DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 26, 2022

Administrator
Essentia Health Virginia Care Cent
901 9th Street North
Virginia, MN 55792

RE: CCN: 245458
Cycle Start Date: February 16, 2022

Dear Administrator:

On April 1, 2022, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

On May 17, 2022, the Minnesota Department of Health, completed a revisit and on April 18, 2022 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance. Based on our visit, we have determine:

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 16, 2022, did not go into effect. (42 CFR 488.417 (b))

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 26, 2022

CMS Certification Number (CCN): 245458

Administrator
Essentia Health Virginia Care Cent
901 9th Street North
Virginia, MN 55792

Dear Administrator:

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 May 4, 2022 the above facility is certified for:

77 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 77 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 26, 2022

Administrator
Essentia Health Virginia Care Cent
901 9th Street North
Virginia, MN 55792

Re: Reinspection Results
Event ID: N1Z512

Dear Administrator:

On April 5, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 16, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 26, 2022

Administrator
Essentia Health Virginia Care Cent
901 9th Street North
Virginia, MN 55792

RE: CCN: 245458
Cycle Start Date: February 16, 2022

Dear Administrator:

On April 1, 2022, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

On May 17, 2022, the Minnesota Department of Health, completed a revisit and on April 18, 2022 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance. Based on our visit, we have determine:

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 16, 2022, did not go into effect. (42 CFR 488.417 (b))

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 4, 2022

Administrator
Essentia Health Virginia Care Cent
901 9th Street North
Virginia, MN 55792

RE: CCN: 245458
Cycle Start Date: February 16, 2022

Dear Administrator:

On February 16, 2022, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 May 16, 2022 (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).

In addition, if substantial compliance with the regulations is not verified by August 16, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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
	245458	A. BUILDING _____ B. WING _____	02/16/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 2/14/22, through 2/16/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/14/22, through 2/16/22, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment	F 636		3/24/22

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

Electronically Signed | 03/09/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 636	Continued From page 1	F 636		

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 636	Continued From page 2 members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly complete an admission Minimum Data Set (MDS) assessment in accordance to the Resident Assessment Instrument (RAI) manual for 1 of 2 resident (R17) identified with incomplete cognitive and mood sections of the MDS. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2019, identified the MDS as an assessment tool which facilities are required to use. The manual provided instructions to ensure accurate and complete coding for each section of the assessment as follows:	F 636	1. R17 will have BIMS and PHQ9 Completed 2. R17's Care plan will be reviewed for accuracy in noted areas of deficiency 3. All Resident's Charts reviewed to ensure BIMS and PHQ9s are completed within last 90 days 4. DON/Designee to Audit MDS assessments for completion for 2 months. Continued audits of 10% of all assessments due, on weekly cadence, for 1 month 5. Social Services Designees to review sections Q, C, D, and E of RAI manual and develop Standard Work Document 6. MDS Policy Reviewed with all members of IDT who are expected to complete 7. All issues will be reported to	

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F 636	Continued From page 3 "Section C: Cognitive Patterns," with a written intent of determining the residents attention, orientation and ability to register and recall new information. These items were listed as "crucial factors in many care planning decisions." "Section D: Mood," with a written intent of addressing mood distress which was labeled as a "serious condition," which was under-diagnosed and under treated in the nursing home setting. R17's annual Minimum Data Set (MDS) dated 2/4/22, identified R17's diagnoses included heart failure and hypertension. Section C (cognitive patterns) and Section D (mood) were not coded rather each field was dashed or had no other values recorded. Section Z of the MDS was signed by the MDS coordinator and dated 2/8/22, which indicated the assessment was complete. During an interview on 2/16/22, at 1:34 p.m. the MDS coordinator, registered nurse (RN)-A stated he was responsible to complete the facility resident MDS assessments. Upon review of R17's annual MDS dated 2/4/22, RN-A stated MDS was missing Section C and Section D was not assessed or "dashed" out. Additionally, R17's Patient Health Questionnaire (PHQ-9) (diagnostic tool used to screen residents for the presence and severity of depression) was not completed. RN-A stated the MDS was always a shared responsibility at the facility with some assessments completed by nursing staff and others completed by the social services designee (SSD). However, RN-A stated he was responsible to ensure this information was entered into the MDS and "sign off" the completion. RN-A stated the electronic medical record (EMR) would alert him if there was a monetary penalty if the MDS	F 636	Administrator immediately for follow up and brough to the QAPI Committee quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 636	Continued From page 4	F 636		

was not entirely completed and he was aware the MDS was not fully completed.

During an interview on 12/16/22, at 2:23 p.m. the SSD stated she was not aware she was responsible for the completion of Section C, Section D or the PHQ-9, had not had any formal MDS training and was "thrown into it" after starting her role in November 2021. However, became aware of her responsibility at the beginning of February 2022 and had been attempting to complete them since.

During an interview on 2/16/22, at approximately 2:23 p.m. the director of nursing (DON) stated she was aware RN-A submitted MDS corrections the day prior, 2/15/22, but was unaware of the extent or the corrections needed. The DON stated the SSD was responsible for Section C, Section D and the PHQ-9, but nursing staff had the ability to complete these as well. The DON further stated when submitting a MDS, RN-A would be alerted by the system that a MDS was "unable to validate" and RN-A would be aware of the sections not completed. The DON also stated she provided the SSD with informal MDS training and she suspected the SSD was completing these sections on paper. Because of this, the DON stated she would need to speak with her staff for further details.

On 2/16/22, at 3:09 p.m. the DON verified the SSD was completing Section C, Section D and the PHQ-9 on paper. RN-A was not entering this information into the MDS and was adding a "dash" to those sections. The DON stated she expected the MDS assessments to be completed and to be notified of any concerns with completion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 636	Continued From page 5 The facility Minimal [sic] Data Set (MDS) Assessment Completion policy dated 7/15/20, directed the registered nurse (RN) MDS coordinator would ensure timely completion of the care area assessments (CAAs) and the MDS. In addition, the policy directed the RN MDS coordinator would conduct or coordinate each assessment and would sign and certify the completion of the assessment. The RN MDS coordinator would transmit the completed MDS assessments to CMS.	F 636		
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete required quarterly Minimum Data Sets (MDS) for 5 of 12 (R4, R2, R19, R6, and R13) reviewed for assessment accuracy. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2019, identified the MDS as an assessment tool which facilities are required to use. The manual provided instructions to ensure accurate and complete coding for each section of the assessment as follows:	F 638	1. R4, R2, R19, R6 and R13 BIMs and PHQ-9 completed 2. R4, R2, R19, R6 and R13 Care Plans reviewed for accuracy in noted areas of deficiency 3. All residents' charts reviewed to ensure BIMS and PHQ-9 completed in the last 90 days 4. DON/Designee to Audit MDS assessments for completion for 2 months. Continued audits of 10% of all assessments due, on weekly cadence, for 1 month 5. Social Services Designees to review sections Q, C, D, and E of RAI manual and develop Standard Work Document	3/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 638	Continued From page 6 "Section C: Cognitive Patterns," with a written intent of determining the residents attention, orientation and ability to register and recall new information. These items were listed as "crucial factors in many care planning decisions." "Section D: Mood," with a written intent to address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable. "Section E: Behavior," with a written intent to identify behavioral symptoms that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment. These behaviors may place the resident at risk for injury, isolation, and inactivity and may also indicate unrecognized needs, preferences or illness. Behaviors include those that are potentially harmful to the resident himself or herself. The emphasis is identifying behaviors, which does not necessarily imply a medical diagnosis. Identification of the frequency and the impact of behavioral symptoms on the resident and on others is critical to distinguish behaviors that constitute problems from those that are not problematic. Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and care plan interventions can be developed to improve the symptoms or reduce their impact. R4's Quarterly Minimum Data Set (MDS) dated	F 638	6. All issues will be reported to Administrator immediately for follow up and brough to the QAPI Committee quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ESSENTIA HEALTH VIRGINIA CARE CENT	901 9TH STREET NORTH VIRGINIA, MN 55792

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F 638	Continued From page 7 1/28/22, identified R4 had diagnoses that included gastrointestinal bleeding, chronic kidney disease, and insomnia. Section C was not coded rather each field was dashed or had no other values recorded. Section Z of the MDS was signed by registered nurse (RN)-A and dated 2/7/22, which indicated the assessment was complete. R2's quarterly MDS dated 1/21/22 identified severe cognitive impairment with short and long term memory issues with inattention and organized thinking. Diagnoses included Alzheimer's disease and psychotic disorder. Section D had no entries, and Section E identified only question one was answered and questions two through eleven were blank. The MDS was signed completed in Section Z by RN-A. R19's minimum data set (MDS) dated 12/23/21, identified R19 had diagnoses including Alzheimer's disease, dementia and depression. The assessment's "Section C: Cognitive Pattern" question number one was answered identifying a brief interview for mental status (BIMS), and "Section D: Mood" question number one identifying the resident's mood interview sections should've been conducted. The remaining questions for both of these sections were not answered or had a dash through them. Section Z of the MDS was signed by the RN-A and dated 12/30/21, which indicated the assessment was complete. R6's quarterly MDS dated 2/3/22, indicated R6 had diagnoses which included depression. Section C, questions C0100 through C1310 of R6's MDS were blank or dashed and no values were recorded. Section D, questions D0100 through D0600 were blank or dashed and no values were recorded.	F 638		

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	245458	A. BUILDING _____ B. WING _____	02/16/2022

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F 638	Continued From page 8	F 638		

R13's quarterly MDS dated 12/10/21, indicated R13's diagnoses included anxiety and depression. Section C, questions C0100 through C1310 of R13's MDS were blank or dashed and no values were recorded. Section D, questions D0100 through D0600 were blank or dashed and no values were recorded.

During an interview on 2/16/22, at 1:34 p.m. registered nurse (RN)-A verified he had been the MDS coordinator since 2018, for the facility. RN-A stated R4's Section C was completed "too early" on 1/21/22, and was not conducted during the MDS assessment period. However, RN-A was aware the MDS was not completed correctly. RN-A stated he was responsible to complete the facility resident MDS assessments. Upon review of R4's quarterly MDS dated 1/28/22, RN-A stated the MDS was missing Section C--it was not assessed or "dashed" out. However, RN-A explained this was due to Section C being completed on 1/21/22, which was not during the assessment period and was "unusable". RN-A stated the MDS was always a shared responsibility at the facility with some assessments completed by nursing staff and others completed by social services. However, RN-A stated he was responsible to ensure this information was entered into the MDS and "sign off" the completion. RN-A stated the electronic medical record (EMR) would alert him if there was a monetary penalty if the MDS was not entirely completed and he was aware the MDS was not fully completed.

RN-A verified R6's and R13's MDS sections C and D were not completed prior to their MDS being submitted. RN-A stated social services should have completed both section C and D.

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F 638	Continued From page 9	F 638		

RN-A stated when the due date was near and information was not added he would typically send out an email to the responsible staff to get the information entered. RN-A stated the facility went for a time period--six months to nine months--without a social worker. During that time nursing staff were responsible for completing the assessments for sections C and D.

During an interview on 12/16/22, at 2:23 p.m. the social services designee (SSD) stated she was not aware she was responsible for the completion of Section C, had not had any formal MDS training and was "thrown into it" after starting her role in November 2021. However, she became aware of her responsibility at the beginning of February 2022 and had been attempting to complete them since.

During an interview on 2/16/22, at approximately 2:30 p.m. the director of nursing (DON) stated she was aware RN-A submitted MDS corrections the day prior, 2/15/22, but was unaware of the extent or the corrections needed. The DON stated social services was responsible for Section C, but nursing staff had the ability to complete these as well. The DON further stated when submitting a completed MDS, RN-A would be alerted by the system that a MDS was "unable to validate" and RN-A would be aware of the sections not completed. The DON also stated she provided the SSD with informal MDS training, and she suspected the SSD was completing these sections on paper. Because of this, the DON stated she would need to speak with her staff for further details.

On 2/16/22, at 3:09 p.m. the DON verified the SSD was completing observations for C and D on

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F 638	Continued From page 10 paper. RN-A was not entering this information into the MDS and was adding a "dash" to those sections. The DON stated she expected the MDS assessments to be completed and to be notified of any concerns with completion. The facility Minimal [sic] Data Set (MDS) Assessment Completion policy dated 7/15/20, directed the registered nurse (RN) MDS coordinator would ensure timely completion of the care area assessments (CAAs) and the MDS. In addition, the policy directed the RN MDS coordinator would conduct or coordinate each assessment and would sign and certify the completion of the assessment. The RN MDS coordinator would transmit the completed MDS assessments to CMS.	F 638		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow doctor's orders	F 686	1. R2 Care Plan updated 2. All Resident Braden scores completed	3/24/22

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F 686	Continued From page 11 and update the care plan for 1 of 12 residents (R2) to aide in the prevention of pressure ulcers. Findings include: R2's quarterly Minimum Data Set (MDS) dated 1/21/22, identified severe cognitive impairment with long- and short-term memory issues. R2 was a extensive assist with bed mobility, transfers and locomotion on and off the unit. The MDS identified R2 was at risk for pressure ulcers. R2's diagnosis list included Alzheimer's disease and peripheral vascular insufficiency (poor blood flow to the hands and feet). A provider's order dated 2/7/22, instructed to offload heels bilaterally (both heels) using pillows or foam boots in bed or chair. R2's progress note from 2/7/22, identified R2 returned from an appointment with a medical doctor (MD) at a local clinic and an order was received to "offload heels using pillows or foam boots in bed or chair. Return in 3 months." R2's care plan dated 2/14/22, did not identify any interventions of using foam boots or pillows to offload pressure on her heels to prevent skin breakdown. On 2/14/22, at 7:23 p.m. R2 was observed sitting in her wheelchair next to her bed. She was slightly reclined, had socks on her feet and was not wearing foam boots nor did she have pillows under her feet. Foam boots were not noted in her room. On 2/15/22, at 8:48 a.m., R2 was sitting in her	F 686	3. All Resident Care Plan and Skin Orders reviewed for Accuracy 4. Order Policy and Skin Care Policy reviewed and updated 5. DON/Designee to audit 3 residents per week with high skin risk to ensure interventions are being followed for 1 month, then bi-monthly for 2 months 6. All issues will be reported to administrator immediately for follow up and brought to the QAPI committee at least quarterly	

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F 686	Continued From page 12	F 686		

wheelchair to eat breakfast. R2 was sitting upright, wearing socks with her left foot directly on the wheelchair footrest and the right foot hanging behind the foot rest. There was not a pillow on the footrest.

On 2/15/22, at 9:45 a.m. R2 was sitting in her wheelchair, slightly reclined, wearing socks. R2's left foot was on the footrest and the right foot was hanging behind the foot rest. R2 was not wearing foam boots and there was not a pillow under her feet.

On 2/15/22, at 10:32 a.m., R2 continued to be in her wheelchair with both feet on the footrests. R2 was wearing socks, was not wearing foam boots nor did she have a pillow under her feet.

On 2/15/22, at 10:44 a.m., R2 continued to be in her wheelchair, but was calling out for help and "I want to lay down". R2 was wearing socks, no foam boots and there was not a pillow under her feet.

During an interview on 2/15/22, at 10:11 a.m. nursing assistant (NA)-A stated she was not aware of any orders to offload R2's heels and identified it was not on the care plan and she was not told of any new interventions.

During an interview on 2/15/22, at 2:46 p.m. NA-B stated the R2's care plan and the nurses aide sheet did not identify R2 needed to have foam boots on, or her heels floated by a pillow.

During an observation and interview on 2/15/22, at 2:53 p.m. registered nurse (RN)-C stated the order to offload heels was received, entered, and verified. RN-C stated the care plan should have

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F 686	Continued From page 13 been updated and the intervention implemented. RN-C then went to check on R2 while in bed and confirmed the order was not being followed as there was no pillow under R2's feet nor was she wearing foam boots. RN-C then placed the blanket back over R2's feet and did not put foam boots on or place a pillow under R2's feet and left the room. During an interview on 2/15/22, at 3:32 p.m. the director of nursing (DON) stated the order was not instituted and currently was noted on the treatment record and was not being done. She stated once the order was entered and verified it should have been implemented immediately per MD order and should be done. The DON also stated new orders should be placed on the care plan so all staff know the intervention and confirmed the order to offload heels and use foam boots or pillows was not on R2's care plan. The facility's Acknowledgement, Coordination and Implementation of Physicians' Orders policy revised 10/16/17, identified once an order was verified the RN was to communicate orders to appropriate staff involved in patient's care.	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695		3/24/22

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F 695	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the oxygen tubing and oxygen humidifier were changed in a timely manner for 1 of 1 residents (R6) reviewed for respiratory care. Findings include: R6's Face Sheet printed on 2/16/22, indicated R6 had diagnoses which included heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), chronic pain, anxiety, obesity, and palliative care. R6's quarterly Minimum Data Set (MDS) dated 2/3/22, indicated R6 was using oxygen therapy. R6's care plan dated 12/31/20, indicated R6 required oxygen therapy at times during the night. Interventions included monitoring and reporting signs and symptoms of hypoxia (deficiency in the amount of oxygen reaching the tissues), keep the oxygen saturation levels greater than 90 percent and administer oxygen per medical doctor (MD) orders. R6's Physician Order Report dated 1/16/22 - 2/16/22, indicated R6 had orders for oxygen one to five liters per nasal cannula for dyspnea, started on 7/30/21. On 2/14/22, at 1:50 p.m. R6 was seated in her wheelchair in her room, she was wearing a nasal cannula with humidified oxygen at two liters per minute. The humidifier and the nasal cannula were not dated.	F 695	1. R6's oxygen tubing was changed 2. Orders placed in EMAR for all residents on oxygen to have tubing changed and dated once weekly 3. Admission and order checklist updated to include if a resident is on oxygen to add order to change and date tubing weekly 4. DON/Designee to complete 2 random audits weekly for 2 months for completion 5. Standard Work reviewed and updated 6. All issues will be reported to administrator immediately for follow up and brought to QAPI committee at least quarterly	

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F 695	Continued From page 15 On 2/15/22, at 2:00 p.m. registered nurse (RN)-B stated he did not know when the oxygen tubing was changed, he said he thought maybe nights changed the tubing. RN-B verified the oxygen humidifier was almost out of water and said it needed to be changed. RN-B verified the oxygen humidifier and oxygen tubing was undated. RN-B stated there were not any nursing orders alerting nursing staff to change the oxygen humidifier and oxygen tubing. On 2/16/22, at 7:55 a.m. the director of nursing (DON) verified oxygen humidifiers and oxygen tubing should be changed weekly. The DON verified there was not a process in place to ensure it was done. The facility Storage and Handling of Supplies and Oxygen policy dated 4/5/19, lacked direction on the frequency of replacing oxygen humidifiers and oxygen tubing.	F 695		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain good repair of the walls in the residents living space for 1 of 1 resident (R19) reviewed for clean living space. Findings include: R19's quarterly Minimum Data Set (MDS) dated	F 921	1. R19 wall was fixed 2. All Resident Rooms evaluated, and maintenance requests submitted where needed 3. Environmental Services to monitor physical environment weekly with deep cleans and submit maintenance requests 4. DON/Designee to complete random	3/24/22

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F 921	Continued From page 16 12/30/21, identified R19 required assistance with all activities of daily living (ADL's). R19's diagnoses list included Alzheimer's disease and dementia. R19's care plan dated 1/20/22, identified R19 required extensive assist of one staff and the use of bilateral grab bars for bed mobility. During observation on 2/14/22, at 1:35 p.m. R19's bed had grab bars attached to the frame on either side of the upper portion of the bed. The bed was in the lowest position, pushed up next to the wall but not touching the wall. The wall had scuff marks and chipped paint in an area approximately 12 inches wide x 18 inches high at the level where the grab bars where located. During observation on 2/16/22, at 8:23 a.m. R19's bed was elevated to mid-thigh level and was pushed close to but not touching the wall. A round, black knob on the grab bars was attached to the bed. The knob on the left side of the bed was touching the wall at the level of the scuff marks and chipped paint. During an interview on 2/15/22, at 10:47 a.m. housekeeper (hskp)-A stated housekeepers went through every room, every day and cleaned the bathroom, mopped the floor, high dusted if needed, swept and mopped the room floor, and wiped down the tables. On bath days they also swept and mopped under the beds and dressers. During an interview on 2/16/22, at 7:46 a.m. licensed practical nurse (LPN)-A stated if staff noticed a wall with chipped paint they would notify the nurse manager. The nurse manager would fill out the online maintenance work order to have	F 921	audits twice monthly for compliance for three months 5. Standard of Work generated for completion of routine checks 6. All issues will be reported to adminstrator immediately for follow up and brought to the QAPI committee at least quarterly	

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F 921	Continued From page 17 it repaired. During an interview on 2/16/22, at 11:53 a.m. nursing assistant (NA)-A and NA-D stated housekeepers would mop the floors, complete general cleaning, dust, and take care of any stains if needed. Maintenance would fix any scrapes or tears in the wallpaper or any painting that needed to be done. During an interview with NA-D and the director of nursing (DON) on 2/16/22, at 12:21 p.m. NA-D stated the black knobs on the grab bars hit the wall when the bed was moved back/forth or up/down. The knobs chipped the paint off the wall and left marks on the wall. The DON stated the paint chips on the floor needed to be cleaned up and the wall in R19's room needed to be repaired. The Facility Maintenance policy revision date 2/1/19, directed staff to maintain repairs of walls.	F 921		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 4, 2022

Administrator
Essentia Health Virginia Care Cent
901 9th Street North
Virginia, MN 55792

Re: State Nursing Home Licensing Orders
Event ID: N1Z511

Dear Administrator:

The above facility was surveyed on February 14, 2022 through February 16, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual life safety recertification survey was conducted on 02/16/2022 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Essentia Health Virginia Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/09/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245458	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/16/2022**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Essentia Health Virginia Care Center is a 4-story building with a full basement. The original building was constructed in 1936, and additions constructed in 1976 and 1999, all of Type II(222). The nursing home occupies the 3rd and 4th floors. A 3 story hospital of the same construction type adjoins the nursing home and is separated by a 2-hour fire-rated barrier, with 1&1/2 hour rated self-closing doors. Therefore, the nursing home was inspected as one building. The building is fully sprinkler protected. The	K 000		

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K 000	Continued From page 2 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 77 beds and had a census of 26 at the time of the survey. The requirements at 42 CFR Subpart 483.70(a) are NOT MET.	K 000		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.2 and 19.7.1.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 02/16/2022, at 11:30 AM., during the review of all available fire drill documentation and	K 712	1. Verify Fire Drill Schedule meets compliance need 2. Review and Update Standard of Work 3. Re-educate all Nurse Supervisors on documentation expectation and procedure 4. DON/Designee will audit compliance and proper documentation of all Fire Drills and provide to Facilities and Emergency Preparedness Assistant for 3 months	3/24/22

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K 712	Continued From page 3 interview with the Maintenance Supervisor, it was revealed that the facility did not conduct 1 of 4 fire drills for the overnight shift in the third calendar quarter. 2. On 02/16/2022, at 11:30 AM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not conduct 1 of 4 fire drills for the evening shift in the fourth calendar quarter. An interview with the Maintenance Supervisor verified these deficient findings at the time of the discovery.	K 712		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or	K 914		3/24/22

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K 914	Continued From page 4 area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the annual electrical outlet testing and maintenance per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/16/2022, at 12:30 PM, during the review of all available electrical outlet maintenance and testing documentation and an interview with the Maintenance Supervisor, it was revealed that the facility had failed to conduct the annual electrical outlet inspection of all electrical outlets located within the patient/resident care areas within the last 12 months. The last documented date of inspection was 10/27/2020. An interview with the Maintenance Supervisor verified these deficient findings at the time of the discovery.	K 914	1. Annual Audit of Electrical Outlets Completed 2. Establish preventive maintenance schedule 3. Procedure updated to include Administrator notification to ensure timely completion of preventative maintenance with copies of documentation.	

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	00603	A. BUILDING: _____ B. WING _____	02/16/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/14/22, through 2/16/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences.	2 540		3/24/22

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2 540	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete an admission Minimum Data Set (MDS) assessment in accordance to the Resident Assessment Instrument (RAI) manual for 1 of 2 resident (R17) identified with incomplete cognitive and mood sections of the MDS. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2019, identified the MDS as an assessment tool which facilities are required to use. The manual provided instructions to ensure accurate and complete coding for each section of the assessment as follows: "Section C: Cognitive Patterns," with a written intent of determining the residents attention, orientation and ability to register and recall new information. These items were listed as "crucial factors in many care planning decisions." "Section D: Mood," with a written intent of addressing mood distress which was labeled as a "serious condition," which was under-diagnosed and under treated in the nursing home setting. R17's annual Minimum Data Set (MDS) dated 2/4/22, identified R17's diagnoses included heart failure and hypertension. Section C (cognitive patterns) and Section D (mood) were not coded rather each field was dashed or had no other values recorded. Section Z of the MDS was signed by the MDS coordinator and dated 2/8/22, which indicated the assessment was complete.	2 540	corrected	

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2 540	Continued From page 4 During an interview on 2/16/22, at 1:34 p.m. the MDS coordinator, registered nurse (RN)-A stated he was responsible to complete the facility resident MDS assessments. Upon review of R17's annual MDS dated 2/4/22, RN-A stated MDS was missing Section C and Section D was not assessed or "dashed" out. Additionally, R17's Patient Health Questionnaire (PHQ-9) (diagnostic tool used to screen residents for the presence and severity of depression) was not completed. RN-A stated the MDS was always a shared responsibility at the facility with some assessments completed by nursing staff and others completed by the social services designee (SSD). However, RN-A stated he was responsible to ensure this information was entered into the MDS and "sign off" the completion. RN-A stated the electronic medical record (EMR) would alert him if there was a monetary penalty if the MDS was not entirely completed and he was aware the MDS was not fully completed. During an interview on 12/16/22, at 2:23 p.m. the SSD stated she was not aware she was responsible for the completion of Section C, Section D or the PHQ-9, had not had any formal MDS training and was "thrown into it" after starting her role in November 2021. However, became aware of her responsibility at the beginning of February 2022 and had been attempting to complete them since. During an interview on 2/16/22, at approximately 2:23 p.m. the director of nursing (DON) stated she was aware RN-A submitted MDS corrections the day prior, 2/15/22, but was unaware of the extent or the corrections needed. The DON stated the SSD was responsible for Section C, Section D and the PHQ-9, but nursing staff had	2 540		

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2 540	Continued From page 5	2 540		

the ability to complete these as well. The DON further stated when submitting a MDS, RN-A would be alerted by the system that a MDS was "unable to validate" and RN-A would be aware of the sections not completed. The DON also stated she provided the SSD with informal MDS training and she suspected the SSD was completing these sections on paper. Because of this, the DON stated she would need to speak with her staff for further details.

On 2/16/22, at 3:09 p.m. the DON verified the SSD was completing Section C, Section D and the PHQ-9 on paper. RN-A was not entering this information into the MDS and was adding a "dash" to those sections. The DON stated she expected the MDS assessments to be completed and to be notified of any concerns with completion.

The facility Minimal [sic] Data Set (MDS) Assessment Completion policy dated 7/15/20, directed the registered nurse (RN) MDS coordinator would ensure timely completion of the care area assessments (CAAs) and the MDS. In addition, the policy directed the RN MDS coordinator would conduct or coordinate each assessment and would sign and certify the completion of the assessment. The RN MDS coordinator would transmit the completed MDS assessments to CMS.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure the quarterly Minimum Data Set (MDS) is filled out completely prior to submitting.
The Director of Nursing or designee could educate all appropriate staff on the policies and

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2 540	Continued From page 6 procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete required quarterly Minimum Data Sets (MDS) for 5 of 12 (R4, R2, R19, R6, and R13) reviewed for assessment accuracy. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2019, identified the MDS as an assessment tool which facilities are required to use. The manual provided instructions to ensure accurate and complete coding for each section of the assessment as follows: "Section C: Cognitive Patterns," with a written intent of determining the residents attention,	2 550	corrected	3/24/22

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2 550	Continued From page 7	2 550		

orientation and ability to register and recall new information. These items were listed as "crucial factors in many care planning decisions."

"Section D: Mood," with a written intent to address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable.

"Section E: Behavior," with a written intent to identify behavioral symptoms that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment. These behaviors may place the resident at risk for injury, isolation, and inactivity and may also indicate unrecognized needs, preferences or illness. Behaviors include those that are potentially harmful to the resident himself or herself. The emphasis is identifying behaviors, which does not necessarily imply a medical diagnosis. Identification of the frequency and the impact of behavioral symptoms on the resident and on others is critical to distinguish behaviors that constitute problems from those that are not problematic. Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and care plan interventions can be developed to improve the symptoms or reduce their impact.

R4's Quarterly Minimum Data Set (MDS) dated 1/28/22, identified R4 had diagnoses that included gastrointestinal bleeding, chronic kidney disease, and insomnia. Section C was not coded rather each field was dashed or had no other

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2 550	Continued From page 8	2 550		

values recorded. Section Z of the MDS was signed by registered nurse (RN)-A and dated 2/7/22, which indicated the assessment was complete.

R2's quarterly MDS dated 1/21/22 identified severe cognitive impairment with short and long term memory issues with inattention and organized thinking. Diagnoses included Alzheimer's disease and psychotic disorder. Section D had no entries, and Section E identified only question one was answered and questions two through eleven were blank. The MDS was signed completed in Section Z by RN-A.

R19's minimum data set (MDS) dated 12/23/21, identified R19 had diagnoses including Alzheimer's disease, dementia and depression. The assessment's "Section C: Cognitive Pattern" question number one was answered identifying a brief interview for mental status (BIMS), and "Section D: Mood" question number one identifying the resident's mood interview sections should've been conducted. The remaining questions for both of these sections were not answered or had a dash through them. Section Z of the MDS was signed by the RN-A and dated 12/30/21, which indicated the assessment was complete.

R6's quarterly MDS dated 2/3/22, indicated R6 had diagnoses which included depression. Section C, questions C0100 through C1310 of R6's MDS were blank or dashed and no values were recorded. Section D, questions D0100 through D0600 were blank or dashed and no values were recorded.

R13's quarterly MDS dated 12/10/21, indicated R13's diagnoses included anxiety and

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2 550	Continued From page 9	2 550		

depression. Section C, questions C0100 through C1310 of R13's MDS were blank or dashed and no values were recorded. Section D, questions D0100 through D0600 were blank or dashed and no values were recorded.

During an interview on 2/16/22, at 1:34 p.m. registered nurse (RN)-A verified he had been the MDS coordinator since 2018, for the facility. RN-A stated R4's Section C was completed "too early" on 1/21/22, and was not conducted during the MDS assessment period. However, RN-A was aware the MDS was not completed correctly. RN-A stated he was responsible to complete the facility resident MDS assessments. Upon review of R4's quarterly MDS dated 1/28/22, RN-A stated the MDS was missing Section C--it was not assessed or "dashed" out. However, RN-A explained this was due to Section C being completed on 1/21/22, which was not during the assessment period and was "unusable". RN-A stated the MDS was always a shared responsibility at the facility with some assessments completed by nursing staff and others completed by social services. However, RN-A stated he was responsible to ensure this information was entered into the MDS and "sign off" the completion. RN-A stated the electronic medical record (EMR) would alert him if there was a monetary penalty if the MDS was not entirely completed and he was aware the MDS was not fully completed.

RN-A verified R6's and R13's MDS sections C and D were not completed prior to their MDS being submitted. RN-A stated social services should have completed both section C and D. RN-A stated when the due date was near and information was not added he would typically send out an email to the responsible staff to get

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the information entered. RN-A stated the facility went for a time period--six months to nine months--without a social worker. During that time nursing staff were responsible for completing the assessments for sections C and D.

During an interview on 12/16/22, at 2:23 p.m. the social services designee (SSD) stated she was not aware she was responsible for the completion of Section C, had not had any formal MDS training and was "thrown into it" after starting her role in November 2021. However, she became aware of her responsibility at the beginning of February 2022 and had been attempting to complete them since.

During an interview on 2/16/22, at approximately 2:30 p.m. the director of nursing (DON) stated she was aware RN-A submitted MDS corrections the day prior, 2/15/22, but was unaware of the extent or the corrections needed. The DON stated social services was responsible for Section C, but nursing staff had the ability to complete these as well. The DON further stated when submitting a completed MDS, RN-A would be alerted by the system that a MDS was "unable to validate" and RN-A would be aware of the sections not completed. The DON also stated she provided the SSD with informal MDS training, and she suspected the SSD was completing these sections on paper. Because of this, the DON stated she would need to speak with her staff for further details.

On 2/16/22, at 3:09 p.m. the DON verified the SSD was completing observations for C and D on paper. RN-A was not entering this information into the MDS and was adding a "dash" to those sections. The DON stated she expected the MDS assessments to be completed and to be notified

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2 550	Continued From page 11 of any concerns with completion. The facility Minimal [sic] Data Set (MDS) Assessment Completion policy dated 7/15/20, directed the registered nurse (RN) MDS coordinator would ensure timely completion of the care area assessments (CAAs) and the MDS. In addition, the policy directed the RN MDS coordinator would conduct or coordinate each assessment and would sign and certify the completion of the assessment. The RN MDS coordinator would transmit the completed MDS assessments to CMS. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure the quarterly Minimum Data Set (MDS) is filled out completely prior to submitting. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced	21665		3/24/22

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21665	Continued From page 12 by: Based on observation and interview the facility failed to maintain good repair of the walls in the residents living space for 1 of 1 resident (R19) reviewed for clean living space. Findings include: R19's quarterly Minimum Data Set (MDS) dated 12/30/21, identified R19 required assistance with all activities of daily living (ADL's). R19's diagnoses list included Alzheimer's disease and dementia. R19's care plan dated 1/20/22, identified R19 required extensive assist of one staff and the use of bilateral grab bars for bed mobility. During observation on 2/14/22, at 1:35 p.m. R19's bed had grab bars attached to the frame on either side of the upper portion of the bed. The bed was in the lowest position, pushed up next to the wall but not touching the wall. The wall had scuff marks and chipped paint in an area approximately 12 inches wide x 18 inches high at the level where the grab bars where located. During observation on 2/16/22, at 8:23 a.m. R19's bed was elevated to mid-thigh level and was pushed close to but not touching the wall. A round, black knob on the grab bars was attached to the bed. The knob on the left side of the bed was touching the wall at the level of the scuff marks and chipped paint. During an interview on 2/15/22, at 10:47 a.m. housekeeper (hskp)-A stated housekeepers went through every room, every day and cleaned the bathroom, mopped the floor, high dusted if needed, swept and mopped the room floor, and	21665	corrected	

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21665	Continued From page 13 wiped down the tables. On bath days they also swept and mopped under the beds and dressers. During an interview on 2/16/22, at 7:46 a.m. licensed practical nurse (LPN)-A stated if staff noticed a wall with chipped paint they would notify the nurse manager. The nurse manager would fill out the online maintenance work order to have it repaired. During an interview on 2/16/22, at 11:53 a.m. nursing assistant (NA)-A and NA-D stated housekeepers would mop the floors, complete general cleaning, dust, and take care of any stains if needed. Maintenance would fix any scrapes or tears in the wallpaper or any painting that needed to be done. During an interview with NA-D and the director of nursing (DON) on 2/16/22, at 12:21 p.m. NA-D stated the black knobs on the grab bars hit the wall when the bed was moved back/forth or up/down. The knobs chipped the paint off the wall and left marks on the wall. The DON stated the paint chips on the floor needed to be cleaned up and the wall in R19's room needed to be repaired. The Facility Maintenance policy revision date 2/1/19, directed staff to maintain repairs of walls SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure walls in resident rooms are kept in good repair. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could	21665		

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21665	Continued From page 14 develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		