DON confirmed the should be treated a locked if not immed was her expectatio were disposed of in of the patch and du LPN. If for some renot be immediately should be double to the medication cart the potential for divpatches where not hours after they had the cupboard in the stored the black bid as the contents of the narcotics and the fanarcotics to be douverified the filled blashould not be left in up. On 9/15/16, at 2:38 confirmed the filled should not be place pick up. In addition the Fentanyl patch destroyed should not. | age 40 I janitors had access). If p.m. director of nursine used Fentanyl patchication and required thing placement and remuched the staff had the the effects of the narce used Fentanyl patches a narcotic, and doubtiately disposed. Howen that the Fentanyl patches and witnessed by an Rhason the Fentanyl patches and witnessed by an Rhason the Fentanyl patches and witnessed of, the used ocked in the narcotic disposed of, the used ocked in the narcotic disposed of for five to disposed | sing hes were he staff hoval of e cotic. es oble ever, it tches emoval N and/or ch could I patch rawer of e was anyl six I verified ch e locked red to be I , DON hers n for pick or ainers oom for hoval of sed to be licy | 21615 | | | |
| | | st co-sign the destruc | | | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 41 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE COMP | E SURVEY PLETED | |
|---|---|---|-----------------------|--|-------------------|--------------------------|--|
| | | 00603 | B. WING | | 09/1 | 5/2016 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | | |
| ESSENTI | A HEALTH VIRGINIA | CARE CENT | TREET NOI MN 55792 | RTH | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE | |
| 21615 | Continued From pa | ge 41 | 21615 | | | | |
| | the black box in the lacked a time frame removal of the patc witnessed and place. Narcotic Monitoring dated 4/28/14, indic locked in narcotic dor the medication relocked when not su SUGGESTED MET. The director of nurs their designee, coulpolicies/procedures medication storage, quality assessment. | rith the patch being placed in a medication room. Policy of what was acceptable from h to when it should be ed in the black box. I and Accountability policy cated all narcotics were kept lawers of the medication carts from, and both must be double pervised. THOD OF CORRECTION: Sing (DON) and pharmacist or lid develop and implement and staff training related to / disposal of medications. The and assurance committee om audits to ensure | | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | | |
| 21685 | MN Rule 4658.1418 Housekeeping, Ope Subp. 2. Physical p including walls, floo systems, and equip continuous state of with regard to the h well-being of the re routine maintenance | 5 Subp. 2 Plant eration, & Maintenance plant. The physical plant, ors, ceilings, all furnishings, oment must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program. | 21685 | | | 10/21/16 | |
| | by: | on, interview and document | | corrected | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 42 of 47

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | SURVEY LETED |
|---|--|---|-----------------------|---|------|--------------------------|
| | | 00603 | B. WING | | 09/1 | 5/2016 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | _ | |
| ESSENT | IA HEALTH VIRGINIA | CARE CENT | TREET NOF MN 55792 | RTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21685 | Continued From pa | ge 42 | 21685 | | | |
| | and homelike envir | ailed to maintain a safe, clean onment in 6 of 35 resident 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. | | | | | |
| | | erail on the side of the bed by iled with a dark colored sticky | | | | |
| | deep gouges. The bathroom door was | r frame to the bathroom had lower outer corner of the chipped and missing thes x 3 inches making it a lable surface. | | | | |
| | non-skid strips on t the toilet and the til brown color. The do | uild up of dirt around the he bathroom floor in front of es under sink were stained a corway to the bathroom was eximately 2 feet up from the | | | | |
| | | ge cupboard over the toilet had e bottom lower edge. | | | | |
| | the base of the toile space had dirt in it. | athroom the caulking around et was missing and the open The toilet riser had feces on d down the back of the inside | | | | |

Minnesota Department of Health

STATE FORM 6899 AQ8U11 If continuation sheet 43 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE COMP | SURVEY LETED | | |
|---|--|---|---------------------|---|-------------------|--------------------------|--|--|
| | | | | | | | | |
| | | 00603 | B. WING | | 09/1 | 5/2016 | | |
| NAME OF I | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH | | | | | | | |
| ESSENT | IA HEALTH VIRGINIA | CARE CENT | MN 55792 | 1111 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE | | |
| 21685 | Continued From pa | ge 43 | 21685 | | | | | |
| | of the riser. | | | | | | | |
| | washed when the bknow how often the done last. When ro bathroom cabinets There was not a pla The FM stated the that any staff could needed cleaning or routine maintenance scheduled equipmed. The facility's Mainted dated 2/15, indicate requested using the Only tenants that do order system were work order form. | FM stated siderails should be beds were washed but did not beds were washed or when oms were remodeled, the were replaced with shelves. In for any further remodeling, facility has a computer system use to inform maintenance of repairs. The facility also had a se computer system with ent and facility areas to check. In enance Work Orders policy and all work requests must be a intranet work order system. The intranet work allowed to use the written. | | | | | | |
| | The director of nurs develop a maintena facility was in good clean, homelike endesignee could edu the program, and c | sing (DON) or designee could ance program to ensure the repaired to maintain a safe, vironment. The DON or acate all appropriate staff on ould develop monitoring ongoing compliance. | | | | | | |
| | TIME PERIOD FOR Twenty-One (21) D | | | | | | | |
| 21810 | MN St. Statute 144 Residents of HC Fa | .651 Subd. 6 Patients & ac.Bill of Rights | 21810 | | | 10/21/16 | | |
| | residents shall have | riate health care. Patients and e the right to appropriate nal care based on individual | | | | | | |

Minnesota Department of Health

PRINTED: 11/06/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00603 09/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH **ESSENTIA HEALTH VIRGINIA CARE CENT** VIRGINIA, MN 55792 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21810 Continued From page 44 21810 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 corrected 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

Minnesota Department of Health STATE FORM

during the assessment period.

daily living (ADL) as needed.

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

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

| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, STATE, ZIP CODE | | | |
|--------------------------|--|---|------------------------------|--|--------------------------|--|
| ESSENT | IA HEALTH VIRGINIA CARE CENT | | TREET NOF MN 55792 | RTH | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIENCY (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM | ES / FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE | |
| 21810 | Continued From page 45 On 9/13/16, at 2:05 p.m. R27's call ligh observed hanging on the bed post at the bed. The call light and bed post we with a white fleece jacket. R27 was sittirecliner. When asked about the call light was unable to find the call light, and the to reach the call light. R27 stated she use call light when she needed something a know what she would do if she did not R27's room was located at the end of the call light for everything; when she nigo to the bathroom, if she wanted a driuwater, dropped something on the floor "Sometimes the over bed table gets stucan't reach something." R27 further stated sometimes I have to apologize to the shecause I put the light on so much. I fe with my call light because I know they when I put the call light on." On 9/14/16, at 10:55 a.m. nursing assis (NA)-A stated sometimes R27 put her coften, usually to go to the bathroom, for or transfer into the wheelchair. NA-A fustated sometimes R27's friend would plight on if he felt she needed something. On 9/15/16, at 8:00 a.m. the administrated she felt she needed something. On 9/15/16, at 8:00 a.m. the administrated she would be able to use the call light expect staff to make sure every resider light was within reach as directed by the plan. On 9/15/15, at 12:15 p.m. registered nut (RN)-A stated R27 was able to use the RN-A stated she would expect staff to rule call light was within reach. RN-A stated she would expect staff to rule call light was within reach. RN-A stated she would expect staff to rule call light was within reach. RN-A stated she would expect staff to rule call light was within reach. RN-A stated she would expect staff to rule call light was within reach. RN-A stated she would expect staff to rule call light was within reach. RN-A stated she would expect staff to rule call light was within reach. RN-A stated she would expect staff to rule call light was within reach. RN-A stated she would expect staff to rule call light was within reach. RN-A stated she would expect staff to rule call light was | re foot of re covered ng in the nt, R27 en unable sed the and did not have it. ne hall. he used eeded to nk of and, rick and I ted, staff el safe vill come stant call light on ra pain pill rther ut the call J. tor stated and would nt's call e care urse call light. make sure ated all | 21810 | | | |

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 46 of 47 AQ8U11

PRINTED: 11/06/2016 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00603 09/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH **ESSENTIA HEALTH VIRGINIA CARE CENT** VIRGINIA, MN 55792 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21810 Continued From page 46 21810 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.

6899