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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: L2NJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00604

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245469**
2.STATE VENDOR OR MEDICAID NO.
(L2) **173347801**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER**
(L4) **5211 HIGHWAY 110**
(L5) **AURORA, MN** (L6) **55705**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/13/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Chris Campbell, Unit Supervisor — 04/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 04/08/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/19/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245469

April 8, 2015

Ms. Laura Ackman, Administrator
Essentia Health Northern Pines Medical Center
5211 Highway 110
Aurora, Minnesota 55705

Dear Ms. Ackman:

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 February 2, 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 Meath

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered

March 5, 2015

Ms. Laura Ackman, Administrator
Essentia Health Northern Pines Medical Center
5211 Highway 110
Aurora, Minnesota 55705

RE: Project Number S5469025

Dear Ms. Ackman:

On January 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 January 8, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On February 13, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 8, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 2, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 8, 2015, effective February 2, 2015 and therefore remedies outlined in our letter to you dated January 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.

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

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

Sincerely,

Mark Meath

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

5469r15

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245469	A. Building B. Wing	2/13/2015

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0323** Reg. # **483.25(h)** LSC	**02/02/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	**02/02/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	**02/02/2015**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** CC/mm	**Date:** 03/05/2015	**Signature of Surveyor:** 13922	**Date:** 02/13/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 1/8/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: L2NJ

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(L2) **173347801**

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(L3) **ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER**
(L4) **5211 HIGHWAY 110**
(L5) **AURORA, MN** (L6) **55705**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/08/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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From (a) :
To (b) :

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE NEII 02/09/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/13/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
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3. Both of the Above :
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04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 26, 2015

Ms. Laura Ackman, Administrator
Essentia Health Northern Pines Medical Center
5211 Highway 110
Aurora, Minnesota 55705

RE: Project Number S5469025

Dear Ms. Ackman:

On January 8, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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:

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

<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:

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537
Telephone: (218) 332-5140
Fax: (218) 332-5196

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 February 17, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved

in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 8, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 8, 2015 (six months after the identification

of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that 1 of 3 residents (R36) was assessed for the safe use of a wheelchair independently and as a safe device following R36 ' s decline in health status and needing a wheelchair for mobility. Findings include: The medical record lacked evidence of an	F 323	Element 1 R36 was assessed by physical therapy per therapy screen and deemed independent with walker and standard chair in room. Element 2 A baseline audit was performed of all residents who use wheel chairs. A Mobility Device Safety Assessment has been completed and therapy referrals were	2/2/15

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

Electronically Signed | 01/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 1 assessment for R36's safe use of a new wheelchair. In order to get her feet to the floor, R36 had to scoot to the front edge of the wheelchair. The inability of R36 to have her feet flat on the floor had the potential to cause a fall that occurred on 1/4/2015; where R36 was sitting in her wheelchair reaching for an item. R36's primary admission diagnosis, as listed in a 1/4/2015 event report, was chronic heart failure. Other diagnoses included delusional disorder, shared psychotic disorder, and acute pain. R36's annual Minimum Data Set (MDS) with registered nurse (RN) signature date of 11/28/2014 indicated that R36 needs no help or staff oversight with transfers, walking in her room or on the unit. R36 was assessed as using a walker for a mobility device and had 2 falls since the prior assessment (reference date 8/19/2014). R36's progress notes indicated six falls in the past three months with the last on 1/4/14 which was when she was seated in the wheelchair and her feet did not touch the floor. R36's fall on 1/4/14 was explained in 1/14/15 progress note as, " Found lying on floor in room. Had been up in wheelchair looking through a magazine just a few minutes prior. Will encourage standard chair in the room and notify maintenance of availability of anti-roll backs for wheelchair. She states she " slipped. " R36 had gripper socks on at the time. The notes continued to state that R36 kept mentioning her sweater which was lying on the floor a few feet from her and she may have been reaching for that. The event report for the 1/14/15 fall provided the following description of incident, "Found lying on the floor in room had been up in w/c [wheelchair]. Sweater was on floor and she kept pointing to it. w/c was not locked."	F 323	made as appropriate. Element 3 The wheel chair positioning policy was reviewed/updated as appropriate and clinical staff was educated regarding proper alignment and wheel chair positioning. Element 4 All residents in wheel chairs are being monitored for proper positioning daily x 7 days weekly x 3 weeks, monthly x 2 months and quarterly ongoing. Variances are reported the administrator for immediate follow up and reviewed at QAPI at least quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 2 On 1/6/2015, at 7:59 a.m., R36 was observed up in the wheelchair with gripper socks on her feet. R36's feet were not touching the floor when seated in the w/c. R36 stated that she was comfortable in the wheelchair, but does not want to stay in it. R36 stated, "People here in them don't get out to walk." R36 stated that she used her arms to move the wheelchair as she's "so short" and her feet did not touch the floor to assist with movement while seated in the w/c. R36 freely swung her feet front to back several times to show how her feet did not touch the floor. When R36 got out of the w/c she had to " jump " down to the floor with feet. The assistant director of nursing (ADON) stated in an interview in regards to R36 ' s wheel chair not allowing her to put her feet flat on the floor when seated in the wheelchair on 1/7/2015, at 9:43 a.m. that there was not an automatic screen by therapy for wheelchair use and fit unless there was a problem noted then they would be notified for an assessment for wheelchair safety and fit. During a follow-up interview on 1/8/2015 at 11:11 a.m., the stated that she, R36's family member (F)-A, and nursing assistant (NA)-D looked at R36 in the smaller wheelchair and noticed that her feet could barely touch the floor. They thought that would be easier on R36 ' s knee pain to not have her feet touch the floor with her feet. However, the ADON stated that this conversation was not documented. Interview on 1/8/2015, at 8:49 a.m. with occupational therapy (OT)-1 and OT-2, confirmed that restorative nursing provided residents with their initial wheelchairs. In a review of their files, OT-1 confirmed they had not worked with nor	F 323		

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F 323	Continued From page 3 provided wheelchair screening for R36. During an interview on 1/8/2015, at 9:00 a.m., NA-D stated R36 previously had a wider wheelchair to sit in and it had been kept in R36's room for traveling longer distances. NA-D continued to explain that R36 used to be independent with transfers and ambulation, using a wheeled walker in her room and to the dining room. During an interview on 01/08/2015, at 11:11 a.m., the assistant director of nursing (ADON) stated R36 had been using a wheelchair more since her first fall in October 2014. The ADON stated nursing determined the use of the wheelchair. NA-D stated when R36's F-A was visiting in December 2014 and a decision was made to get a smaller wheelchair since R36 was using her wheelchair more. During this interview, while observing R36 in the smaller wheelchair, NA-D stated it probably would be better if R36's feet were on the floor. However, the wheelchair which prevented R36 ' s feet from touching the floor was used. It was later learned that NA-D's duties involved with restorative care, was responsible to fit residents in wheelchairs. R36's care plan problem category for safety included the following approaches: · Encourage use of standard chair when in room alone. · Independent ambulation with walker. Transfers independently. · Keep pathways clear of obstacles. Encourage use of adaptive devices (walker, hand rails). · Leave wheelchair within reach at bedside during evening hours. The care plan lacked evidence of interventions based on R36's increased use of wheelchair for mobility due to her health decline in December	F 323		

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F 323	Continued From page 4 2014. Furthermore, the ADON specified in an interview on 1/8/2015, at 11:11 a.m., that the IDT had planned to remove the wheelchair from R36's room, as she had increased in strength and mobility again. The ADON further stated that the wheelchair was now removed from R36's room and would be available if R36 needed to go longer distances in or out of the facility. This was done following the questioning about R36 ' s current wheelchair being a safety issue due to R36 ' s feet not touching the floor when seated in the wheelchair.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.	F 356		2/2/15

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F 356	Continued From page 5 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the daily nurse staff posting included actual hours worked by licensed and unlicensed direct care staff on duty. This had the potential to affect all 44 residents in the facility. Findings include: During the initial tour on 1/5/2015 at 1:30 p.m., the nurse staff posting included the census at 45, the correct date, total registered nurse (RN) hours per shift, licensed practical nurse (LPN) hours per shift, and nursing assistant (NA) hours per shift. However, the posting lacked the actual hours worked by licensed and unlicensed direct care staff. Throughout the survey, from 1/5/2015 through 1/8/2015, the nurse staff posting format remained the same, and did not include the actual hours worked by licensed and unlicensed direct care staff. On 1/8/2015 at 9:44 a.m., the director of nursing (DON) stated the RN was responsible to complete and post the nurse staff posting each day. The DON stated that all the staff in the facility work eight hour shifts and that those shifts	F 356	Element 1 The posted nurse staffing information was immediately changed to reflect the actual hours worked by RNs, LPNs, and CNAs of each shift. Element 2 Review of nurse staffing information over last 18 months displayed shifts (day/afternoon/midnight) without listing actual hours. This was changed during the survey visit. Element 3 Policy was reviewed/updated to reflect the regulation requirements and licensed nurses were educated to reflect the updated policy and requirements. Element 4 Nurse staffing information was monitored by the RN daily x 7 days, weekly x 3 weeks, monthly x 2 months and quarterly ongoing. Variances are reported to the administrator and reviewed at QAPI at least quarterly for immediate follow up.	

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F 356	Continued From page 6 are 10:30 p.m. to 6:30 a.m., 6:30 a.m. to 2:30 p.m. and 2:30 p.m. to 10:30 p.m. She agreed that this could not be known by looking at the nurse staff posting. The facility's Nurse Staffing Requirements policy, reviewed and revised on 10/24/2014, directed the facility must post the following information on a daily basis: · Facility name · The current date · The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: o Registered nurse o Licensed practical nurses or vocational nurses (as defined under State law). o Certified nurse aides o Resident census	F 356		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		2/2/15

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F 441	Continued From page 7 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to prevent the potential for cross contamination by ensuring proper foot and wound coverage for 1 resident (R2) while using facility common areas. This has the potential to affect 41 residents who use the facility common areas. In addition, the facility failed to prevent the potential for cross contamination by properly cleaning the sit-to-stand assist lift between resident use for one resident without proper foot coverage (R2). This has the potential to affect the 7 residents who use the stand-assist lift. Findings include:	F 441	Element 1 We have met with R2 and he has agreed to allow us to cover the whole foot, including toes and heel with a gauze dressing. R2 changes his mind readily. Therefore, we are preparing options for alternate foot covering that may be more acceptable to R2. There is an order to ensure covering and ensure proper foot coverage to prevent cross contamination form wound drainage. All non-critical equipment is disinfected periodically and when visibly soiled. Element 2 A baseline audit was performed of all	

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F 441	Continued From page 8 The signed physician orders dated 12/2/14, indicated R2 had diagnoses that included diabetes with neurological manifestations, Polyneuropathy in diabetes (nerve pain), venous insufficiency (poor circulation in the veins), Peripheral vascular disease (poor blood flow to the legs and arms), History of methicillin resistant staph aureus (infection resistant to some antibiotics), cellulitis/abscess of the foot (infection of foot wound), and the face sheet further identifies a foot ulcer. The quarterly Minimum Data Set (MDS) dated 10/16/14, indicated R2 was cognitively intact, had minimal mood symptoms, and rejected care daily. R2 required supervision or staff assist of one with bed mobility, and required extensive assist of one staff with transfers, dressing, toilet use and bathing, and limited assist of one staff for personal hygiene. The MDS further indicated R2 had 5 venous ulcers (wounds related to poor circulation). The Care Area Assessment (CAAs) for pressure ulcers dated 4/22/14, indicated R2 had an ulcer on the foot and was at high risk for pressure ulcers due to impaired mobility and diabetes. R2's care plan edited 10/30/14, indicated R2 had actual ulcers to left foot related to peripheral vascular disease, that were worsening with increased drainage and R2 was at risk for amputation, and R2 has the potential for infection related to history of MRSA, communal living, chronic kidney disease, diabetes, peripheral vascular disease, and history of urinary tract infections. The care plan directed nursing to perform dressing changes as ordered. The care	F 441	residents with infections who have potential for cross contamination and there are none. Element 3 Protocol is to follow CDC guidelines to prevent cross contamination. Education was provided to nursing to staff regarding wound dressings/coverings and lift equipment disinfection. Element 4 Dressing will be monitored by a licensed nurse for containment of wound and drainage daily ongoing per the treatment administration record. The sit to stand lift will be monitored for cleansing per CDC guidelines daily x 7 days, weekly x 3 weeks, monthly x 2 months, quarterly on going. Variances will be reported to the administrator for immediate follow up and reviewed at QAPI at least quarterly.	

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F 441	Continued From page 9	F 441		

plan edited 6/9/14, directed staff to transfer R2 with the assist of a sit to stand lift and may transfer to the toilet with stand by assist and a gait belt as tolerated. The care plan dated 4/11/14, indicated R2 was to wear nonskid footwear when up.

R2 had specific orders for treatment of the foot ulcer by podiatry to be performed twice daily.

The progress notes dated 12/31/14, indicated R2's ulcer measured 11.3 centimeters (cm) x 10 cm x 0.3 cm and the old dressing was partially saturated with straw-colored drainage. The progress notes dated 12/3/14, indicated the ulcers and the top edges of the ulcer was greenish in color. R2 saw podiatry the day prior. R2 had complained of more pain in the foot and the lower leg was red, but not warm.

A progress note by the nurse practitioner, dated 10/30/14, indicated the date and source of R2's first known MRSA was 6 /19/14 of the foot. The medical record lacked documentation of any further wound cultures.

The medication administration record dated September 2014, indicated R2 refused to wear a Rooke Boot on the left foot throughout the month. The progress note dated 10/14/14, indicated R2 refused the boot because it made the foot too hot.

On 1/5/15, at 5:44 p.m., R2 was observed in the dining room with a dressing covered with an ACE wrap on the left foot. The toes and heel were uncovered and touching the dining room floor.

On 1/6/15, at 3:47 p.m., R2 was sitting in the

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F 441	Continued From page 10	F 441		

dining room at a table, with the left foot toes and heel uncovered. The remainder of the foot had a dressing covered with an ace wrap on it. The heel was resting on the dining room floor.

On 1/7/15, at 7:13 a.m., R2 was observed up in the wheelchair and dressed in the bedroom. The left foot dressing had a light-colored stain on top of the large toe/foot area, and was soiled. The ace wrap covered the remainder of the dressing with the 3rd and 4th toes, and the heel exposed. There was a sheepskin lined boot on R2's lap. R2 stated it was worn when to doctor appointments. R2 denied wearing a boot or a stocking when in the facility. R2 propelled the wheelchair down the hall.

On 1/7/15, at 8:34 a.m. R2 was observed to propel the wheelchair down the long hall to get the boot on the left foot, prior to leaving the facility for the appointment. R2 stated he/she would be willing to wear something in the facility to cover the toes/heel.

During an interview on 1/7/15, at 1:36 p.m., nursing assistant (NA)-F stated R2 wore a boot to go out of the facility, but does not wear a boot or slipper in the facility.

During an interview on 1/7/15, at 1:49 p.m. the director of nursing (DON) and registered nurse (RN)-A, they stated R2 has refused to elevate the foot and leg and has refused the foot pedals on the wheelchair previously. RN-A stated they try to keep R2's foot wrapped and verified R2 has had MRSA in the foot at one time, transfers with a stand assist, and uses the shared bathroom. The DON verified R2 is at risk for infections because of the choice to not follow medical advice. RN-A

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F 441	Continued From page 11 stated a surgical boot was tried, but R2 threw it out. On 1/8/15, at 8:44 a.m., the sit-to-stand assist lift was in the common bathroom near the dining area. The foot gripper material on the left side of the foot plate was half torn off and the remaining half, had a jagged edge. The right side foot gripper had a raised, light brown colored debris stuck on it. Another piece of raised, light brown colored debris was stuck on the left side of the metal foot plate. There was loose dirt along the edges of the fool plate. On 1/8/15, at 10:35 a.m. the sit-to-stand assist lift was removed from the common bathroom after R2 used it in the bathroom. R2 exited the bathroom after using the toilet with exposed toes and heel on the left. The sit-to-stand had the same debris on the foot plate as it was previously observed. NA-B was observed to wipe the handles and controls with a germicidal wipe as she brought the lift to another part of the facility. When interviewed, NA-B stated she cleans anything she or the resident touches after each use. NA-B verified she does not clean the foot plate between each use because residents have shoes or some kind of socks on. NA-B stated she did not realize that R2 did not have a shoe on. NA-B also verified the foot plate had debris on it and had not been cleaned. During an interview on 1/8/15, at 10:44 a.m. NA-G stated she had helped R2 transfer off the toilet using the stand-to-sit assist lift. She stated the sit-to-stand assist lifts are cleaned between residents including the handles, and controls using the wipes. She stated that she did not realize there was debris on the sit-to-stand assist	F 441		

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F 441	Continued From page 12 lift that was used by R2 and thought it had been cleaned. During an interview on 1/8/15, at 11:40 a.m. RN-A stated the NAs are trained to clean equipment between uses, including the foot plate on the sit-to-stand assist lifts, though the standard is to clean it periodically and as needed. RN-A stated they prevent cross contamination by cleaning lifts, housekeepers clean the floors, and in the past, several foot covers had been tried for R2. She stated the ACE wraps are washed after every time they are used. Prevent cross contamination: cleaning lifts, housekeepers clean floors multiple times/day, multiple covers have been tried. ACE wraps washed every time the dressing is changed. Assumes they go to laundry. Soiled dressings are wrapped in a red bag and put into hazardous waste if they are visibly soiled. During this interview, the assistant director of nursing (ADON), stated R2 had a wound culture done on 6/19/15, but did not have the culture results. An Essentia Health training program for lifts, presented to facility staff on 4/23/14, directed staff to ensure equipment is properly cleaned as instructed by the manufacturer. The facility was unable to provide policies and procedures for cleaning of equipment and infection control regarding cross contamination, wound care, and handling of dressings.	F 441		

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	245469	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/06/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Essentia Northrn Pines C & NC 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 Northern Pines C & NC is a 1-story building with no basement. The original building was constructed in 1959, with an addition in 1970. Both buildings are of the same type construction, Tyep II (111). therefore the facility was inspected as one building. The nursing home is properly 2 hour fire seperated from the attached hospital. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 50 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

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.