### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

		ARE/MEDICAL TO BE COMPI							D: HL2V acility ID: 00	0461
1. MEDICARE/MEDICAID PROVID (L1) 245512 2.STATE VENDOR OR MEDICAID I (L2) 381347904		3. NAME AND AL (L3) ESSENTIA I (L4) 900 HILLIG (L5) FOSSTON, I	HEALTH FOS	SSTON	UTHEAST (L6) 5	56542	1. Initia 3. Tern 5. Valid	nination	2. Recert 4. CHOW 6. Comple	tification V
5. EFFECTIVE DATE CHANGE OF (L9)  6. DATE OF SURVEY  8. ACCREDITATION STATUS:  0 Unaccredited  1 TJC	OWNERSHIP  5/2015 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	OPPLIER CATEO  05 HHA  06 PRTF  07 X-Ray  08 OPT/SP	GORY  09 ESRD  10 NF  11 ICF/III  12 RHC	02 (L7) 13 PTIP 14 CORF D 15 ASC 16 HOSPICE	22 CLIA	8. Full	Survey After ( EAR ENDIN		(L35)
2 AOA 3 Other  11. LTC PERIOD OF CERTIFICATIO  From (a):  To (b):  12.Total Facility Beds  13.Total Certified Beds	50 (L18) 50 (L17)	Complianc1. A		gram	2. Techr 3. 24 Ho 4. 7-Day 5. Life S	y RN (Rural SN Safety Code	6. \$7. 1 7. 1 8. 1	g Requirement Scope of Serv Medical Direct Patient Room Beds/Room	vices Limit	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MI	EETS				
18 SNF 18/19 SNF 50 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or	1861 (j) (1):		(L15)		
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):						
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	VEY AGENCY	APPROVAL		Date:	
Theresa Gullingsrud,	HFE NEII	1	0/08/2015	(L19)	Mark	Meath	, Enforcem	nent Specia	list 10/0	08/2015 (L20)
PA	RT II - TO BE (	COMPLETED I	BY HCFA RI	EGIONA	L OFFICE OR	SINGLE S	TATE AGI	ENCY		
19. DETERMINATION OF ELIGIBII  _X 1. Facility is Eligible to I  2. Facility is not Eligible	Participate		IPLIANCE WITH	H CIVIL	2. O	atement of Finar wnership/Contro oth of the Above	l Interest Disc			
22. ORIGINAL DATE  OF PARTICIPATION  01/01/1988	23. LTC AGREEN BEGINNING		4. LTC AGREEN ENDING DA		26. TERMINAT  VOLUNTARY  01-Merger, Closu	_00		(I INVOLUNT 05-Fail to M		Safety
(L24)	(L41)		(L25)		02-Dissatisfaction			06-Fail to M	leet Agreeme	ent
25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS a of Admissions: aspension Date:	(L44) (L45)		03-Risk of Involui 04-Other Reason	=	n	OTHER 07-Provider 00-Active	Status Char	nge
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS					
	(L28)	03001		(L31)						
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAI	L DATE						

(L33)

DETERMINATION APPROVAL

09/28/2015

(L32)



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245512

October 8, 2015

Mr. Kevin Dish, Administrator Essentia Health Fosston 900 Hilligoss Boulevard Southeast Fosston, Minnesota 56542

Dear Mr. Dish:

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

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

Effective September 22, 2015 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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 Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered October 8, 2015

Mr. Kevin Dish, Administrator Essentia Health Fosston 900 Hilligoss Boulevard Southeast Fosston, Minnesota 56542

RE: Project Number S5512025

Dear Mr. Dish:

On August 26, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 13, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On September 25, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 13, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 22, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 13, 2015, effective September 22, 2015 and therefore remedies outlined in our letter to you dated August 26, 2015, will not be imposed.

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

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

Sincerely,

Mark 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

Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

ld	rovider / Supplier / CLIA / lentification Number 45512	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/25/2015
Name of I	Facility		Street Address, City, State, Zip Code	
ESSE	ENTIA HEALTH FOSSTON		900 HILLIGOSS BOULEVARD SOU FOSSTON, MN 56542	THEAST

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

(Y4) Item	C	(5) Date	(Y4)	ltem	(Y5)	Date	(Y4)	Item	(	Y5) I	Date
ID Prefix	F0279	Correction Completed 09/22/2015	II	O Prefix	F0280	Correction Completed 09/22/2015		ID Prefix	F0282		Correction Completed 09/22/2015
Reg. # LSC	483.20(d), 483.20(k)(1)	_		Reg. # LSC	483.20(d)(3), 483.10(k)(2)	-		Reg. # LSC	483.20(k)(3)(ii)		_ _
ID Prefix Reg. # LSC	483.25	Correction Completed 09/22/2015	II	D Prefix Reg. # LSC	F0314 483.25(c)	Correction Completed 09/22/2015			F0323 483.25(h)		Correction Completed 09/22/2015
ID Prefix Reg. # LSC	F0329 483.25(I)	Correction Completed 09/22/2015	11	D Prefix Reg. # LSC	_F0441 483.65	Correction Completed 09/22/2015		ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC			II	O Prefix Reg. # LSC							Correction Completed
ID Prefix Reg. # LSC			II	D Prefix Reg. # LSC		=					
Reviewed By	Reviewe	d By	Date	:	Signature of Surve	yor:				Date:	
State Agency	, LB/i	nm	10	/08/20	15	3	356	2		09/25	5/2015
Reviewed By CMS RO	Reviewe	d By	Date	:	Signature of Surve	eyor:				Date:	
Followup to	Survey Completed on: 8/13/2015				Check for any Uncorrecte				a Summary of to the Facility?	YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

October 8, 2015

Mr. Kevin Dish, Administrator Essentia Health Fosston 900 Hilligoss Boulevard Southeast Fosston, MN 56542

Re: Reinspection Results - Project Number S5512025

Dear Mr. Dish:

On September 25, 2015 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 August 13, 2015. 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 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

### State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00461	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/25/2015
Name	of Facility		Street Address, City, State, Zip Code	
ES	SENTIA HEALTH EOSSTON		900 HILLIGOSS BOULEVARD SOU	ITHEAST

FOSSTON, MN 56542

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).

**ESSENTIA HEALTH FOSSTON** 

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
			Correction					Correction					Correction
ID Prefix	20560		Completed 09/22/2015		ID Prefix	20565		Completed <b>09/22/2015</b>		ID Prefix	20570		Completed <b>09/22/2015</b>
Reg. # LSC	MN Rule 4658.040	5 Subp. 2			Reg. # LSC	MN Rule 4658.0405 S	ubp. 3	3		Reg. # LSC	MN Rule 465	8.0405 Sub	p. 4
			Correction Completed					Correction Completed					Correction Completed
ID Prefix	20830		09/22/2015		ID Prefix	20835		09/22/2015		ID Prefix	20900		09/22/2015
Reg. # LSC	MN Rule 4658.052	0 Subp. 1			Reg. # LSC	MN Rule 4658.0520 S	ubp. 2	? A		Reg. # LSC	MN Rule 465	8.0525 Sub	p. 3
ID Prefix	21390	(	Correction Completed 09/22/2015		ID Prefix	21540		Correction Completed 09/22/2015		ID Prefix	21675		Correction Completed 09/22/2015
	MN Rule 4658.080		<b>A</b> -l		•	MN Rule 4658.1315 S				•	MN Rule 465		<u> </u>
ID Prefix Reg. # LSC			Correction Completed		ID Prefix Reg. # LSC			Correction Completed		ID Prefix Reg. # LSC			
ID Prefix Reg. # LSC			Correction Completed		ID Prefix Reg. # LSC			Correction Completed		ID Prefix Reg. # LSC			
Reviewed By	Re	viewed By	y	Dat	te:	Signature of	Surve	or:				Date:	
State Agency	, L	B/mm		10	)/08/20	15		3356	62			09/	25/2015
Reviewed By CMS RO	Re	viewed By	y	Dat	te:	Signature of	Surve	yor:				Date:	
•	Survey Completed 8/13/201	15					•				a Summary o to the Facility		NO

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: HL2V

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

	PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY AGE	NCY		Facility ID: 00461
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245512 2.STATE VENDOR OR MEDICAID NO. (L2) 381347904	).	3. NAME AND ADD (L3) ESSENTIA F (L4) 900 HILLIG (L5) FOSSTON, N	HEALTH FOSST OSS BOULEVA	TON	EAST (L6) 5	6542	4. TYPE OF ACTIO  1. Initial  3. Termination  5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)		7. PROVIDER/SUI	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit  8. Full Survey After	9. Other · Complaint
6. DATE OF SURVEY <b>08/13/</b> 8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDIN	NG DATE: (L35)
11. LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12. Total Facility Beds  13. Total Certified Beds	50 (L18) 50 (L17)	X B. Not in Com	equirements Based On:	m	2. Technic	cal Personnel ir RN RN (Rural SNF) ifety Code	Following Requirements:  6. Scope of Se 7. Medical Dii 8. Patient Roo 9. Beds/Room  (L12)	ervices Limit rector m Size
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEE	TS		
18 SNF 18/19 SNF 50	19 SNF	ICF	IID		1861 (e) (1) or 186	61 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	SHOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVE	Y AGENCY APP		Date:
Rebecca Haberle, HF	E NEII		09/08/2015	(L19)		Enforcemen	t Specialist	09/28/2015 (L20
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAL	OFFICE OR SI	NGLE STATI	E AGENCY	
DETERMINATION OF ELIGIBILITY	cipate		IPLIANCE WITH ( HTS ACT:	CIVIL	2. Ow		al Solvency (HCFA-2572) nterest Disclosure Stmt (HC	CFA-1513)
	(L21)							
22. ORIGINAL DATE  OF PARTICIPATION  01/01/1988  (L24)	23. LTC AGREEM! BEGINNING (L41)		24. LTC AGREEM ENDING DAT (L25)		26. TERMINATIO  VOLUNTARY  01-Merger, Closure  02-Dissatisfaction W	00	05-Fail to	(L30) INTARY Meet Health/Safety Meet Agreement
25. LTC EXTENSION DATE:  (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions:	(L44)		03-Risk of Involunta 04-Other Reason for	-	OTHER 07-Provid 00-Active	der Status Change e
	B. Resema sus	pension Bate.	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (	OF APPROVAL DA					
	(L32)			(L33)	DETERMINAT	ION APPROV	VAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered August 26, 2015

Mr. Kevin Dish, Administrator Essentia Health Fosston 900 Hilligoss Boulevard Southeast Fosston, Minnesota 56542

RE: Project Number S5512025

Dear Mr. Dish:

On August 13, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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

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

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

### **DEPARTMENT CONTACT**

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

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104 Fax: (218) 308-2122

#### **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 22, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 22, 2015 the following remedy will be imposed:

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

### ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that

Essentia Health Fosston August 26, 2015 Page 4

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

### Original deficiencies not corrected

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

### Original deficiencies not corrected and new deficiencies found during the revisit

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

### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 13, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

Essentia Health Fosston August 26, 2015 Page 5

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 13, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

### INFORMAL DISPUTE RESOLUTION

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

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

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

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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.

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

PRINTED: 09/08/2015 FORM APPROVED OMB NO. 0938-0391

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	()		E SURVEY PLETED
		245512	B. WING _			08/	13/2015
	PROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP C 900 HILLIGOSS BOULEVARD SOUT FOSSTON, MN 56542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ΓS	F 0	00			
F 279 SS=D	as your allegation of Department's accepenrolled in ePOC, yat the bottom of the form. Your electror be used as verificated.  Upon receipt of an on-site revisit of you validate that substate regulations has been your verification.  483.20(d), 483.20(k) COMPREHENSIVE A facility must use to develop, review a comprehensive plane.	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with (x)(1) DEVELOP E CARE PLANS  The results of the assessment and revise the resident's	F 2	79			9/22/15
	plan for each reside objectives and time medical, nursing, a	ent that includes measurable tables to meet a resident's nd mental and psychosocial tified in the comprehensive					
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident'	t describe the services that are ttain or maintain the resident's physical, mental, and leing as required under ervices that would otherwise \$483.25 but are not provided as exercise of rights under the right to refuse treatment.).					
LABORATOR	(	NED/CLIDDLIED DEDDECENITATIVE'S SICI		TITLE			(Y6) DATE

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

Electronically Signed 09/04/2015

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		E SURVEY PLETED
		245512	B. WING _	<del> </del>	08/	13/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		10/2010
ESSENT	IA HEALTH FOSSTOI	N		900 HILLIGOSS BOULEVARD SOUTH FOSSTON, MN 56542	HEAST	
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 279	Continued From pa	age 1	F 27	79		
	by: Based on observareview, the facility finclude the use of vand positioning needs who required the use. Findings include: R33's care plan da assist R33 with transtroke with left side did not address any positioning needs. On 8/11/15, at 10:3 seated in a wheelc R33's wheelchair would up, left arm rebed pillow was obsand tucked into the R33's left arm was the pillow. At the tirleft arm was observed to hang uphysical therapy as reposition R33's arrest. On 8/12/15, at 11:5 seated in her wheeleft arm. R33's on her lap with the of her knees in a defingers and hand were with the of her knees in a defingers and hand were with the of her knees in a defingers and hand were with the of her knees in a defingers and hand were with the of her knees in a defingers and hand were with the of her knees in a defingers and hand were with the of her knees in a definger and hand were with the of her knees in a definger and hand were with the of her knees in a definger and hand were with the of her knees in a definger and hand were with the of her knees in a definger and hand were with the of her knees in a definger and hand were with the of her knees in a defined and the with	NT is not met as evidenced tion, interview and document ailed to develop a care plan to wheelchair positioning devices eds for 1 of 1 resident (R33) see of positioning devices.  Ited 7/20/15, directed staff to nesfers due to history of a ed weakness. The care plan by special wheelchair  Itel a.m. R33 was observed hair in the south dining room. Itel are also as the care plan are to the arm rest exide of the chair next to R33. Observed positioned on top of the observed positioned on top of the of the observation, R33's arm was artill 11:02 a.m. at which time a sesistant (PTA) was observed to m on top of the pillow / arm  Itel a.m. R33 was observed to more of the chair. R33's arm was artill 11:02 a.m. at which time a sesistant (PTA) was observed to more of the endependent position. R33's was observed resting hand positioned over the endependent position. R33's was not observed to move		First Care Living Center polithe development of, review, of the resident; s compreher care with measurable object timetables to meet a residen nursing, and mental and psy needs that are identified in the comprehensive assessment. A. Review and updates to Comprehensive, Care Plann Revision of Care Plan, Care policies completed 9-3-15.  B. Review and updates to Policy & Preventative and All Device Policy completed 9-3-15.  Care Plan update of R33 on re-eval and Care Plan update of R33 on re-eval and Care Plan update -31-15. Plan to continue ther week and make ongoing chaneded.  D. RN MDS Coordinator co comprehensive assessment plan updates for resident R3 posey support cushion on he on 8/30/15.  E. All residents with position will have RN re-assessment Plan review/updates by 9-22 assessments and care plan with new residents or change current residents.  F. Point of care charting in for task to be signed off by NG. All staff attendees educated of the policy of the compliance with following care compliance with following care compliance with following care care in the care charting in for task to be signed off by NG. All staff attendees educated compliance with following care care charting in for task to be signed off by NG. All staff attendees educated compliance with following care care care care care care care care	and revision asive plan of ives and takes medical, chosocial and a Plan Audit Repositioning ternative and 8-14-15, PT e of R33 on 8 rapies 5x ranges as and care 3 for left armer wheelchair and Care and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	` '	SURVEY PLETED
		245512	B. WING			08/1	13/2015
	PROVIDER OR SUPPLIER	N		9	TREET ADDRESS, CITY, STATE, ZIP CODE 00 HILLIGOSS BOULEVARD SOUTHEAST COSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	on 8/12/15, at 12:5 sleeping in her whe walked by R33's roalright. PTA-A state fell off of the arm rehand was not be st device but rather reR33 did not have the reposition her hand move her hand and on 8/13/15, at 10:4 her room. A 1/4 lay the floor of her roor attempted to use the arm/hand in place of into her ribs and was staff had placed the chair but that too win place on the whe started using the besone support. The was observed to co foam was observed to co foam was observed support next to the on 8/13/15, at 10:5 arm frequently fell of She stated staff had times a day as R33 arm back on the pill on 8/13/15, at 11:0	dition in which her hand would and allow for blood flow.  To p.m. R33 was observed selchair in her room. PTA-A om and asked if R33 was ed R33's left hand frequently est or pillow. He stated R33's rapped into the arm support esting on a pillow. PTA-A stated he ability to independently therefore staff would have to directly a reposition when needed.  To a.m. R33 was interviewed in the tray was observed sitting on m. R33 stated staff had he lap tray to hold her left on the chair, but the tray cut has not comfortable. She stated as hot enough to keep her arm rest cushion on her hand. As not able to move her left had frequently fell off of the blue lateral support device over the arm rest, however, the disticking out of the lateral wheelchair armrest.  To a.m. NA-B stated R33's left off of the positioning pillows. It is a mot able to reposition the arm several as was not able to reposition the	F 2	279	proper positioning devices at Licens Staff meeting 9-2-15 and NAR staff meeting 9-3-15.  H. Staff not attending provided ed on Repositioning Policy & Preventa Alternative Device policy, and Care policy to be read/understood prior to next scheduled shift and with all neemployee orientation.  I. RN Coordinators will audit by vobservation to ensure all residents having their care plans followed for positioning device weekly until satist x 4 weeks, then randomly thereafted will document audit results.  J. DON or her designee will audit documentation by nursing staff, ME coding, and Care Plan for 3 resider weekly x 4 weeks until satisfactory, randomly thereafter and will document audit be added to out program by DON and reported to Comeetings quarterly.  L. Completion date 9-22-15.	ucation ative & Plan o their w isual are sfactory er and OS ats then tent ur QA	

F 279 Continued From page 3 wheelchair were placed by occupational therapy to ensure proper body alignment while in the wheelchair. RN-A reviewed the care plan and verified the plan did not address what type of supports were needed in / on R33's wheelchair.  On 8/13/15, at 12:20 p.m. the director of nurses verified R33's care plan did not address supportive devices to be used while in the wheelchair.  On 8/13/15, at 2:55 p.m. contact with the occupational therapist was attempted without success.  A policy related to care plan development was requested and none was provided.		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		RIPLE CONSTRUCTION  NG		E SURVEY IPLETED
ESSENTIA HEALTH FOSTON  (X4.10) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 279 Continued From page 3 wheelchair. RN-A reviewed the care plan and verified the plan did not address what type of supports were needed in / on R33's wheelchair.  On 8/13/15, at 12:20 p.m. the director of nurses verified R33's care plan did not address supportive devices to be used while in the wheelchair.  On 8/13/15, at 2:55 p.m. contact with the occupational therapist was attempted without success.  A policy related to care plan development was requested and none was provided.  F 280 A3.20(d)(3), 433.10(k)(2) RIGHT TO SS=D PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,			245512	B. WING		08/	13/2015
PRÉFIX TAG  I(EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 279  Continued From page 3 wheelchair were placed by occupational therapy to ensure proper body alignment while in the wheelchair. RN-A reviewed the care plan and verified the plan did not address what type of supports were needed in / on R33's wheelchair.  On 8/13/15, at 12:20 p.m. the director of nurses verified R33's care plan did not address supportive devices to be used while in the wheelchair.  On 8/13/15, at 2:55 p.m. contact with the occupational therapist was attempted without success.  A policy related to care plan development was requested and none was provided.  483.20(d)(3), 483.10(k)(2) RIGHT TO SS=D PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,			l		900 HILLIGOSS BOULEVARD SOUTHEAST	-	
wheelchair were placed by occupational therapy to ensure proper body alignment while in the wheelchair. RN-A reviewed the care plan and verified the plan did not address what type of supports were needed in / on R33's wheelchair.  On 8/13/15, at 12:20 p.m. the director of nurses verified R33's care plan did not address supportive devices to be used while in the wheelchair.  On 8/13/15, at 2:55 p.m. contact with the occupational therapist was attempted without success.  A policy related to care plan development was requested and none was provided.  F 280  48.32.0(d)(3), 48.3 10(k)(2) RIGHT TO FARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	( (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	D BE	COMPLETION
the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	wheelchair were plato ensure proper bowheelchair. RN-Arverified the plan dissupports were need. On 8/13/15, at 12:2 verified R33's care supportive devices wheelchair.  On 8/13/15, at 2:55 occupational therapsuccess.  A policy related to crequested and none 483.20(d)(3), 483.1 PARTICIPATE PLA  The resident has thincompetent or othe incapacitated under participate in plannichanges in care an A comprehensive as interdisciplinary teal physician, a registe for the resident, and disciplines as deter and, to the extent puthe resident, the resident revised by a teal of the	aced by occupational therapy ody alignment while in the reviewed the care plan and I not address what type of ded in / on R33's wheelchair.  O p.m. the director of nurses plan did not address to be used while in the  p.m. contact with the post was attempted without  are plan development was a was provided.  O(k)(2) RIGHT TO  NNING CARE-REVISE CP  re right, unless adjudged erwise found to be the laws of the State, to fing care and treatment or direatment.  are plan must be developed the completion of the sessment; prepared by an m, that includes the attending red nurse with responsibility did other appropriate staff in mined by the resident's needs, racticable, the participation of sident's family or the resident's e; and periodically reviewed				9/22/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245512	B. WING		08/13/2015
	PROVIDER OR SUPPLIER	1	9	TREET ADDRESS, CITY, STATE, ZIP CODE  00 HILLIGOSS BOULEVARD SOUTHEAST  OSSTON, MN 56542	
(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 SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 280	Continued From pa	ge 4	F 280		
	by: Based on observar review, the facility f include target beha medication for 1 of received anti-anxie: Findings include:  R55's quarterly Min 7/28/15, indicated f impairment and dia depressive disorde also identified R55 hopeless one day of and felt tired or have everyday. The MD received antianxiety R55's Psychotropic Assessment (CAA) had a diagnosis of (an antianxiety medicate) feelings of anxiousi R55's Care Plan da received anti-anxiety of anxiety and direct use effectiveness a monitor mood and update family and of Care Plan also india would review R55's	imum Data Set (MDS) dated R55 had moderate cognitive gnoses that included anxiety, r and hypertension. The MDS felt down, depressed or luring the assessment period ing had little energy nearly S further identified R55 y medication daily.  Medication Use Care Area dated 4/30/15, indicated R55 anxiety and was on alprazolam dication) to help with her ness.  Atted 8/5/15, identified R55 ty medication for the treatment adverse consequences, response to medication and doctor of any concerns. The cated the pharmacy consultant medications monthly.  Plan did not identify target		First Care Living Center policies recthe residents/family/legal represental participate in planning care and treator changes in care and treatment. Oplans are developed by interdiscipling team within 7 days after the comprehensive assessment is done plan reviewed and revised at least quarterly and with significant change plan of care.  A. Review and update to Care Plan Preliminary policy, Care Planning & Revision of Care Plan policy completed 9-3-15.  B. Review and updates to the Behamonitoring Policy completed 9-3-15.  C. Care plan revision 8-20-15 comfor R55 to include identified target behaviors for the use of antianxiety medication per RN MDS Coordinator assessment.  D. RN MDS Coordinator assessment and care plan updates for all resider an antianxiety medication to include identified target behaviors.  E. Primary care physician visit for lon 9-2-15 confirms therapeutic leve antianxiety medication regimen.  F. Point of care charting in EHR sy for task to be signed by NARs, to idetarget behaviors of all residents on a antianxiety medication.  G. Psychopharmacologic Medication.	ative to the transport of the transport of the transport of the transport of transp

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG		PLETED
		245512	B. WING _		08/1	13/2015
	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542		
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	(RN)-A confirmed to identified or monito alprazolam use.  On 08/13/2015, at nursing (DON) confinct identified or mothe care plan lacked	1:39 p.m. registered nurse arget behaviors were not red for R55's anxiety and 2:29 p.m. the director of irmed target behaviors were nitored for R55 and verified	F 28	in LTC inservice scheduled with Phronsultant 9-28-15 to focus on targe behavior charting.  H. IDT team meetings monthly to resident target behaviors.  I. SSD or her designee will audit documentation of target behaviors x 4 weeks, and then audit monthly charting/target behaviors on all res receiving antianxiety medication.  J. All licensed staff attendees education for compliance with identifying targe behaviors and to document finding EHR at licensed staff meeting 9-2-K. All NAR staff attendees educating reporting indentified target behavior charge nurse & charting on task in at NAR meeting 9-3-15.  L. Staff not attending provided ed on Behavior Monitoring Policy to be read/understood & education on chon task in EHR prior to their next scheduled shift and with all new en orientation.  M. Compliance will be added to ou program by DON and reported to Comeetings monthly.	review R55 weekly idents ucated et s in 15. ed for rs to EHR ucation enarting nployee ur QA	
F 282 SS=D	( / ( / ( /	RVICES BY QUALIFIED ARE PLAN	F 28	N. Completion date 9-22-15.		9/22/15
	must be provided b	led or arranged by the facility y qualified persons in ch resident's written plan of				
	This REQUIREMEN	NT is not met as evidenced				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY PLETED
		245512	B. WING _		08/-	13/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
ESSENT	IA HEALTH FOSSTO	N		900 HILLIGOSS BOULEVARD SOUTH FOSSTON, MN 56542	IEAST	
(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 A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	by: Based on observareview, the facility fassistance as direct plan for 1 of 1 residuative pressure ulcombility. The plan active pressure ulcombil	tion, interview and document ailed to provide repositioning sted by the individualized care dent (R10) reviewed with an er.  ted 6/24/15, indicated R10 was ulcers related to decreased also indicated R10 had a cer on her mid back, along the staff to keep a pressure in the seat and back of R10's offload (relieve pressure) R10 ile seated.  2:50 p.m. to 3:37 p.m. R10 bserved seated in a standard lobby area. The recliner was nain any type of pressure ons. During the observation, wed to be repositioned. Stated R10 was to receive costioning every three hours. In a ssist R10 to stand and transfer at this time, NA-C stated R10 mer since 12:30 p.m. a total of	F 28	First Care Living Center striv services by qualified persons accordance with each reside plan of care.  A. Review and update to C Preliminary policy completed B. Review and updates to F Policy and Monitoring, Turnin Repositioning and Toileting F completed 9-3-15.  C. RN MDS Coordinator concomprehensive assessment, tolerance, and care plan reviet for R10 on 8-10-15.  D. All residents at risk for prulcers will have RN re-assess plan review/ updates, and updates to NA sheets/EHR profile for approre repositioning schedule by 9-2 E. All new residents have P Care Plan implemented within admission by RN MDS Coordinators quality and the signee.  F. Review & Updates will be by RN MDS coordinators quality and the signee.  G. DON or her designee will appropriate repositioning schedules for pressure weekly x 4 weeks until satisfar andomly.  H. Licensed staff education Repositioning Policy & repo	are Plan 9-3-15. Repositioning ng, Policy mpleted a tissue ew/updates ressure sment, care care priate 22-15. reliminary in 24 hours of dinators or e maintained arterly, with change in I audit nedules on 2 ulcers actory then provided on itioning ith risk for	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		245512	B. WING _		08/	13/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENTI	A HEALTH FOSSTON	I		900 HILLIGOSS BOULEVARD SOUTHEAS' FOSSTON, MN 56542	Γ	
(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) COMPLETION DATE
F 309 SS=D	remained in her whactivitiesAt 6:20 p.m. NA-Finto the restroomAt 7:12 p.m. NA-Frepositioned every had not been assist hour and 50 minute.  On 8/13/15, at 8:46 (LPN)-D was obseron R10's mid-spine dressing had been LPN-D measured thopen area measure wound bed was pinyellow slough.  On 8/13/15, at 11:0 to be positioned every wheelchair because.  On 8/13/15, at 12:0 (RN)-A stated R10 1.5 hours when sea directed by the care on 8/13/15, at 12:3 confirmed R10 was hours as directed to in plan was requested.	eelchair during the evening was observed to wheel R10 stated R10 was to be 2-3 hours She verified R10 ded since 4:30 p.m. a total of 1 s earlier.  a.m. licensed practical nurse wed to compete wound care following a bath. The old removed during the bath. The wound and reported the ded 1.4 cm x 0.4 cm. The k with a small amount of  0 a.m. NA-B stated R10 was bery hour while seated in the ele of the sore on her back.  0 p.m. registered nurse was to be repositioned every sted in the wheelchair, as a plan.  0 p.m. the director of nurses to be repositioned every 1.5 by the care plan.  mplementation of the care and none was provided. CARE/SERVICES FOR	F 28	Policy & repositioning schedules residents with risk for pressure ul NA care sheets and accessing the resident profile on the EHR syste NAR 9-3-15.  J. Staff not attending provided on the Repositioning Policy and repositioning schedules, for all rewith risk for pressure ulcers, to be and understood prior to their next scheduled shift and with all new orientation.  K. LPNs will put laminated ¿pur eggs¿ underneath a resident whe wheelchair or bed, then the NARs the ¿purple egg¿ to the LPN whe & document results. Documentati Purple Egg Monitoring Form will be reviewed by DON or her designed weekdays at AM report. This will the length of time between reposition fresidents. Purple Egg audits do weekly on 10 residents who are a pressure ulcers x 4 weeks until satisfactory, then randomly therea Current staff are familiar with the purple egg practice and all new she educated to the repositioning a practice in orientation.  L. Compliance will be added to program by DON and reported to meetings quarterly.  M. Completion date 9-22-15.	cers on e m at ducation sidents e read employee en in sereturn n found on on one e e e e e e e e e e e e e e e	
00=D	Each resident must	receive and the facility must ary care and services to attain				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		E SURVEY PLETED
		245512	B. WING _	<del></del>	08/	13/2015
	PROVIDER OR SUPPLIER	N		STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAS FOSSTON, MN 56542	•	
(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 CORRECTI ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	or maintain the high mental, and psychological accordance with the and plan of care.  This REQUIREMED by:	age 8 hest practicable physical, psocial well-being, in e comprehensive assessment  NT is not met as evidenced tion, interview and document	F 3	First Care Living Center will ensu	ire that	
	review, the facility f wheelchair position the sample reviewe needs.  Findings include:  R33's admission M 7/6/15, indicated R3 diagnosed with dial a stroke with left sid indicated R33 requitwo staff for bed mounable to ambulate	ailed to provide proper ing for 1 of 1 resident (R33) in ed for wheelchair positioning inimum Data Set (MDS) dated 33 had intact cognition, was betes mellitus and a history of ded weakness. The MDS also ired extensive assistance of obbility, transfers and was		each resident will receive and the will provide the necessary care ar services to attain or maintain the practicable physical, mental, and psychosocial well-being, in accord with the comprehensive assessmiplan of care.  A. Review and updates to Preve and Alternative Devices Policy co 9-3-15.  B. OT re-eval of left arm suppor Care Plan update of R33 on 8-14 re-eval and Care Plan update of I-31-15. Plan to continue therapies week and make ongoing changes	facility nd highest dance ent and entative mpleted t and ents, PT R33 on 8 s 5x	
	Assessment (CAA) was unable to be in following her stroke R33's care plan datassist R33 with tranaddress any special needs.  On 8/11/15, at 10:3 seated in a wheelch R33's wheelchair was an each of the seated in t	Daily Living Care Area dated 7/14/15, indicated R33 dependent in mobility e.  ted 7/20/15, directed staff to a sfers. The care plan did not all wheelchair positioning e.  22 a.m. R33 was observed thair in the south dining room. It was observed equipped with a st (lateral support). A full sized		needed. C. RN MDS Coordinator comple comprehensive assessment and plan updates for resident R33 for posey support cushion on her wh on 8/30/15. D. All residents with positioning will have RN re-assessment and Plan review/updates by 9-22-15. E. Upon admit/readmit to facility with significant changes, resident assessed for use of preventative alternative devices by therapy or staff. Education provided to direct	care left arm eelchair devices Care , and s will be and Licensed	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING				E SURVEY PLETED		
		245512	B. WING		08/-	13/2015
	PROVIDER OR SUPPLIER	· ·	,	STREET ADDRESS, CITY, STATE, ZIP COE 900 HILLIGOSS BOULEVARD SOUTHI FOSSTON, MN 56542	)E	
(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 CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	bed pillow was obsand tucked into the R33's left arm was the pillow. At the tir left arm was observed to hang uphysical therapy as reposition R33's ar rest.  On 8/12/15, at 11:5 seated in her whee her left arm. R33's on her lap with the of her knees in a difingers and hand wred/purple color. Rher hand into a posnot be a dependent on the beautiful of the the side of the there walked by R33's roalright. PTA-A statifiell off of the arm rehand was not be stand was not be stand was not be stand was not her hand and on 8/13/15, at 10:4 her room. A 1/4 lapthe floor of her room attempted to use the arm/hand in place of into her ribs and was not was not her room attempted to use the arm/hand in place of into her ribs and was not her ribs and w	erved on top of the arm rest side of the chair next to R33. observed positioned on top of the of the observation, R33's yed to fall off the pillow and of the chair. R33's arm was intil 11:02 a.m. at which time a sistant (PTA) was observed to m on top of the pillow / arm  7 a.m. R33 was observed lchair with a bed pillow under left arm was observed resting hand positioned over the end apendent position. R33's ere observed to be a deep 33 was not observed to move sition in which her hand would than allow for blood flow.  60 p.m. R33 was observed selchair in her room. PTA-A om and asked if R33 was ed R33's left hand frequently est or pillow. He stated R33's rapped into the arm support esting on a pillow. PTA-A stated the ability to independently I therefore staff would have to distribute the rest of the chair, but the tray cut as not comfortable. She stated as hole arm rest cushion on her other arm rest cushion on her allowed arm rest cushion on he	F 309	staff under the direction of lice on how to use the positioning F. Point of care charting in E for task to be signed off by NAG. All staff attendees educate compliance with following care proper positioning devices for other residents with positionin Licensed Staff meeting 9-2-15 staff meeting 9-3-15.  H. Staff not attending provide on Preventative and Alternative Policy & Care Plan policy to be read/understood prior to their scheduled shift and with all neorientation.  I. RN Coordinators will audit observation to ensure all reside following care plan for position weekly until satisfactory x 4 were randomly thereafter and will deaudit results.  J. Compliance will be added program by DON and reported meetings quarterly.  K. Completion date 9-22-15.	devices. EHR system ARs. ed for e plan for R33 and all g devices at and NAR ed education re Device be next ew employee t by dents are ning device eeks, then ocument I to our QA d to QAPI	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245512	B. WING		08	/13/2015
	PROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP C 900 HILLIGOSS BOULEVARD SOUT FOSSTON, MN 56542	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		SHOULD BE	(X5) COMPLETION DATE
F 309	chair but that too win place on the whe started using the bester of the weak hand by herself and pillow support. The was observed to compare to the was observed to compare the was observed support next to the on 8/13/15, at 10:5 arm frequently fell of the stated staff had times a day as R33 reposition the arm to the weak weak the weak of R33's clinicated for the weak of R33's occupation the release which may have the lateral arm support as she lear times which may have the lateral arm support as the lateral arm support are the lateral arm support as th	as not enough to keep her arm relchair. R33 stated staff then red pillow to support her hand. As not able to move her left of it had frequently fell off of the blue lateral support device over the arm rest, however, the disticking out of the lateral wheelchair armrest.  5 a.m. NA-B stated R33's left off of the positioning pillows. It to reposition the arm several was not able to independently back on the pillow.  Inical record indicated R33 was nal therapy five days a week of to the stroke.  The rapy progress note dated R33's half tray on the langed out to a lateral arm need heavily into the tray at lave been the contributing of the rib area on the left. The note in R33's arm did not remain on cort and directed the arm to be into place on the support in ability to independently	F3	909		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245512	B. WING		08/	13/2015	
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH FOSSTON	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
the record had not on R33's hand on the sto use a bed pillow, She stated R33 did consistently reposition dependent upon state verified R33's care position R33's hand was to be used.  On 8/13/15, at 12:20 verified R33's clinical support devices to be wheelchair.  On 8/13/15, at 2:55 occupational therap success.  Review of the Repositional therap success.  Review of the Repositional the wheelch how to use positional 483.25(c) TREATM PREVENT/HEAL Plassed on the comp resident, the facility who enters the facil does not develop prindividual's clinical of they were unavoidal pressure sores received.	B's clinical record and verified directed staff how to position support device nor direct staff lateral support or lap tray. not have the ability to ion her hand and was aff for positioning. RN-A plan did not direct staff how to dor what supportive devices  O p.m. the director of nurses all record did not address be used while in the  p.m. contact with the positioning policy dated 8/2006, sure proper postural alignment hair. It did not direct the staffing devices.  ENT/SVCS TO RESSURE SORES  Tehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that alble; and a resident having gives necessary treatment and a healing, prevent infection and	F3			9/22/15	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245512	B. WING		08/13/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENT	A HEALTH FOSSTOR	N		900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542		
(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 APPROPF DEFICIENCY)	BE COMPLÉTIC	ON
F 314	This REQUIREMEI by: Based on observareview, the facility fassistance as directly fassistance and required staff at a Findings include: R10's quarterly Min 6/15/15, indicated fanxiety, orthopnea lying), one stage two layer of skin and paskin is damaged or at risk for the development of the MDS also indicassistance with becactivities of daily lived R10's Pressure Ulc (CAA) dated 3/27/1 extensive assistance stage one pressure worsening and have R10's care plan datat risk for pressure mobility. The plan active pressure ulc spine and directed reducing cushion in	tion, interview and document ailed to provide repositioning sted by the individualized care vent and / or promote the related ulcers for 1 of 1 had an active pressure ulcer assistance for repositioning.  Inimum Data Set (MDS) dated R10 was diagnosed with (difficulty breathing while vo (partial thickness, the outer art of the underlying layer of rolost.) pressure ulcer and was dopment of pressure ulcers. Cated R10 required extensive dimobility, transferring and ring.  Ser Care Area Assessment 5, indicated R10 required ex with bed mobility, had a equicer which was at risk of ing increased pain.  Ited 6/24/15, indicated R10 was ulcers related to decreased also indicated R10 had an er on her mid back along the staff to keep a pressure in the seat and the back of the offload (relieve pressure) R10	F 314	First Care Living Center will ensure resident who enters the facility withe pressure sore does not develop presores unless the individual; sclinical condition demonstrates that they we unavoidable, and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevesores from developing.  A. Review and update to Skin Assessment policy completed 9-2-1B. Review and updates to Reposit Policy completed 9-2-15.  C. Review and updates to Prevent and Alternative Device policy complete comprehensive assessment, tissue tolerance, and care plan review/upd for R10 on 8-10-15.  E. All residents at risk for pressure ulcers will have RN re-assessment, current tissue tolerance, care plan review/updates, and updates to NA sheets/EHR profile for appropriate repositioning schedule by 9-22-15.  F. Review & Updates will be maint on NA care sheets/ EHR profile by IMDS coordinators quarterly, with each ange of condition, or change in schedule.  G. DON or her designee will audit appropriate repositioning schedule documentation of Purple Egg Monit	out a essure all ere ent new 5. ioning eative eted 9 d a lates e care tained RN each eating oring oring	
	R10's Braden Asse	essment (skin risk assessment)		forms on 10 residents at risk for pre- ulcers weekly x 4 weeks until satisfa		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTI A. BUILDING				E SURVEY IPLETED		
		245512	B. WING		08/	13/2015
	PROVIDER OR SUPPLIER	N		STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEA FOSSTON, MN 56542	•	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	dated 6/15/15, indiced development of preserved in the staff to assist R10 whours while seated bed.  Review of R10's preserved in the staff to assist R10 was staff to assist R10 whours while seated bed.  Review of R10's preserved in the staff preserved	cated R10 was at risk for the essure ulcers.  Sue Tolerance (pressure ssment dated 6/12/15, at risk for ulcers and directed with repositioning every 1.5 and every 3 hours while in ogress notes revealed the admitted to the facility with ness, skin may be painful, but tears) pressure ulcer on her spine. The wounds measure entimeters (cm) and 4.0 cm x placed a pressure reducing d and placed a Mepilex unds to prevent worsening.  Indicate the facility with ness, skin may be painful, but tears and the wounds measure entimeters (cm) and 4.0 cm x placed a pressure reducing d and placed a Mepilex unds to prevent worsening.	F 31	then randomly. H. Licensed staff education pro Skin Assessment Policy and Repositioning Policy & reposition schedules for all residents with pressure ulcers 9-2-15. I. Education for NARs on Repolicy & repositioning schedules residents with risk for pressure NA care sheets and accessing the resident profile on the EHR system NAR 9-3-15. J. Staff not attending provided on the Repositioning Policy and repositioning schedules, for all rewith risk for pressure ulcers, to and understood prior to their nescheduled shift and with all new orientation. K. Compliance will be added to program by DON and reported the meetings quarterly. L. Completion date 9-22-15.	ning risk for cositioning s for all ulcers on he em at education residents be read xt employee	

	PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			` ,	TE SURVEY MPLETED	
		245512	B. WING		08	/13/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 900 HILLIGOSS BOULEVARD SOUTH FOSSTON, MN 56542	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 314	Wound measured green and white no surrounded by a the - 7/2/15, wound me 0.1 cm depth. The duoderm dressing 7/9/15, the woun with beefy red cent is pink scar tissue 7/16/15, the woun with pink scar tissue surrounding 7/23/15, the wound a beefy red center colored slough also - 7/23/15, a second by her primary phy avoid prolonged prolong	to the back was changed. 6.0 cm x 3.0 cm with light on-odorous wound bed in red border. easured 3.4 cm x 2.9 cm and wound was covered with a d measured 3.4 cm by 2.2 cm ter and rolled outer edges that and measured 2.4 cm x 1.4 cm with rolled edges.	F3	314		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION		E SURVEY IPLETED
		245512	B. WING			08/	13/2015
	PROVIDER OR SUPPLIER	ı		900 F	ET ADDRESS, CITY, STATE, ZIP CODE HILLIGOSS BOULEVARD SOUTHEAST STON, MN 56542	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 314	not observed to corpressure redistribut observation, R10 w -At 3:30 p.m. NA-E assistance with rep -At 3:37 p.m. nursir were observed to a into a wheelchair. A had sat in the reclin of three hours and repositioning assist.  On 8/12/15, at 4:40 seated in the south evening meal. R10 equipped with a foat the seat and the basin the dining room ushe was wheeled in remained in her whactivitiesAt 6:20 p.m. NA-F into the restroomAt 7:12 p.m. NA-F repositioned every had not been reposof 1 hour and 50 million on 8/13/15, at 8:46 (LPN)-D was obseron R10's mid-spined dressing had been LPN-D measured thopen area measured	ntain any type of special ion cushions. During this as not observed to reposition. stated R10 was to receive ositioning every three hours. In a sasistant (NA)-C and NA-D saist R10 to stand and transfer at this time, NA-C stated R10 are since 12:30 p.m. for a total rainutes without ance.  p.m. R10 was observed dining room waiting for the 's wheelchair was observed are redistribution cushion on ck of the chair. R10 remained until 5:26 p.m. at which time ato the main lobby area. R10 eelchair during the evening was observed to wheel R10 stated R10 was to be 2-3 hours. NA-F verified R10 itioned since 4:30 p.m. a total	F3	314			
	wound was healed.	open area along the main  LPN-D stated the second eaction to tape. She					

OAFF10 D WING	8/13/2015
245512 B. WING 0	
NAME OF PROVIDER OR SUPPLIER  ESSENTIA HEALTH FOSSTON  STREET ADDRESS, CITY, STATE, ZIP CODE  900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314  Continued From page 16 explained the facility was now using a more gentle tape on R10's wound area.  On 8/13/15, at 11:00 a.m. NA-B stated R10 was to be positioned every hour while seated in the wheelchair because of the sore on her back.  On 8/13/15, at 12:00 p.m. registered nurse (RN)-A stated R10 was to be repositioned every 1.5 hours when seated in the wheelchair, as directed by her care plan. RN-A stated staff had been educated on how to ensure R10 was offloaded off of the back every 1.5 hours and should have provided that assistance. RN-A verified R10 routinely sat in a recliner in the lobby area however, the facility had not placed a pressure redistribution cushion in that chair. She verified R10 required additional interventions and was to be repositioned according to the care plan.  On 8/13/15, at 12:30 p.m. the director of nurses confirmed R10 was to be repositioned every 1.5 hours as directed by the care plan.  The Repositioning policy dated 8/2006, directed staff to reposition the resident according to the individual tissue tolerance assessment.  F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	9/22/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	G	X3) DATE SURVEY COMPLETED
		245512	B. WING _		08/13/2015
	PROVIDER OR SUPPLIER	900 HILLIGOSS BOULEVARD SOUTHEAST		30,10,20.10	
(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)	
F 323	Continued From pa	ge 17	F 32	3	
	by: Based on observation review, the facility for were identified and been implemented falls / accidents and (R10) identified at refindings include:			First Care Living Center will ensure resident environment remains as fre accident hazards as is possible; and resident receives adequate supervis and assistance devices to prevent accidents.  A. IDT team met 9-1-15 to review processes for LTC Fall Prevention Program and EHR event: Falls Scer Investigation Report.  B. RN MDS Coordinator assessments	l each sion ne ent
	6/15/15, indicated F impairment, was at extensive staff assi transferring and act also indicated R10 orthopnea (difficulty pain. In addition, the	imum Data Set (MDS) dated R10 had severe cognitive risk for falls and required stance with bed mobility, tivities of daily living. The MDS was diagnosed with anxiety, by breathing when lying) and e MDS indicated R10 had ore falls within the MDS		and care plan updates for R10 for fa interventions and fall prevention dev completed on 8-30-15.  C. All residents will have falls risk assessment by RN MDS Coordinate care plan updates for fall intervention and fall prevention devices by 9-28-D. All LTC Staff will be provided education to ensure the Falls Scene Investigation Report is filled out completely and to ensure new interventions immediately/care plan	or and ns 15.
	4/2/15, indicated Rassistance with actipoor balance. The	rea Assessment (CAA) dated 10 required extensive ivities of daily living and had assessment indicated she r continued falls and potential		updates with each resident fall at Licensed Staff Meeting 9-2-15 and N staff meeting on 9-3-15.  E. Staff not attending provided edu on the LTC Fall Prevention Program completing the Falls Scene Investiga Report completely, implementing ne	cation and ation w
	R10's Fall assessm R10 was at high ris	nent dated 6/10/15, indicated k for falls.		interventions at the time of the fall & update care plan, to be read and understood prior to their next schedushift and with all new employee orientation.	
	R10's care plan dat	ed 6/24/15, indicated R10 was		F. RN MDS Coordinator will review	and

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F 323	risk for falling related history of falls and program. The plant back wheelchair de R10 to ask for assistransfer, to keep Riwith brakes locked, foot wear and to ke area when restless.  Review of R10's Extended foot wear and to ke area when restless.  Review of R10's Extended foot wear and to ke area when restless.  Review of R10's Extended foot wear and to ke area when restless.  - 3/21/15, at 4:15 a in her room next to sustained. The fact plant to include assis hours at night. In a placed in the lowes.  - 3/31/15, at 5:50 a floor in her room. Note that the plant was report directed staff common area at night. The bed was report directed staff common area at night. The hallway. R10 right buttock. The R10's fall intervention of the pendently walk team meeting note.	ed to decreased mobility, was to be on a fall prevention directed staff to utilize anti-roll evices, a chair alarm, remind stance to ambulate and 10's bed in the lowest position to ensure R10 wore proper tep R10 in a highly visualized went Reports revealed the ment of the management of the managemen	F 325	audit all falls using the Falls So Investigation Report to ensure complete and care plan update weekly falls meetings.  G. Fall Prevention Team will rand will consist of DON, SSD, Therapy, Nursing staff. Team vetermine of root cause and suinterventions to track and reviet trending information. IDT team week audit all Falls Scene Invereports for interventions/care pupdates.  H. Compliance will be added program by DON and reported meetings quarterly.  I. Completion date 9-22-15.	it is es prior to neet weekly ADM, vill assist to uggest w fall will each estigation lan to our QA		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245512	B. WING			08/-	08/13/2015	
NAME OF PROVIDER OR SUPPLIER  ESSENTIA HEALTH FOSSTON				90	TREET ADDRESS, CITY, STATE, ZIP CODE 00 HILLIGOSS BOULEVARD SOUTHEAST OSSTON, MN 56542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	REGULATORY OR LSC IDENTIFYING INFORMATION)		F 3					
	facility by a visitor. off of the curb outsi The Falls Team me	m. R10 was assisted out of the R10 wheeled her wheelchair de and fell. No injury noted. eting notes indicated a placed to alert staff of when						
	On 8/12/15, at 3:24	p.m. nursing assistant (NA)-C						

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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NAME OF PROVIDER OR SUPPLIER  ESSENTIA HEALTH FOSSTON				90	TREET ADDRESS, CITY, STATE, ZIP CODE 00 HILLIGOSS BOULEVARD SOUTHEAST COSSTON, MN 56542		
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F 323	R10 from the reclin was observed to be transfer into the who bearing assistance. At 3:27 p.m. R10 was observed to habars and transfer with two nursing assistations. At 4:38 p.m. R10 win the South dining.  On 8/12/15, at 7:07 (LPN)-A stated who assessed the residinjured, assisted the then attempted to fit LPN-A stated R10 who herself from bed. So on her bed to alert to get up.  On 8/12/15, at 7:15 history of falls. She her as much as possible of the possible	served to extensively assist er and into a wheelchair. R10 e able to stand and pivot eelchair with the NAs weight.  I was assisted to the toilet. R10 and onto the bathroom safety with extensive assistance of the ants.  I p.m. licensed practical nurse en a resident fell, the nurse ent to make sure they were not e resident off of the floor and igure out why the resident fell. Often attempted to transfer She stated R10 had an alarm the staff when she was trying  I p.m. NA-F stated R10 had a e stated staff tried to monitor esible.  I p.m. NA-G stated R10 was to on the bed and chair to alert	F3	123			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION  NG		COMPLETED	
		245512	B. WING _		08	/13/2015
	PROVIDER OR SUPPLIER	N		STREET ADDRESS, CITY, STATE, ZIP COL 900 HILLIGOSS BOULEVARD SOUTH FOSSTON, MN 56542	DE	
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F 323	(RN)-A stated the fan immediate assethe fall and then revof the fall by talking interventions based updating the care properties of the fall by talking interventions based updating the care properties of the fall state of the fall could have the	o a.m. registered nurse acility fall process was to make ssment for injuries following view to look for the root cause to the staff and determining don the root cause followed by plan.  55 p.m. the director of nurses ving each fall, the facility ediate assessment of the ved the situation to determine if been anticipated / prevented. The e6/6/15, fall intervention of the vwas discontinued as the ove of the use of body pillows revention, rather a restraint DON was asked what further implemented following the		23		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	N	STREET ADDRESS, CITY, STATE, ZIP CODE  900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542					
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F 323 F 329 SS=D	assure it is relative and any recommer the RN falls champ	to the foot cause of the falls adation were to be forwarded to sion for implementation.  EGIMEN IS FREE FROM	F 3			9/22/15		
	unnecessary drugs drug when used in duplicate therapy); without adequate n indications for its u adverse consequen	ig regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nces which indicate the dose or discontinued; or any e reasons above.						
	resident, the facility who have not used given these drugs therapy is necessa as diagnosed and crecord; and resider drugs receive grad behavioral interven	chensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical hts who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these						
	by: Based on interviev facility failed to ens	NT is not met as evidenced v and document review, the ure target behaviors were tored for 1 of 5 residents (R55) anxiety medication		First Care Living Center will each resident; s drug regiment free from unnecessary drugs.  A. Review and updates to the	n must be			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245512	B. WING			08/1	13/2015
NAME OF PROVIDER OR SUPPLIER				S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				9	000 HILLIGOSS BOULEVARD SOUTHEAST		
ESSENTIA HEALTH FOS	STON	l			FOSSTON, MN 56542		
PREFIX (EACH DEF	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
7/28/15, indice impairment a and depressive identified R55 one day during tired or having. The MDS further antianxiety material R55's Psychological R55's R5	de:  ly Minated Fred diagraph	imum Data Set (MDS) dated R55 had moderate cognitive gnoses that included anxiety order. The MDS also own, depressed or hopeless assessment period and felt little energy nearly everyday. entified R55 received ion daily.  Medication Use Care Area dated 4/30/15, indicated R55 anxiety and was on alprazolam lication) to help with her ness.  er Report dated cluded orders for alprazolam one tablet twice a day for one tablet at bedtime to help enxiety.  ministration History dated 2/15, indicated R55 received one tablet twice a day and 1	F3	329	Monitoring Policy and Consultant Pharmacist Medication Regimen R Policy completed 9-3-15.  B. Care plan revision completed 8 for R55 to include identified target behaviors/symptoms of anxiety for of antianxiety medication per RN M Coordinator assessment.  C. RN MDS Coordinator assessment and care plan updates for all reside an antianxiety medication to include identified target behaviors/symptom anxiety.  D. Primary care physician visit for on 9-2-15 confirms therapeutic lever antianxiety medication regimen.  E. Point of care charting in EHR s for task to be signed by NARs, to it target behaviors/symptoms of anxiall residents on an antianxiety medicated by RN MDS Coordinators each med change or change in rescondition.  F. Consultant Pharmacy will review monthly all resident; s medication of to ensure they are free from unneed drugs & list target behaviors.  G. Psychopharmacologic Medicat in LTC inservice scheduled with Phonicultant 9-28-15 to focus on targe behavior charting and nonpharmacinterventions.  H. IDT team meetings monthly to resident target behaviors/symptom anxiety.  I. SSD or her designee will audit target behaviors weekly x 4 weeks, then audit monthly charting/target	the use IDS  lent ents on ens of R55 el of	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245512	B. WING	· · · · · · · · · · · · · · · · · · ·	08/	13/2015	
	PROVIDER OR SUPPLIER	N		STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHE, FOSSTON, MN 56542	•		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 329	have any prn order chemical substance and results in altera consciousness), or review did not identisymptoms related to R55's Care Plan dareceived anti-anxie of anxiety and directiveness a monitor mood and update family and of Care Plan also indition would review R55's However, the Care behaviors / sympto On 8/13/15, at 1:07 demonstrated on a behavior monitoring facility. NA-A state monitoring complet there was no promimonitoring by the Nourses might docurrent a reason antianxiety medical antianxiety medical antianxiety medical basis so no docum stated she did not on R55's anxiety but in a furrowed brow, we	r and anxiety states. Does not s for psychotropics (a e that changes brain function ations in perception, mood, or ally scheduled meds." The drug tify specific target behaviors / to R55's anxiety.  ated 8/5/15, identified R55 ty medication for the treatment cted staff to monitor for drug and adverse consequences, response to medication and doctor of any concerns. The cated the pharmacy consultant is medications monthly.  Plan did not identify target ms related to R55's anxiety.  7 p.m. nursing assistant (NA)-A computer workstation how g was done by the NAs for the d there was no behavior ted for R55. She indicated pt in the computer requiring NAs for R55 and stated the	F 329	residents receiving antianxiety J. All licensed staff attendees for compliance with identifying behaviors/symptoms of anxiety document findings in EHR at lice staff meeting 9-2-15. K. All NAR staff attendees educe reporting indentified target behaviors/symptoms of anxiety nurse & charting on task in EHI meeting 9-3-15. L. Staff not attending provided on Behavior Monitoring Policy to read/understood & education of on task in EHR, indentifying syntal anxiety prior to their next scheol and with all new employee ories M. Compliance will be added to program by DON and reported meetings monthly. N. Completion date 9-22-15.	educated target and to censed ucated for to charge R at NAR deducation o be n charting mptoms of duled shift intation.		

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245512	B. WING _		08/	13/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542		
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329		:39 p.m. registered nurse	F 32	9		
	identified or monitoral alprazolam use.	arget behaviors were not red for R55's anxiety and 2:29 p.m. the director of				
	nursing (DON) conf not identified or mo	irmed target behaviors were nitored for R55 and verified d target behaviors for anxiety.				
F 441 SS=F	indicated the purpo- to targeted behavior develop intervention plan to meet the rest also indicated resid would have the beh POC [care plan], pr [computer system] indicated residents antipsychotic medic	oring policy dated 4/2015, se was to collect data related rs, analyze the data and as in the individualized care sident's needs. The policy ents who exhibited behaviors aviors documented on the ogress note and Matrix profile. The policy further on antianxiety and rations would be included. I CONTROL, PREVENT	F 44	1		9/22/15
	The facility must es Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a omfortable environment and development and transmission otion.				
	Program under which (1) Investigates, continuous in the facility; (2) Decides what program (2) Program	tablish an Infection Control				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245512	B. WING		08/13/2015	
	PROVIDER OR SUPPLIER	· ·		STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542	DDE	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE COMPLÉTION	
F 441	(c) Linens Perediting Spreaditions related to in  (b) Preventing Spreadition (1) When the Infect determines that a reprevent the spreadition (2) The facility must communicable disc from direct contact direct contact will transport to the facility must hands after each direct contact will transport to the facility must hands after each direct contact will transport to the facility must hand washing is incompressional practice.	ord of incidents and corrective infections.  ead of Infection tion Control Program esident needs isolation to of infection, the facility must .  It prohibit employees with a ease or infected skin lesions with residents or their food, if cansmit the disease. It require staff to wash their irect resident contact for which dicated by accepted	F 441			
	by: Based on observa review, the facility f infection control pre linen handling in or infection. This prace all 40 residents whe their linens washed the facility failed to trending and analys included symptoms treatment and reso infections. This had	tion, interview and document ailed to ensure appropriate ocedures were followed for der to prevent the spread of tice had the potential to affect oresided in the facility and had by facility staff. In addition, perform adequate tracking, sis of resident infections which is, identified organism, lution dates of resident the potential to affect all 40 and staff in the facility.		First Care Living Center strives to a safe, sanitary, and comfortable environment and to help prevent the development and transmission of and infection. Personnel must han store, process and transport linent to prevent the spread of infections A. Review & updates to First Car Center Laundry policies: Sorting L Bagging of Linen, Washing and Dr. Nursing laundry, Sanitizing Laundry Barrels, Cleaning of Washers and 9-3-15.	ne disease dle, s so as . e Living aundry, rying	

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

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	` '	SURVEY PLETED
		245512	B. WING	i		08/1	13/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
					00 HILLIGOSS BOULEVARD SOUTHEAST		
ESSENT	IA HEALTH FOSSTON	<b>I</b>			OSSTON, MN 56542		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLÉTION DATE
F 441	Continued From pa	ge 27	F	441			
	Findings include:				B. Review of Prairie Pines Assisted Living Standard Precautions for Infe	ection	
	Linen Handling:				policy & Essentia Health isolation que reference guide, education provided	d to	
	During an interview			Assisted Living Laundry staff 9-3-15 C. Assisted Living Staff Laundry st			
		on 8/13/15, at 7:20 a.m., aide (TMA)-A stated laundry			have been educated on the policies		
		ne facility was completed on			the importance of wearing both glov		
		stated, she picked up the			and gowns during the sorting of laur		
		ow bin" and brought it to the			3-15.	,	
		t, wash, dry and fold. TMA-A			D. Assisted Living staff laundry have		
		orted laundry she wore gloves			been educated on the policy update		
		protective gown. TMA-A stated,			the use of yellow infectious linen ba		
		etergent provided by the			be torn open and contaminated laur		
	facility and used big	each on the white clothes.			put directly into the washers 9-3-15.		
	During an interview	on 8/13/15, at 7:54 a.m., the			E. Disposable gowns presently on level and are restocked by supply	a par	
		ger (MM) stated that personal			personnel.		
		led were placed in a bag			F. Audits of use of gowns/gloves w	vill be	
		aminated linens. He stated,			done nightly by LPN nursing staff x		
		ppen and wash the laundry."			week and randomly thereafter.		
	3	,			G. Compliance will be added to ou	r QA	
	During an interview	on 8/13/15, at 11:26 a.m., the			program by DON and reported to Q	API	
		(DON) stated, the facilities			meetings quarterly.		
		ent into a white mesh bag and			H. Completion date 9-22-15		
		bins. She stated the sorting			F 6		
		ndry was done in the laundry			First Care Living Center strives to p	rovide	
		uld be wearing gloves and			a safe, sanitary, and comfortable		
		g dirty laundry. The DON			environment and to help prevent the		
		esident had an infection such			development and transmission of di and infection by established and	sease	
		n difficile colitis which is a swelling and irritation of the			maintained infection control program	n and	
		blon that can be passed from			prevent the spread of disease by tra		
		or MRSA (methicillin-resistant			and trending illnesses.	.omig	
		reas which is a strain of			A. Review and updates to: Illness		
		ecome resistant to antibiotics),			Report-Employee policy & Essentia		
		'check the policy" but			Health Infection Prevention and Cor		
		ere available for use. She also			Program Policy 9-3-15,		
		s were cleaned every shift.			B. Updated Report of Employee		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245512	B. WING		08/1	3/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	33,1	0,1010
ECCENT		M		900 HILLIGOSS BOULEVARD SOUTHEAST		
ESSENT	IA HEALTH FOSSTOI	<b>\</b>		FOSSTON, MN 56542		
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	p.m., revealed a rodryers, a sink, multapproximately six folding. An inspecticabinets revealed when sorting laund.  Review of a policy Center: SORTING instructed staff to stemperature while equipment: gown a correct sorting of s.  Infection tracking a Review of Residen (RITF) for May 201 August 2015, direct have signs or symptomate influenza like illness date, resident nam (vaccination) and a The May 2015 RIT symptoms of infect (upper respiratory in name along with the infection. No symptomate was listed, no date was an indication of an wound. No symptomate was listed, no	ry facility on 8/13/15, at 12:33 om with two washers, two ciple cabinets and one counter eet in length for sorting and on of the laundry room and no gowns were present for use ry.  Iabeled First Care Living LAUNDRY, dated 6/8/15, cort linen according to color and wearing personal protective and gloves, to ensure the oiled linen.	F 44	,	eport of aff  d in  Dyee fection nding  w illy for ment & weekly itrol  ns plete eport es/ ness g, and n ism, it it it & ant is ent	
	names but no sym	otoms were noted, no f antibiotics and no resolution		on all residents who have had infect the past month and documentation	tions in	

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

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245512	B. WING			08/	13/2015
	PROVIDER OR SUPPLIER	ı		9	TREET ADDRESS, CITY, STATE, ZIP CODE 00 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542		
(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 441	had symptoms of in noted to be URI's. Coughing and fever antibiotic, none lister resident were identibut no symptoms wand the source of the One resident was natibiotic on two sethe skin, no organis symptoms were list identified.  The July 2015 RITE were receiving antiblisted with no indicate resolution dates not have a urinary tractorganism, symptom Two residents had antibiotic noted with The August RITE in symptoms of infection noted with no symptoms of infection of the URI's with noted. Two resident due to URI's with noted to URI's with noted with resident resident recking Center: Employee I Rates indicated reswere tracked by typother tracking information.	F indicated seven residents affection. Four infections were One noted symptoms of all four indicated use of an ed a resolution date. Two affect as receiving antibiotics, were noted, no resolution date the infection was not identified. To to to to be receiving an aparate dates for infection of an ed and no resolution date was deand no resolution date was deand no resolution date was deand no resident was noted to infection (UTI), with no as or resolution date identified. Only the names of the no other information.  Indicated three residents had the no other information.  Indicated three residents had the notated three residents had	F 4	141	presented to monthly Infection Cor Team Meeting.  L. Compliance will be added to or program by DON and reported to Comeetings quarterly & Essentia Infection Control meetings quarterly.  M. Completion date 9-22-15.	ır QA DAPI	

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

	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		COMPLETED	
		245512	B. WING		08	08/13/2015	
	PROVIDER OR SUPPLIER	I	•	STREET ADDRESS, CITY, STATE, ZIP COD 900 HILLIGOSS BOULEVARD SOUTHE FOSSTON, MN 56542	)E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 441	Employee Illness recorrelation between other tracking or tree.  During an interview DON stated she trabasis on the RITF aillness for comparishallways to see if the specific hallways," organism." She state UTI's for a quality in quarterly hand was DON did not identify	Surveillance report and eport identified no noted a staff and resident illness. No ending was identified.  on 8/13/15 at 11:33 a.m., the cked infections on a daily and tracked staff and resident on. She stated, "I track be infection is contained on but stated, "I do not track the ted she is currently tracking inprovement project and that thing audits were done. The yany tracking and trending of or analysis of the information	F4	141			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES F5 5/2024 CENTERS FOR MEDICARE & MEDICAID SERVICES

(X2) MULTIPLE CONSTRUCTION

Printed: 08/14/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY A. BUILDING 01 - NURSING HOME AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 245512 B. WING 08/12/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 HILLIGOSS BOULEVARD SOUTHEAST **ESSENTIA HEALTH FOSSTON** FOSSTON, MN 56542 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Essentia Health Care-Fosston was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Essentia Health Care-Fosston is a one story building with a no basement. The building was constructed in 1972 & 1997, Type II(111) Construction. It is properly 2 hour fire separated from the attached hospital and assisted living. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 50 beds and had a census of 41 at the time of the survey. At this time, the conditions of 42 CFR, Subpart 483.70(a) is met.

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.

(X6) DATE

TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered August 26, 2015

Mr. Kevin Dish, Administrator Essentia Health Fosston 900 Hilligoss Boulevard Southeast Fosston, Minnesota 56542

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5512025

Dear Mr. Dish:

The above facility was surveyed on August 10, 2015 through August 13, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Essentia Health Fosston August 26, 2015 Page 2

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 Lyla Burkman at (218) 308-2104 or email: lyla.burkman@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 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

PRINTED: 09/08/2015 FORM APPROVED

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00461	B. WING		08/1	3/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENTIA HEALTH FOSSION			GOSS BOUL I, MN 56542	LEVARD SOUTHEAST		
(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
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correspursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber and MN Rumber and mumber and mu	nether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments 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.s	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** 09/04/15

STATE FORM 6899 HL2V11 If continuation sheet 1 of 35

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00461	B. WING		08/1	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ESSENT	IA HEALTH FOSSTON		GOSS BOUL 1, MN 56542	EVARD SOUTHEAST		
(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	(X5) COMPLETE DATE
2 000	you electronically, is necessary for State enter the word "corn text. You must then State licensure proceedings of the state licensure proceedings of the state licensure proceedings of the state licensure procedures are issued. Electronic plan of coreviewed these ord they will be complemented they will be complemented to make the state Licensing federal software. The assigned to Minnes Nursing Homes.  The assigned tag in column entitled "ID statute/rule out of complemented they will be complemented to the statement of the statemented the statemented the statemented the statemented the Suggested of the Suggested	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.  8/12/15, and 8/13/15 epartment's staff, visited the the following correction Please indicate in your orrection that you have ers, and identify the date when ted.  Inent of Health is documenting Correction Orders using ag numbers have been nota state statutes/rules for  umber appears in the far left of Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and crection.  ARD THE HEADING OF THE WHICH STATES,	2 000			
	"PROVIDER'S PLA	N OF CORRECTION." THIS				

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STATE FORM 6899 HL2V11 If continuation sheet 2 of 35

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00461	B. WING		08/1	3/2015	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE LEVARD SOUTHEAST			
ESSENT	IA HEALTH FOSSTON		I, MN 56542				
(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 APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 000	Continued From pa	ge 2	2 000				
	THIS WILL APPEA	R ON EACH PAGE.					
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.					
2 560	MN Rule 4658.0409 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			9/22/15	
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The con must include the inc	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, vchosocial needs that are apprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).					
	by: Based on observati review, the facility fi include the use of v and positioning nee	on, interview and document ailed to develop a care plan to wheelchair positioning devices eds for 1 of 1 resident (R33) se of positioning devices.		Corrected			
	Findings include:						
	assist R33 with transtroke with left side	red 7/20/15, directed staff to nsfers due to history of a d weakness. The care plan v special wheelchair					
	seated in a wheelch	2 a.m. R33 was observed nair in the south dining room. as observed equipped with a					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00461	B. WING		08/1	3/2015
NAME OF PROVIDER OR SUPPLIER  ESSENTIA HEALTH FOSSTON	900 HILLIO		TATE, ZIP CODE EVARD SOUTHEAST		
PREFIX (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
bed pillow was obse and tucked into the R33's left arm was of the pillow. At the time left arm was observed hang down the side observed to hang urphysical therapy assisted in her wheeled her left arm. R33's on her lap with the hof her knees in a defingers and hand we red/purple color. R3 her hand into a position to be a dependent.  On 8/12/15, at 12:50 sleeping in her wheeled hand was not be a dependent.  On 8/12/15, at 12:50 sleeping in her wheeled hand was not be strated fell off of the arm resultand was not be strated was not be strated was not be strated was not have the reposition her hand move her hand and.  On 8/13/15, at 10:47 her room. A 1/4 lap the floor of her room attempted to use the arm/hand in place of into her ribs and was not was not her ribs and	t (lateral support). A full sized erved on top of the arm rest side of the chair next to R33. observed positioned on top of the of the observation, R33's ed to fall off the pillow and of the chair. R33's arm was ntil 11:02 a.m. at which time a sistant (PTA) was observed to n on top of the pillow / arm  7 a.m. R33 was observed chair with a bed pillow under left arm was observed resting nand positioned over the endopendent position. R33's ere observed to be a deep 33 was not observed to move tion in which her hand would and allow for blood flow.  9 p.m. R33 was observed elchair in her room. PTA-A om and asked if R33 was od R33's left hand frequently st or pillow. He stated R33's apped into the arm support sting on a pillow. PTA-A stated e ability to independently therefore staff would have to reposition when needed.  7 a.m. R33 was interviewed in tray was observed sitting on a R33 stated staff had e lap tray to hold her left in the chair, but the tray cut is not comfortable. She stated blue arm rest cushion on her	2 560			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00461	B. WING		08/13/2015	
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/1	3/2013
	IA HEALTH FOSSTON	900 HILLI	, ,	EVARD SOUTHEAST		
(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
2 560	chair but that too win place on the whe started using the be She verified she wahand by herself and pillow support. The was observed to co foam was observed support next to the On 8/13/15, at 10:5 arm frequently fell of She stated staff had times a day as R33 arm back on the pillon On 8/13/15, at 11:0 (RN)-A stated the lawheelchair were plato ensure proper bowheelchair. RN-Ar verified the plan did supports were need On 8/13/15, at 12:2 verified R33's care supportive devices wheelchair.  On 8/13/15, at 2:55 occupational therap success.  A policy related to corequested and none of the state of the plan did supports were need to support the supportive devices wheelchair.	as not enough to keep her arm selchair. R33 stated staff then ed pillow to support her hand. As not able to move her left it had frequently fell off of the blue lateral support device over the arm rest, however, the it sticking out of the lateral wheelchair armrest.  5 a.m. NA-B stated R33's left off of the positioning pillows. It to reposition the arm several was not able to reposition the low independently.  0 a.m. registered nurse ateral supports on the aced by occupational therapy ody alignment while in the reviewed the care plan and a not address what type of ded in / on R33's wheelchair.  0 p.m. the director of nurses plan did not address to be used while in the oist was attempted without the same plan development was a was provided.  ETHOD FOR CORRECTION:	2 560			
		sing could review and revise ocedures related to the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00461	B. WING		08/1	3/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	·	
ESSENT	IA HEALTH FOSSTON	d .	GOSS BOUL 1, MN 56542	LEVARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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
2 560	could provide educifacility could develor ensure ongoing confindings to the Quantime PERIOD FOR (21) days.	re plans. She or designee ation to all involved staff. The op a monitoring system to appliance and report the lify Assurance Committee.	2 560			
2 565	Plan of Care; Use Subp. 3. Use. A co	5 Subp. 3 Comprehensive omprehensive plan of care personnel involved in the incomprehensive plan of care in the incomprehensive plan of ca	2 565			9/22/15
	by: Based on observati review, the facility for assistance as direct	ent is not met as evidenced ion, interview and document ailed to provide repositioning ted by the individualized care lent (R10) reviewed with an er.		Corrected		
	at risk for pressure mobility. The plan a current pressure ule spine, and directed reducing cushion of	ted 6/24/15, indicated R10 was ulcers related to decreased also indicated R10 had a cer on her mid back, along the staff to keep a pressure in the seat and back of R10's offload (relieve pressure) R10 ile seated.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  COMI		SURVEY LETED		
		00461	B. WING		08/1	3/2015
	PROVIDER OR SUPPLIER	900 HILLI		STATE, ZIP CODE LEVARD SOUTHEAST		
(X4) ID PREFIX TAG	ÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 565	On 8/12/15, from 13 was continuously of recliner in the front not observed to corredistribution cushic R10 was not observed. At 3:30 p.m. NA-E assistance with repart 3:37 p.m. nursing were observed to a into a wheelchair. A had sat in the reclination three hours and seven on 8/12/15, at 4:40 seated in the south evening meal. R10 equipped with a foat the seat and the bain the dining room ushe was wheeled in remained in her whactivities.  -At 6:20 p.m. NA-F into the restroomAt 7:12 p.m. NA-F repositioned every and not been assist hour and 50 minute.  On 8/13/15, at 8:46 (LPN)-D was obser on R10's mid-spined dressing had been LPN-D measured thopen area measure wound bed was pinyellow slough.	2:50 p.m. to 3:37 p.m. R10 bserved seated in a standard lobby area. The recliner was stain any type of pressure ons. During the observation, wed to be repositioned. stated R10 was to receive ositioning every three hours. In a assistant (NA)-C and NA-D ssist R10 to stand and transfer at this time, NA-C stated R10 her since 12:30 p.m. a total of wen minutes.  In p.m. R10 was observed dining room waiting for the large wheelchair was observed arm redistribution cushion on ck of the chair. R10 remained until 5:26 p.m. at which time into the main lobby area. R10 eelchair during the evening was observed to wheel R10 stated R10 was to be 2-3 hours. She verified R10 ted since 4:30 p.m. a total of 1	2 565			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00461	B. WING		08/1	3/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH FOSSTON	J	GOSS BOUL I, MN 56542	EVARD SOUTHEAST		
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 7	2 565			
	to be positioned every hour while seated in the wheelchair because of the sore on her back.					
	(RN)-A stated R10	0 p.m. registered nurse was to be repositioned every ated in the wheelchair, as e plan.				
	On 8/13/15, at 12:3 confirmed R10 was hours as directed b	0 p.m. the director of nurses to be repositioned every 1.5 y the care plan.				
		mplementation of the care I and none was provided.				
	The director of nurs the policies and pro- care plans. She or education to all invo- develop a monitorir	ETHOD FOR CORRECTION: sing could review and revise occdures related to following designee could provide olived staff. The facility could not system to ensure ongoing port the findings to the Qualify tee.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one				
2 570	MN Rule 4658.0409 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			9/22/15
	care must be review interdisciplinary tea physician, a registe for the resident, and	A comprehensive plan of wed and revised by an m that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs,				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMP	SURVEY LETED
00461 B. WING 08/1	3/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
ESSENTIA HEALTH FOSSTON  900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542	
(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
2 570  Continued From page 8 and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.  This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include target behaviors for the use of antianxiety medication for 1 of 5 residents (R55) who received anti-anxiety medication.  Findings include:  R55's quarterly Minimum Data Set (MDS) dated 7/28/15, indicated R55 had moderate cognitive impairment and diagnoses that included anxiety, depressive disorder and hypertension. The MDS also identified R55 felt down, depressed or hopeless one day during the assessment period and felt tired or having had little energy nearly everyday. The MDS further identified R55 received antianxiety medication daily. R55's Psychotropic Medication Use Care Area Assessment (CAA) dated 4/30/15, indicated R55 had a diagnosis of anxiety and was on alprazolam (an antianxiety medication) to help with her feelings of anxiousness.  R55's Care Plan dated 8/5/15, identified R55 received anti-anxiety medication for the treatment of anxiety and directed staff to monitor for drug use effectiveness and adverse consequences, monitor mood and response to medication and	

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STATEMENT OF DEFICIENCIES (X1)

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00461	B. WING		08/1	3/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENT	IA HEALTH FOSSTON	4	GOSS BOOL I, MN 56542	EVARD SOUTHEAST		
(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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From page 9		2 570			
	would review R55's medications monthly. However, the Care Plan did not identify target behaviors related to R55's anxiety.					
	On 08/13/2015, at 1:39 p.m. registered nurse (RN)-A confirmed target behaviors were not identified or monitored for R55's anxiety and alprazolam use.					
	nursing (DON) conf	2:29 p.m. the director of firmed target behaviors were nitored for R55 and verified d target behaviors.				
	No policy regarding provided.	care plan revision was				
	The director of nurs the policies and pro of care plans. She education to all invo develop a monitorir	ETHOD FOR CORRECTION: sing could review and revise ocedures related to the revision or designee could provide olived staff. The facility could no system to ensure ongoing port the findings to the Qualify tee.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			9/22/15
	receive nursing car custodial care, and individual needs an	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	
ı		00461	B. WING		08/1	3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD		STATE, ZIP CODE		
ESSENT	IA HEALTH FOSSTON	l .	GOSS BOUL	EVARD SOUTHEAST		
(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
2 830	plan of care as des 4658.0405. A nursi of bed as much as written order from the	scribed in parts 4658.0400 and ang home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830			
	by: Based on observati review, the facility fa were identified and been implemented	ent is not met as evidenced on, interview and document ailed to ensure causal factors adequate interventions had in order to minimize the risk of d / or injury for 1 of 1 resident isk for falls.		Corrected		
	Findings include:					
	6/15/15, indicated Fimpairment, was at extensive staff assi transferring and act also indicated R10 orthopnea (difficulty pain. In addition, the	imum Data Set (MDS) dated R10 had severe cognitive risk for falls and required stance with bed mobility, tivities of daily living. The MDS was diagnosed with anxiety, breathing when lying) and e MDS indicated R10 had ore falls within the MDS				
	4/2/15, indicated Rassistance with actipoor balance. The	rea Assessment (CAA) dated 10 required extensive vities of daily living and had assessment indicated she r continued falls and potential				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		00461	B. WING		08/	13/2015
	PROVIDER OR SUPPLIER	900 HILL		STATE, ZIP CODE EVARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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
2 830	Continued From pa	ge 11	2 830			
	R10's Fall assessm R10 was at high ris	nent dated 6/10/15, indicated k for falls.				
	risk for falling related history of falls and a program. The plan back wheelchair de R10 to ask for assistransfer, to keep Rawith brakes locked,	ted 6/24/15, indicated R10 was ed to decreased mobility, was to be on a fall prevention directed staff to utilize anti-roll evices, a chair alarm, remind stance to ambulate and 10's bed in the lowest position to ensure R10 wore proper ep R10 in a highly visualized.				
	Review of R10's Ev following:	rent Reports revealed the				
	in her room next to sustained. The fac plan to include assi	.m. R10 was found on the floor her night stand. No injuries ility updated R10's toileting sting R10 to the toilet every 4 ddition R10's bed was to be t position.				
	floor in her room. N The follow up repor spontaneous and d self. The bed was	.m. R10 was found on the lo injuries were noted. It indicated R10 was very id not recognize danger to in the lowest position. The f to allow R10 to sleep in the ght.				
	in the hallway. R10	.m. R10 was found on the floor I sustained a bruise to her facility made no changes to				

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WIIIIII	ila Departificiti di Fie	ailii				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00461	B. WING	B. WING		3/2015
					1 00/1	0/2010
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENT	IA HEALTH FOSSTON	l .		LEVARD SOUTHEAST		
		FOSSTON	I, MN 56542			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
IAG		33 12 2.11.11 1 11.13 11.11 3 1 11.11 11.11 11.11	IAG	DEFICIENCY)		
0.000	Outle of France	10	0.000			
2 830	Continued From pa	ge 12	2 830			
	R10's fall intervention	ons at that time.				
	- 5/5/15. at 8:56 a.n	n. R10 was seated at the				
		stood up and attempted to				
		and fell. No injuries. The falls				
		indicated R10 was working				
		sing on a walking program as				
		walk on her own. No other				
		e to R10's care plan following				
	the fall.					
	6/6/15 at 2:40 a n	n. R10 was found on the floor				
		st her bed. No injuries. The				
		pillow next R10 while in bed.				
		ctor of nurses removed the				
		re R10 was not restrained. No				
		e made to R10's care plan				
	following the fall.					
	ŭ					
		m. R10 was found on the floor				
		R10's chair alarm was				
		attempted to stand and sat				
		The Falls Team meeting note				
		ed need not met," R10				
		ing to stand up." No other				
	<u> </u>	e to R10's care plan following				
	the fall.					
	- 6/25/15 at 8:20 n	.m. R10 was found on the				
		ing public restroom. No injury				
		did not contain further				
	documentation rela					
	2200					
	- 7/21/15, 12:27 p.r	m. R10 was found on the floor				
		ne bed alarm was working. No				
		changes were made to R10's				
	care plan following	the fall.				
	-7/21/15 at 3:45 p.s	m R10 was assisted out of the				

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facility by a visitor. R10 wheeled her wheelchair

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00461	B. WING		08/	13/2015
	PROVIDER OR SUPPLIER	900 HILLI		STATE, ZIP CODE LEVARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	off of the curb outsi The Falls Team me wandergaurd was p R10 left the facility.  On 8/12/15, at 3:24 and NA-D were obs R10 from the reclin was observed to be transfer into the wh bearing assistanceAt 3:27 p.m. R10 v was observed to ha bars and transfer w two nursing assista -At 4:38 p.m. R10 v in the South dining  On 8/12/15, at 7:07 (LPN)-A stated whe assessed the reside injured, assisted the then attempted to fi LPN-A stated R10 of herself from bed. So on her bed to alert to get up.  On 8/12/15, at 7:15 history of falls. She her as much as pos On 8/12/15, at 7:15 have a bed alarm of staff she needed as On 8/13/15, at 6:58 asleep, in bed. R10	de and fell. No injury noted. eting notes indicated a placed to alert staff of when p.m. nursing assistant (NA)-C served to extensively assist er and into a wheelchair. R10 e able to stand and pivot eelchair with the NAs weight was assisted to the toilet. R10 and onto the bathroom safety with extensive assistance of the nts. was observed seated at a table room.  In p.m. licensed practical nurse en a resident fell, the nurse ent to make sure they were not e resident off of the floor and igure out why the resident fell. Often attempted to transfer the stated R10 had an alarm the staff when she was trying  In p.m. NA-F stated R10 had a estated staff tried to monitor esible.  In p.m. NA-G stated R10 was to an the bed and chair to alert	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00461	B. WING		08/1	13/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH FOSSTON		GOSS BOUL 1, MN 56542	EVARD SOUTHEAST		
(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 SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 14	2 830			
	observed to assist I extensive assistance	a.m. NA-H and NA-I were R10 from bed. R10 required to e. R10 was not observed to or participate with weight transfer.				
	(RN)-A stated the fa an immediate asset the fall and then rev of the fall by talking	O a.m. registered nurse acility fall process was to make ssment for injuries following view to look for the root cause to the staff and determining I on the root cause followed by lan.				
	(DON) stated follow performed an immeresident and review the fall could have to the DON stated the placement of a pillofacility did not approas an effective interdevice. When the D	5 p.m. the director of nurses ving each fall, the facility ediate assessment of the red the situation to determine if peen anticipated / prevented. e 6/6/15, fall intervention of the was discontinued as the pove of the use of body pillows evention, rather a restraint DON was asked what further implemented following the not respond.				
	completed a compr quarterly and with e assessment. She s had added the inter alarm, however, it h plan. She verified comprehensive ass causal factors relate determined if further	p.m. RN-A stated the facility ehensive fall assessment each significant change stated at some point the staff eventions of utilizing a bed had not been added to the care the facility had not completed eessment which included ed to the falls and had not er interventions were needed.				
	The undated Long	Term Care Fall Prevention				

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Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP		SURVEY PLETED		
			7. BOILDING.	,		
		00461	B. WING		08/1	3/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH FOSSTON		GOSS BOUL I, MN 56542	LEVARD SOUTHEAST		
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From page 15		2 830			
	at least weekly and discuss the root car also to review the ir assure it is relative and any recommen	ne fall prevention team to meet review the fall report to use of the fall. The team was ntervention put into place to to the foot cause of the falls dation were to be forwarded to ion for implementation.				
	The director of nurs the policies and pro- falls. She or design all involved staff. T monitoring system	ETHOD FOR CORRECTION: sing could review and revise ocedures related to resident nee could provide education to the facility could develop a to ensure ongoing compliance ngs to the Qualify Assurance				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one				
2 835	MN Rule 4658.0520 Proper Nursing Car	O Subp. 2 A Adequate and re; Criteria	2 835			9/22/15
	proper care. The cadequate and proper Evidence of adequate	ate care and kind and ent at all times. Privacy must				
	by: Based on observati review, the facility f wheelchair position	ent is not met as evidenced on, interview and document ailed to provide proper ing for 1 of 1 resident (R33) in d for wheelchair positioning		Corrected		

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 16 of 35 HL2V11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
		00461	B. WING		08/1	13/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENT	IA HEALTH FOSSTON	u .	GOSS BOUL 1, MN 56542	LEVARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT 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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 835	Continued From pa	ge 16	2 835			
	needs.					
	Findings include:					
	7/6/15, indicated R3 diagnosed with diak a stroke with left sic indicated R33 requitwo staff for bed mounable to ambulate R33's Activities of E Assessment (CAA)	Daily Living Care Area dated 7/14/15, indicated R33				
	following her stroke R33's care plan dat assist R33 with tran	ted 7/20/15, directed staff to nsfers. The care plan did not all wheelchair positioning				
	seated in a wheelch R33's wheelchair w built up, left arm res bed pillow was obseand tucked into the R33's left arm was the pillow. At the tin left arm was observed to hang uphysical therapy as	2 a.m. R33 was observed nair in the south dining room. ras observed equipped with a st (lateral support). A full sized erved on top of the arm rest side of the chair next to R33. observed positioned on top of the of the observation, R33's red to fall off the pillow and of the chair. R33's arm was intil 11:02 a.m. at which time a sistant (PTA) was observed to m on top of the pillow / arm				
	seated in her whee	7 a.m. R33 was observed lchair with a bed pillow under left arm was observed resting				

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STATE FORM 6899 HL2V11 If continuation sheet 17 of 35

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  900 HILLIGOSS BOULEVARD SOUTHEAST FOSTON, MN 56542  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 835  Continued From page 17 on her lap with the hand positioned over the end of her knees in a dependent position. R33's fingers and hand were observed to be a deep red/purple color. R33 was not observed to move her hand into a position in which her hand would not be a dependent and allow for blood flow.  On 8/12/15, at 12:50 p.m. R33 was observed sleeping in her wheelchair in her room. PTA-A walked by R33's room and asked if R33 was alright. PTA-A stated R33's left hand frequently	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
### ESSENTIA HEALTH FOSSTON  ### POSSTON  ### POUNDER'S PLAN OF CORRECTION  ### PREFIX TAG  ##			00461	B. WING	· · · · · · · · · · · · · · · · · · ·	08/1	3/2015
(X4) ID PREFIX TAG STON (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 835 Continued From page 17 on her lap with the hand positioned over the end of her knees in a dependent position. R33's fingers and hand were observed to be a deep red/purple color. R33 was not observed to move her hand into a position in which her hand would not be a dependent and allow for blood flow.  On 8/12/15, at 12:50 p.m. R33 was observed sleeping in her wheelchair in her room. PTA-A walked by R33's room and asked if R33 was	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 835  Continued From page 17  on her lap with the hand positioned over the end of her knees in a dependent position. R33's fingers and hand were observed to be a deep red/purple color. R33 was not observed to move her hand into a position in which her hand would not be a dependent and allow for blood flow.  On 8/12/15, at 12:50 p.m. R33 was observed sleeping in her wheelchair in her room. PTA-A walked by R33's room and asked if R33 was	ESSENT	TA HEALTH FOSSTO	N				
on her lap with the hand positioned over the end of her knees in a dependent position. R33's fingers and hand were observed to be a deep red/purple color. R33 was not observed to move her hand into a position in which her hand would not be a dependent and allow for blood flow.  On 8/12/15, at 12:50 p.m. R33 was observed sleeping in her wheelchair in her room. PTA-A walked by R33's room and asked if R33 was	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
fell off of the arm rest or pillow. He stated R33's hand was not be strapped into the arm support device but rather resting on a pillow. PTA-A stated R33 did not have the ability to independently reposition her hand therefore staff would have to move her hand and reposition when needed.  On 8/13/15, at 10:47 a.m. R33 was interviewed in her room. A 1/4 lap tray was observed sitting on the floor of her room. R33 stated staff had attempted to use the lap tray to hold her left arm/hand in place on the chair, but the tray cut into her ribs and was not comfortable. She stated staff had placed the blue arm rest cushion on her chair but that too was not enough to keep her arm in place on the wheelchair. R33 stated staff then started using the bed pillow to support her hand. She verified she was not able to move her left hand by herself and if had frequently fell off of the pillow support. The blue lateral support device was observed to cover the arm rest, however, the foam was observed sticking out of the lateral support next to the wheelchair armrest.  On 8/13/15, at 10:55 a.m. NA-B stated R33's left arm frequently fell off of the positioning pillows. She stated staff had to reposition the arm several times a day as R33 was not able to independently reposition the arm back on the pillow.	2 835	on her lap with the of her knees in a difingers and hand wred/purple color. Fher hand into a posnot be a dependen On 8/12/15, at 12:5 sleeping in her who walked by R33's roalright. PTA-A statifell off of the arm rehand was not be st device but rather reR33 did not have threposition her hand move her hand and On 8/13/15, at 10:4 her room. A 1/4 lapthe floor of her room attempted to use tharm/hand in place into her ribs and was staff had placed the chair but that too win place on the who started using the boshe verified she was and by herself and pillow support. The was observed to co foam was observe	hand positioned over the end ependent position. R33's were observed to be a deep as was not observed to move sition in which her hand would the and allow for blood flow.  To p.m. R33 was observed elechair in her room. PTA-A som and asked if R33 was ed R33's left hand frequently est or pillow. He stated R33's trapped into the arm support esting on a pillow. PTA-A stated the ability to independently the therefore staff would have to distributed the reposition when needed.  To a.m. R33 was interviewed in the tray was observed sitting on m. R33 stated staff had the lap tray to hold her left on the chair, but the tray cut as not comfortable. She stated the blue arm rest cushion on her was not enough to keep her arm the elchair. R33 stated staff then elected in the support her hand. The arm rest, however, the disticking out of the lateral wheelchair armrest.  To a.m. NA-B stated R33's left off of the positioning pillows. In the position of the lateral wheelchair armrest.  To a.m. NA-B stated R33's left off of the position of the arm several arm was not able to independently.	2 835			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00461	B. WING		08/1	3/2015
	PROVIDER OR SUPPLIER	900 HILLIO	, ,	STATE, ZIP CODE LEVARD SOUTHEAST		
(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
2 835	Continued From page 18		2 835			
	receiving occupation for treatment related					
	7/16/15, indicated F wheelchair was cha support as she lear times which may ha factor to R33's sore continued to explair the lateral arm supp strapped / secured	nerapy progress note dated R33's half tray on the anged out to a lateral arm need heavily into the tray at ave been the contributing or rib area on the left. The note in R33's arm did not remain on cort and directed the arm to be into place on the support in ability to independently				
	R33's clinical record documentation reladevices.	d lacked further ted to wheelchair positioning				
	(RN)-A stated R33's placed on the whee RN-A reviewed R33 the record had not on R33's hand on the sto use a bed pillow, She stated R33 did consistently reposit dependent upon staverified R33's care	0 a.m. registered nurse is lateral arm support were elchair by occupational therapy. It's clinical record and verified directed staff how to position support device nor direct staff lateral support or lap tray. Not have the ability to ion her hand and was aff for positioning. RN-A plan did not direct staff how to it or what supportive devices				
	verified R33's clinic	0 p.m. the director of nurses al record did not address be used while in the				

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00461	B. WING		08/1	3/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH FOSSTON	u .	GOSS BOUL I, MN 56542	EVARD SOUTHEAST		
(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
2 835	Continued From pa	ge 19	2 835			
		p.m. contact with the pist was attempted without				
	directed staff to ens	ositioning policy dated 8/2006, sure proper postural alignment hair. It did not direct the staffing devices.				
	The director of nurs the policies and pro- wheelchair seating. provide education t could develop a mo	ETHOD FOR CORRECTION: sing could review and revise occdures related to the proper. She or designee could o all involved staff. The facility onitoring system to ensure e and report the findings to the Committee.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one				
2 900	MN Rule 4658.0529 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			9/22/15
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure s pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	B. a resident w	rho has pressure sores				

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STATE FORM 6899 HL2V11 If continuation sheet 20 of 35

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00461	B. WING		08/13/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	-	
ESSENT	IA HEALTH FOSSTON	l .	GOSS BOUL I, MN 56542	EVARD SOUTHEAST		
(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
2 900	Continued From pareceives necessary promote healing, promote healing, promote healing, promote healing, promote healing, promote healing, promote healing of pressure review, the facility from the plan in order to president (R10) who and required staff and required staff are resident (R10) who and required staff and required staff are resident (R10), one stage two layer of skin and paskin is damaged or at risk for the devel The MDS also indicassistance with becautivities of daily liver R10's Pressure Ulca (CAA) dated 3/27/1 extensive assistance	ge 20  y treatment and services to revent infection, and prevent yeloping.  ent is not met as evidenced on, interview and document ailed to provide repositioning ted by the individualized care went and / or promote the related ulcers for 1 of 1 had an active pressure ulcer assistance for repositioning.  imum Data Set (MDS) dated R10 was diagnosed with (difficulty breathing while o (partial thickness, the outer art of the underlying layer of lost.) pressure ulcers and was opment of pressure ulcers. Eated R10 required extensive in mobility, transferring and ing.  er Care Area Assessment 5, indicated R10 required ex with bed mobility, had a ulcer which was at risk of	2 900			
	R10's care plan dat at risk for pressure mobility. The plan active pressure ulco spine and directed	red 6/24/15, indicated R10 was ulcers related to decreased also indicated R10 had an er on her mid back along the staff to keep a pressure the seat and the back of the				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00461	B. WING		08/1	3/2015
	PROVIDER OR SUPPLIER	900 HILLIO	, ,	STATE, ZIP CODE LEVARD SOUTHEAST		
(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)	JLD BE	(X5) COMPLETE DATE
2 900	wheelchair and to devery 1.5 hours while R10's Braden Assedated 6/15/15, indicated 6/15/15, indicated R10's quarterly Tiss redistribution) assessindicated R10 was staff to assist R10 whours while seated bed.  Review of R10's profollowing:  - 3/21/15, R10 was two stage one (redrit has no breaks or mid back along her 5.0 cm x 6.0 cm cet 2.6 cm. The staff pmattress on her bed dressing on the word was cream colored The skin surroundir cm x 0.8 cm and was colored The skin surroundir cm x 0.8 cm and was wound measured 1 width.  - 6/11/15, the red at 10.0 cm x 6.4 cm were colored at 2.5 cm where colored The skin surroundir cm x 0.8 cm and was colored The skin surroundir cm x 0.8 cm and x 0.8 cm a	offload (relieve pressure) R10 ille seated.  ssment (skin risk assessment) cated R10 was at risk for the ssure ulcers.  sue Tolerance (pressure ssment dated 6/12/15, at risk for ulcers and directed with repositioning every 1.5 and every 3 hours while in ogress notes revealed the admitted to the facility with ness, skin may be painful, but tears) pressure ulcer on her spine. The wounds measure intimeters (cm) and 4.0 cm x alaced a pressure reducing d and placed a Mepilex unds to prevent worsening.  ds had opened. The center measuring 0.7 cm x 0.6 cm. ing the wound measured 0.9	2 900			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00461	B. WING		08/1	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH FOSSTON	<b>J</b>	GOSS BOUL I, MN 56542	EVARD SOUTHEAST		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From page 22		2 900			
	- 6/12/15, R10 was placed on an every 1.5 hour repositioning schedule. The record indicated "primary area of concern is her back so this needs to be fully offloaded."					
	- 6/23/15, dressing to the back was changed. Wound measured 6.0 cm x 3.0 cm with light green and white non-odorous wound bed surrounded by a thin red border.					
	- 7/2/15, wound measured 3.4 cm x 2.9 cm and 0.1 cm depth. The wound was covered with a duoderm dressing.					
		d measured 3.4 cm by 2.2 cm er and rolled outer edges that				
	- 7/16/15, the woun with pink scar tissursurrounding.	d measured 2.4 cm x 1.4 cm e with rolled edges				
		d measured 2.6 x 1.4 cm with with small specks of cream mixed in.				
	by her primary phys	note indicated R10 was seen sician which directed staff to essure on the back ulcer.				
	,	d measured 2.5 x 1.2 cm. ed to be beefy red with rolled				
	without drainage. 1	measured 2.0 cm x 3.0 cm There was a second wound to a wound which measured 2.0				
	On 8/12/15, from 13	2:50 p.m. to 3:37 p.m. R10				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00461	B. WING		08/1	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, S	TATE, ZIP CODE		
ESSENT	IA HEALTH FOSSTON		IGOSS BOUL N, MN 56542	EVARD SOUTHEAST		
(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)	JLD BE	(X5) COMPLETE DATE
2 900	was continuously of recliner in the front not observed to corpressure redistribut observation, R10 w-At 3:30 p.m. NA-E assistance with rep-At 3:37 p.m. nursir were observed to a into a wheelchair. A had sat in the reclin of three hours and repositioning assist	oserved seated in a standard lobby area. The recliner was stain any type of special ion cushions. During this as not observed to reposition. stated R10 was to receive ositioning every three hours. In assistant (NA)-C and NA-D sesist R10 to stand and transfer at this time, NA-C stated R10 er since 12:30 p.m. for a total 7 minutes without	2 900			
	evening meal. R10 equipped with a foathe seat and the basin the dining room ushe was wheeled in remained in her whactivitiesAt 6:20 p.m. NA-Finto the restroomAt 7:12 p.m. NA-Frepositioned every had not been reposof 1 hour and 50 million on R13/15, at 8:46 (LPN)-D was obseron R10's mid-spine dressing had been LPN-D measured thopen area measure bed was pink with a slough. The small of the said the sai	's wheelchair was observed m redistribution cushion on ck of the chair. R10 remained intil 5:26 p.m. at which time to the main lobby area. R10 eelchair during the evening was observed to wheel R10 stated R10 was to be 2-3 hours. NA-F verified R10 itioned since 4:30 p.m. a total				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00461	B. WING		08/13/2015	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENTIA HEALTH FOSSTON			I, MN 56542	EVARD SOUTHEAST		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
2 900	Continued From page 24		2 900			
	wound was a skin reaction to tape. She explained the facility was now using a more gentle tape on R10's wound area.					
	On 8/13/15, at 11:00 a.m. NA-B stated R10 was to be positioned every hour while seated in the wheelchair because of the sore on her back.					
	On 8/13/15, at 12:00 p.m. registered nurse (RN)-A stated R10 was to be repositioned every 1.5 hours when seated in the wheelchair, as directed by her care plan. RN-A stated staff had been educated on how to ensure R10 was offloaded off of the back every 1.5 hours and should have provided that assistance. RN-A verified R10 routinely sat in a recliner in the lobby area however, the facility had not placed a pressure redistribution cushion in that chair. She verified R10 required additional interventions and was to be repositioned according to the care plan.					
		0 p.m. the director of nurses to be repositioned every 1.5 y the care plan.				
	staff to reposition th	policy dated 8/2006, directed ne resident according to the erance assessment.				
	The director of nurs the policies and pro- pressure ulcer care provide education to could develop a mo-	ETHOD FOR CORRECTION: sing could review and revise ocedures related to the second of the could of all involved staff. The facility onitoring system to ensure the and report the findings to the Committee.				

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Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		00461	B. WING		08/1	3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH FOSSTON		GOSS BOUL I, MN 56542	EVARD SOUTHEAST		
(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
2 900	Continued From pa	ge 25	2 900			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				
21390	MN Rule 4658.0800	Subp. 4 A-I Infection Control	21390			9/22/15
	control program mu procedures which p 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 cont E. a resident he immunization progradefined in part 465 procedures of resid the prevention and F. the development of the procedures of resid the prevention and formulation progradefined in part 465 G. a system for the products which affed disinfectants, antised incontinence products. In methods for	ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; nent and implementation of dicies and infection control a tuberculosis program as 8.0815; reviewing antibiotic use; review and evaluation of ct infection control, such as eptics, gloves, and				
	by: Based on interview	and document review the orm adequate tracking,		Corrected		

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Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00461	B. WING		08/1	13/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ESSENT	IA HEALTH FOSSTON		GOSS BOUL 1, MN 56542	EVARD SOUTHEAST		
(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)	JLD BE	(X5) COMPLETE DATE
	included symptoms treatment and reso infections. This had residents, visitors at Findings include:  Review of Resident (RITF) for May 201 August 2015, direct have signs or symptinfluenza like illness date, resident name (vaccination) and at The May 2015 RITI symptoms of infecti (upper respiratory in name along with the infection. No symptoms of infection. No symptoms of infection. No symptoms of an indication of an indication of an indication of an indication for use of dates were identified. The June 2015 RIT had symptoms of innoted to be URI's. Coughing and fever antibiotic, none listed	sis of resident infections which, identified organism, lution dates of resident I the potential to affect all 40 and staff in the facility.  Illiness Tracking Forms 5, June 2015, July 2015 and 5 staff to record all resident that stoms of illness due to 6. The form had categories for 6, s/s (sings/symptoms), VAC ge/sex of resident.  Findicated nine residents had on. One resident had URI antibiotic used to treat the oms were noted and no findicated. Four residents had infection of their skin or ms were noted, no resolution was an organism identified. antibiotics listed next to their otoms were noted, no fantibiotics and no resolution d.  Findicated seven residents affection. Four infections were one noted symptoms of antibiotics and no resolution d.  Findicated seven residents affection. Four infections were one noted symptoms of all four indicated use of an ed a resolution date. Two	21390	DEFICIENCY)		
	but no symptoms wand the source of the	ified as receiving antibiotics, were noted, no resolution date the infection was not identified. to oted to be receiving an				

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH FOSSTON	d .	GOSS BOUL I, MN 56542	EVARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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	Continued From page 27		21390			
	the skin, no organis	parate dates for infection of sm was identified, no red and no resolution date was				
	were receiving antil listed with no indica resolution dates no have a urinary tract organism, symptom Two residents had	F indicated eight residents piotics. Five residents had URI ation of symptoms and no ted. One resident was noted to infection (UTI), with no as or resolution date identified. only the names of the no other information.				
	The August RITF indicated three residents had symptoms of infection. One resident had URI noted with no symptoms and no resolution dated noted. Two residents were receiving antibiotics due to URI's with no resolution dates noted.					
	Center: Employee I Rates indicated res	g form titled First Care Living Ilness Report and Nosocomial ident and employee illness be of illness, but revealed no mation.				
	Prevention Commit review of the 2015, Employee Illness re correlation between	d, Meeting Agenda: Infection tee, dated 7/02/15, indicated Surveillance report and eport identified no noted a staff and resident illness. No ending was identified.				
	DON stated she tra basis on the RITF a illness for comparis hallways to see if th specific hallways,"	on 8/13/15 at 11:33 a.m., the acked infections on a daily and tracked staff and resident son. She stated, "I track he infection is contained on but stated, "I do not track the ted she is currently tracking				

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` 'cor		(X3) DATE	SURVEY LETED
7.110 1 27.11	or contribution	BENTH TOX THOM TOWN BETTE	A. BUILDING:		00	
		00461	B. WING		08/1	3/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH FOSSTON	N .	GOSS BOUL I, MN 56542	EVARD SOUTHEAST		
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21390	Continued From page 28  UTI's for a quality improvement project and that quarterly hand washing audits were done. The DON did not identify any tracking and trending of resident infections or analysis of the information		21390			
21540	SUGGESTED ME The director of nurs the policies and pro control surveillance provide education t could develop a mo ongoing compliance Qualify Assurance TIME PERIOD FOR (21) days.	THOD FOR CORRECTION: sing could review and revise ocedures related to infection e. She or designee could o all involved staff. The facility onitoring system to ensure e and report the findings to the	21540			9/22/15
21010	Usage; Monitoring Subp. 2. Monitoring monitor each reside unnecessary drug to home's policies and pharmacist must re resident's attending physician does not home's recomment adequate justification believes the reside adversely affected,	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the eport any irregularity to the g physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist ent's quality of life is being the pharmacist must refer the cal director for review if the	21010			3/22/13

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  DEFICIENCY  21540  Continued From page 29 medical director is not the attending physician. If			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
### ESSENTIA HEALTH FOSTON  ### 900 HILLIGOSS BOULEVARD SOUTHEAST FOSTON, MN 56542    (X4) ID		00461		B. WING		08/1	3/2015
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  POSSTON, MN 56542  ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)  21540 Continued From page 29  21540	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21540 Continued From page 29    SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE)    COMPLETE OF THE APPROPRIATE DATE	ESSENTIA HEALTH FOSSTON						
	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.  This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure target behaviors were identified and monitored for 1 of 5 residents (R55) who received anti-anxiety medication (alprazolam).  Findings include:  R55's quarterly Minimum Data Set (MDS) dated 7/28/15, indicated R55 had moderate cognitive impairment and diagnoses that included anxiety and depressive disorder. The MDS also identified R55 felt down, depressed or hopeless one day during the assessment period and felt tired or having had little energy nearly everyday. The MDS further identified R55 received antianxiety medication daily.  R55's Psychotropic Medication Use Care Area Assessment (CAA) acted 4/30/15, indicated R55 had a diagnosis of anxiety and was on alprazolam (an antianxiety medication) to help with her feelings of anxiousness.  The Physician Order Report dated	21540	medical director is the medical director physician does not the order and if the change the order, the change the order, the treview to the Qualit (QAA) committee rothe attending physisthe consulting phar directly to the QAA.  This MN Requirements: Based on interview facility failed to ensidentified and monity who received anti-action (alprazolam).  Findings include:  R55's quarterly Min 7/28/15, indicated Fimpairment and dia and depressive discidentified R55 felt done day during the tired or having had The MDS further id antianxiety medicated R55's Psychotropic Assessment (CAA) had a diagnosis of (an antianxiety medicated feelings of anxiousing the tired or having had The MDS further id antianxiety medicated R55's Psychotropic Assessment (CAA) had a diagnosis of (an antianxiety medicated feelings of anxiousing the tired or having had a diagnosis of (an antianxiety medicated feelings of anxiousing the tired or having had a diagnosis of (an antianxiety medicated feelings of anxiousing the tired or having had a diagnosis of (an antianxiety medicated feelings of anxiousing the tired feeling the tired feeling	not the attending physician. If r determines that the attending have adequate justification for attending physician does not the matter must be referred for ty Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter that the transport of the matter than the transport of the matter than the transport of	21540	Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00461		B. WING		08/1	3/2015	
ESSENTIA HEALTH FOSSTON 900 HILLIO				STATE, ZIP CODE LEVARD SOUTHEAST		
(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
21540	7/13/15-8/13/15, inc 0.5 milligrams (mg) anxiety and 1 mg, or sleep and relieve at The Medication Adr 5/1/15, through 8/12 alprazolam 0.5 mg mg tablet at bedtim R55's Quarterly Psy 7/27/15, identified and Dosage and Freque twice daily and 1 mg Under the section la Moods Warranting review listed "meds depressive disorder have any prn orders chemical substance and results in altera consciousness), on review did not ident symptoms related to R55's Care Plan dareceived anti-anxiet of anxiety and direct use effectiveness a monitor mood and it update family and of Care Plan also indiction would review R55's However, the Care	cluded orders for alprazolam one tablet twice a day for one tablet at bedtime to help inxiety.  ministration History dated 2/15, indicated R55 received one tablet twice a day and 1 e daily.  //chotropic Drug Review dated Anti-Anxiety Drugs with ency to be: alprazolam 0.5 mg g at bedtime for anxiety states. abeled Specific Behaviors or Use of Medication, the drug [medications] used for and anxiety states. Does not a for psychotropics (a e that changes brain function ations in perception, mood, or ly scheduled meds." The drug ify specific target behaviors /				
	On 8/13/15, at 1:07 p.m. nursing assistant (NA)-A demonstrated on a computer workstation how behavior monitoring was done by the NAs for the facility. NA-A stated there was no behavior					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BUILDING:			
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21540	O Continued From page 31		21540			
	monitoring complet there was no promy monitoring by the N nurses might docur.  On 08/13/2015, at nurse (LPN)-C indicated comment a reason antianxiety medical antianxiety medical basis so no docum stated she did not constant the state of th	ted for R55. She indicated pt in the computer requiring IAs for R55 and stated the				
	On 08/13/2015, at 1:39 p.m. registered nurse (RN)-A confirmed target behaviors were not identified or monitored for R55's anxiety and alprazolam use.  On 08/13/2015, at 2:29 p.m. the director of nursing (DON) confirmed target behaviors were not identified or monitored for R55 and verified the care plan lacked target behaviors for anxiety.					
	indicated the purpo to targeted behavior develop intervention plan to meet the re- also indicated resid would have the beh POC [care plan], pro [computer system] indicated residents	toring policy dated 4/2015, ase was to collect data related ors, analyze the data and ans in the individualized care sident's needs. The policy lents who exhibited behaviors naviors documented on the rogress note and Matrix profile. The policy further on antianxiety and cations would be included.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
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NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENT	IA HEALTH FOSSTON		GOSS BOUL I, MN 56542	LEVARD SOUTHEAST		
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21540	A SUGGESTED ME The director of nurs the policies and pro monitoring. She or education to all invo develop a monitorin compliance and rep Assurance Commit	ETHOD FOR CORRECTION: sing could review and revise acedures related medication designee could provide olived staff. The facility could ag system to ensure ongoing port the findings to the Qualify tee.  R CORRECTION: Twenty one	21540			
21675	. , .		21675	Corrected		9/22/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
00461		B. WING		08/1	3/2015	
NAME OF PR	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	•	
ESSENTIA HEALTH FOSSTON		IGOSS BOUL N, MN 56542	EVARD SOUTHEAST			
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L Etifitialist strategy of the	rained medication a or the nursing hom he night shift. She saundry from a "yello aundry from a "yello aundry room to sor stated, when she so but did not wear a pashe used laundry deacility and used ble During an interview maintenance managinens that were soil designated for contastaff tear the bag of During an interview director of nursing (personal laundry we blaced in the yellow of the personal laundry we blaced in the yellow of the personal laundry we be comediated, if a reast c-diff (clostridium pacteria that causes arge intestine or constaphylococcus auropacteria that has be she would have to "disposable bags we stated the machines."  A tour of the laundry oun, revealed a room and stated a room, revealed a room.	on 8/13/15, at 7:20 a.m., aide (TMA)-A stated laundry e facility was completed on stated, she picked up the tow bin" and brought it to the t, wash, dry and fold. TMA-A preted laundry she wore gloves protective gown. TMA-A stated, etergent provided by the each on the white clothes.  on 8/13/15, at 7:54 a.m., the ger (MM) stated that personal led were placed in a bag aminated linens. He stated, spen and wash the laundry."  on 8/13/15, at 11:26 a.m., the DON) stated, the facilities ent into a white mesh bag and bins. She stated the sorting adry was done in the laundry all do wearing gloves and a dirty laundry. The DON esident had an infection such a difficile colitis which is a swelling and irritation of the elon that can be passed from a MRSA (methicillin-resistant to antibiotics), the check the policy" but the available for use. She also is were cleaned every shift.	21675			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00461	B. WING		08/1	3/2015	
			DRESS, CITY, S	STATE, ZIP CODE	1 00/1	0,2010	
	ESSENTIA HEALTH FOSSTON  900 HILLIGOSS BOULEVARD SOUTHEAST						
ESSENT	IA REALIN FOSSION	FOSSTON	I, MN 56542				
(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	
21675	Continued From pa	ge 34	21675				
	folding. An inspection cabinets revealed in when sorting launding						
	Review of a policy labeled First Care Living Center: SORTING LAUNDRY, dated 6/8/15, instructed staff to sort linen according to color and temperature while wearing personal protective equipment: gown and gloves, to ensure the correct sorting of soiled linen.  A SUGGESTED METHOD FOR CORRECTION: The director of environmental services could review and revise the policies and procedures related to linen handling. He/she or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee.						
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one					

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