

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



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



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



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

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As authorized by CMS the remedy of:

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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



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

PRINTED: 04/05/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245458	B. WING_		02/	16/2022
	PROVIDER OR SUPPLIER	CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792	,	
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E 000	Initial Comments		E 00	0		
	compliance with Ap Preparedness Requestions and acted during a	ph 2/16/22, a survey for spendix Z, Emergency uirements, §483.73(b)(6) was standard recertification was IN compliance.				
F 000	signature is not req page of the CMS-2 correction is require	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents.	F 00	0		
	recertification surve facility by the Minne determine if your fa requirements of 42	gh 2/16/22, a standard by was completed at your desota Department of Health to acility was in compliance with CFR Part 483, Subpart B, ong Term Care Facilities. Your compliance.				
	as your allegation of Department's acce enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required the first page of the CMS-2567 ic submission of the POC will tion of compliance.				
	onsite revisit of you validate substantial regulations has been	sessments & Timing	F 63	6		3/24/22
	§483.20 Resident A					
ABORATORY	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Electronically Signed

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 pursing homes, the findings stated above are disclosuble 90 days.

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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F 636	The facility must coa a comprehensive, a reproducible assess functional capacity. §483.20(b) Compre §483.20(b)(1) Res A facility must mak assessment of a regoals, life history a resident assessment by CMS. The assest the following: (i) Identification and (ii) Customary rout (iii) Cognitive patte (iv) Communication (v) Vision. (vi) Mood and behad (vii) Psychological (viii) Physical funct (ix) Continence. (x) Disease diagnod (xi) Dental and nutro (xi) Dental and nutro (xii) Skin Condition (xiii) Activity pursuif (xiv) Medications. (xv) Special treatm (xvi) Discharge plad (xvii) Documentation regarding the addition the care areas to the Minimum Data (xviii) Documentation assessment. The include direct observith the resident, as	enduct initially and periodically accurate, standardized sment of each resident's ehensive Assessments ident Assessment Instrument. e a comprehensive esident's needs, strengths, and preferences, using the nt instrument (RAI) specified essment must include at least demographic information ine. rns. in. evior patterns. evell-being. ioning and structural problems. esis and health conditions. ritional status. s. t. ents and procedures. enting. on of summary information ional assessment performed riggered by the completion of	F 6	36		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING		E SURVEY PLETED
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F 636	members on all shi §483.20(b)(2) Whe timeframes prescrichapter, a facility massessment of a retimeframes specific through (iii) of this sprescribed in §413. apply to CAHs. (i) Within 14 calend excluding readmissing significant change mental condition. (I "readmission" mea following a tempora or therapeutic leave (iii) Not less than on This REQUIREMED by: Based on interview facility failed to thom Minimum Data Set accordance to the Instrument (RAI) midentified with incorsections of the MD Findings include: The Centers for Me (CMS) Long-Term (Assessment Instrudated 10/2019, ideassessment tool who was. The manual p	en required. Subject to the bed in §413.343(b) of this nust conduct a comprehensive esident in accordance with the ed in paragraphs (b)(2)(i) section. The timeframes .343(b) of this chapter do not dar days after admission, sions in which there is no in the resident's physical or For purposes of this section, ns a return to the facility ary absence for hospitalization e.) nce every 12 months. NT is not met as evidenced and document review, the roughly complete an admission (MDS) assessment in Resident Assessment nanual for 1 of 2 resident (R17) mplete cognitive and mood S. edicare and Medicaid Services Care Facility Resident ment (RAI) 3.0 User's Manual ntified the MDS as an hich facilities are required to rovided instructions to ensure olete coding for each section of	F6	1. R17 will have BIMS and Completed 2. R17's Care plan will be r accuracy in noted areas of 3. All Resident's Charts revensure BIMS and PHQ9s awithin last 90 days 4. DON/Designee to Audit assessments for completic Continued audits of 10% or assessments due, on weel 1 month 5. Social Services Designe sections Q, C, D, and E of and develop Standard Wor 6. MDS Policy Reviewed version of IDT who are ecomplete 7. All issues will be reporte	reviewed for deficiency viewed to are completed MDS on for 2 months. If all kly cadence, for es to review RAI manual to Document with all expected to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 636	"Section C: Cogniti intent of determinir orientation and abil information. These factors in many car "Section D: Mood," addressing mood o "serious condition,' and under treated in R17's annual Minimal Minim	we Patterns," with a written ing the residents attention, lity to register and recall new is items were listed as "crucial re planning decisions." I with a written intent of distress which was labeled as a 'which was under-diagnosed in the nursing home setting. Inum Data Set (MDS) dated 17's diagnoses included heart insion. Section C (cognitive ion D (mood) were not coded as dashed or had no other ection Z of the MDS was a coordinator and dated 2/8/22, as assessment was complete. I on 2/16/22, at 1:34 p.m. the registered nurse (RN)-A stated as to complete the facility essments. Upon review of dated 2/4/22, RN-A stated Section C and Section D was ashed" out. Additionally, R17's estionnaire (PHQ-9) (diagnostical residents for the presence pression) was not completed. DS was always a shared	F 63	Administrator immediately and brough to the QAPI of quarterly		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
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F 636	was not entirely composed by the Section D and the section D and the the ability to composed by all the sections on DON stated she would be alerted by "unable to validate the sections on DON stated she was aware and she suspected the PHQ-9 on papinformation into the "dash" to those see expected the MDS section D and the sections are stated the SSD was completed by the sections on DON stated she was aware RI the day prior, 2/15 extent or the corresponding to the section D and the section D and the sections not composed by the sections on DON stated she was saff for further decomposed by the PHQ-9 on papinformation into the "dash" to those see expected the MDS section by the PHQ-9 on papinformation into the "dash" to those see expected the MDS sections on the provided the SSD was completed by the PHQ-9 on papinformation into the "dash" to those see expected the MDS sections on the provided the MDS sections on the	mpleted and he was aware the completed. w on 12/16/22, at 2:23 p.m. the as not aware she was completion of Section C, PHQ-9, had not had any formal was "thrown into it" after November 2021. However, her responsibility at the uary 2022 and had been plete them since. w on 2/16/22, at approximately ctor of nursing (DON) stated N-A submitted MDS corrections /22, but was unaware of the ections needed. The DON as responsible for Section C, PHQ-9, but nursing staff had lete these as well. The DON n submitting a MDS, RN-A by the system that a MDS was ell and RN-A would be aware of completed. The DON also stated SSD with informal MDS training d the SSD was completing paper. Because of this, the yould need to speak with her	F	536			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	Assessment Comp directed the register coordinator would experience area assessment addition, the policy coordinator would completion of the accoordinator would the accoordinator would the assessments to CN Qrtly Assessment and CFR(s): 483.20(c) §483.20(c) Quarter A facility must assequanterly review instant approved by Conce every 3 months.	[sic] Data Set (MDS) letion policy dated 7/15/20, red nurse (RN) MDS ensure timely completion of the ents (CAAs) and the MDS. In directed the RN MDS conduct or coordinate each ould sign and certify the ssessment. The RN MDS ransmit the completed MDS MS. It Least Every 3 Months Ily Review Assessment ss a resident using the trument specified by the State MS not less frequently than	F 6			3/24/22	
	Based on interview facility failed to com Minimum Data Sets R19, R6, and R13) accuracy. Findings include: The Centers for Me (CMS) Long-Term (Assessment Instrudated 10/2019, ideassessment tool whuse. The manual properties of the content of the	and document review, the aplete required quarterly (MDS) for 5 of 12 (R4, R2, reviewed for assessment) adicare and Medicaid Services Care Facility Resident ment (RAI) 3.0 User's Manual antified the MDS as an anich facilities are required to rovided instructions to ensure lete coding for each section of follows:		1. R4, R2, R19, R6 and R13 BIMs PHQ-9 completed 2. R4, R2, R19, R6 and R13 Care reviewed for accuracy in noted are deficiency 3. All residents' charts reviewed to BIMS and PHQ-9 completed in the days 4. DON/Designee to Audit MDS assessments for completion for 2 Continued audits of 10% of all assessments due, on weekly cade 1 month 5. Social Services Designees to resections Q, C, D, and E of RAI ma and develop Standard Work Docu	e Plans eas of ensure e last 90 months. ence, for eview enual		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245458	B. WING			02/	16/2022
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F 638	"Section C: Cogniti- intent of determinin orientation and abil information. These factors in many car "Section D: Mood," address mood distrunderdiagnosed and home and is associated is particularly imposymptoms of mood residents because can be treatable. "Section E: Behavioral and in the care environmental distress to the residentify behavioral and in the care environmental and in the care en	we Patterns," with a written g the residents attention, ity to register and recall new items were listed as "crucial e planning decisions." with a written intent to tess, a serious condition that is d undertreated in the nursing lated with significant morbidity. ortant to identify signs and distress among nursing home these signs and symptoms or," with a written intent to symptoms that may cause dent, or may be distressing or residents, staff members or ent. These behaviors may at risk for injury, vity and may also indicate s, preferences or illness. hose that are potentially ent himself or herself. The ving behaviors, which does not medical diagnosis. frequency and the impact of ans on the resident and on distinguish behaviors that a from those that are not the frequency and impact of an are accurately determined, and care plan interventions or improve the symptoms or	F6	38	6. All issues will be reported to Administrator immediately for followand brough to the QAPI Committee quarterly		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245458	B. WING_		02/	16/2022	
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F 638	1/28/22, identified Fincluded gastrointedisease, and insome rather each field was values recorded. So signed by registere 2/7/22, which indicated complete. R2's quarterly MDS severe cognitive important term memory issues organized thinking. Alzheimer's diseased Section D had no expended the completed in R19's minimum date identified R19 had a completed in R19's minimum date identified R19 had a complete interview for more inter	R4 had diagnoses that stinal bleeding, chronic kidney mia. Section C was not coded as dashed or had no other ection Z of the MDS was dinurse (RN)-A and dated ated the assessment was didated the assessment was didated 1/21/22 identified pairment with short and long s with inattention and Diagnoses included and psychotic disorder. Intries, and Section E identified was answered and questions were blank. The MDS was in Section Z by RN-A. It is a set (MDS) dated 12/23/21, diagnoses including and depression. Section C: Cognitive Pattern are was answered identifying a mental status (BIMS), and question number one ent's mood interview sections ducted. The remaining of these sections were not dash through them. Section Z and by the RN-A and dated dicated the assessment was didated 2/3/22, indicated R6 ch included depression. In the control of the color of the	F 63	38			

	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING ———————————————————————————————————			(X3) DATE SURVEY COMPLETED			
		245458	B. WING	i	02	/16/2022	
	PROVIDER OR SUPPLIER	CARE CENT	STREET ADDRESS, CITY, STATE, ZIP COI 901 9TH STREET NORTH VIRGINIA, MN 55792			DE	
(X4) I D PREF I X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPR I ATE	(X5) COMPLETION DATE	
F 638	R13's quarterly MD R13's diagnoses in depression. Section C1310 of R13's MI no values were reconcted by the MDS coordinator sistered nurse (RMDS coordinator sistered R4's Section on 1/21/22, and was MDS assessment paware the MDS was RN-A stated he was facility resident MD of R4's quarterly MI the MDS was missi assessed or "dashe explained this was completed on 1/21/assessment period stated the MDS was responsibility at the assessments compothers completed by RN-A stated he was information was enoff" the completion medical record (EN was a monetary peentirely completed was not fully complex.	S dated 12/10/21, indicated cluded anxiety and n C, questions C0100 through DS were blank or dashed and orded. Section D, questions 600 were blank or dashed and orded. Ton 2/16/22, at 1:34 p.m. N)-A verified he had been the nce 2018, for the facility. RN-A in C was completed "too early" is not conducted during the period. However, RN-A was is not completed correctly. It is responsible to complete the is assessments. Upon review DS dated 1/28/22, RN-A stated and Section Cit was not early out. However, RN-A due to Section C being 22, which was not during the and was "unusable". RN-A is always a shared facility with some pleted by nursing staff and y social services. However, is responsible to ensure this stered into the MDS and "sign RN-A stated the electronic IR) would alert him if there inalty if the MDS was not and he was aware the MDS	F6	638			
	being submitted. R	npleted prior to their MDS N-A stated social services eted both section C and D.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245458	B. WING_		02	/16/2022
	PROVIDER OR SUPPLIER IA HEALTH VIRGINIA	CARE CENT		STREET ADDRESS, CITY, STATE, ZIF 901 9TH STREET NORTH VIRGINIA, MN 55792		
(X4) I D PREF I X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPR I ATE	(X5) COMPLETION DATE
F 638	RN-A stated when information was no send out an email the information ent went for a time per monthswithout a nursing staff were assessments for second services desonot aware she was of Section C, had retraining and was "trole in November 2 aware of her response february 2022 and complete them since 2:30 p.m. the direct she was aware RN the day prior, 2/15/extent or the correct stated social service C, but nursing staff these as well. The submitting a complate the system of the system	the due date was near and at added he would typically to the responsible staff to get ered. RN-A stated the facility iodsix months to nine social worker. During that time responsible for completing the ections C and D. You on 12/16/22, at 2:23 p.m. the signee (SSD) stated she was responsible for the completion not had any formal MDS hrown into it" after starting her 2021. However, she became nsibility at the beginning of thad been attempting to	F 63	38		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245458	B. WING_		02/	16/2022
	ROVIDER OR SUPPLIER A HEALTH VIRGINIA	CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686 SS=D	the MDS and was a sections. The DON assessments to be of any concerns with The facility Minimal Assessment Comp directed the register coordinator would be care area assessment and we completion of the area coordinator would the accoordinator woul	ot entering this information into adding a "dash" to those stated she expected the MDS completed and to be notified the completion. [sic] Data Set (MDS) letion policy dated 7/15/20, red nurse (RN) MDS ensure timely completion of the ents (CAAs) and the MDS. In directed the RN MDS conduct or coordinate each could sign and certify the ssessment. The RN MDS ransmit the completed MDS MS. Prevent/Heal Pressure Ulcer 1)(i)(ii) egrity sure ulcers. orehensive assessment of a	F 68	38		3/24/22
	new ulcers from de This REQUIREMEN by: Based on observat	revent infection and prevent veloping. NT is not met as evidenced tion, interview and document ailed to follow doctor's orders		R2 Care Plan updated All Resident Braden scores comp	bleted	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUC			(3) DATE SURVEY COMPLETED		
		245458	B. WING_		02/	16/2022
	PROVIDER OR SUPPLIER IA HEALTH VIRGINIA	CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792		
(X4) I D PREF I X TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPR I ATE	(X5) COMPLETION DATE
F 686	and update the car (R2) to aide in the principles include: R2's quarterly Minit 1/21/22, identified with long- and shor a extensive assist volcomotion on and identified R2 was a R2's diagnosis list and peripheral vasiflow to the hands a A provider's order offload heels bilate or foam boots in be R2's progress note returned from an adoctor (MD) at a loreceived to "offload boots in bed or characteristics of using offload pressure or breakdown. On 2/14/22, at 7:23 in her wheelchair in slightly reclined, han to wearing foam bunder her feet. For room.	e plan for 1 of 12 residents prevention of pressure ulcers. mum Data Set (MDS) dated severe cognitive impairment teterm memory issues. R2 was with bed mobility, transfers and off the unit. The MDS at risk for pressure ulcers. included Alzheimer's disease cular insufficiency (poor blood and feet). dated 2/7/22, instructed to rally (both heels) using pillows	F 68	3. All Resident Care Plan a reviewed for Accuracy 4. Order Policy and Skin Coreviewed and updated 5. DON/Designee to audit week with high skin risk to interventions are being follomonth, then bi-monthly for 6. All issues will be reported administrator immediately and brought to the QAPI colleast quarterly	Care Policy 3 residents per 9 ensure lowed for 1 7 2 months ed to for follow up	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245458	B. WING		02	/16/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 901 9TH STREET NORTH VIRGINIA, MN 55792		
(X4) I D PREF I X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 686	wheelchair to eat bupright, wearing so on the wheelchair thanging behind the pillow on the footree. On 2/15/22, at 9:45 wheelchair, slightly left foot was on the hanging behind the foam boots and the feet. On 2/15/22, at 10:3 her wheelchair with was wearing socks nor did she have a On 2/15/22, at 10:4 her wheelchair, but want to lay down". foam boots and the feet. During an interview nursing assistant (I aware of any order identified it was no not told of any new During an interview stated the R2's car sheet did not identificated it was no not told of any new During an observating	preakfast. R2 was sitting picks with her left foot directly footrest and the right foot e foot rest. There was not a set. 5 a.m. R2 was sitting in her reclined, wearing socks. R2's a footrest and the right foot was a foot rest. R2 was not wearing ere was not a pillow under her as a set. 82 a.m., R2 continued to be in a both feet on the footrests. R2 as not wearing foam boots pillow under her feet. 84 a.m., R2 continued to be in the was calling out for help and "I R2 was wearing socks, no ere was not a pillow under her won 2/15/22, at 10:11 a.m. NA)-A stated she was not is to offload R2's heels and it on the care plan and she was	F6	86		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ion 	(X3) DATE SURVEY COMPLETED	
		245458	B. WING_	B. WING		02/	16/2022
	PROVIDER OR SUPPLIER A HEALTH VIRGINIA	CARE CENT		STREET ADDRES 901 9TH STREE VIRGINIA, MN			
(X4) I D PREF I X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	VIDER'S PLAN OF CORRE CORRECTIVE ACTION SH REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 686	been updated and to RN-C then went to confirmed the order	the intervention implemented. check on R2 while in bed and was not being followed as	F 68	36			
	wearing foam boots blanket back over F	under R2's feet nor was she s. RN-C then placed the R2's feet and did not put foam pillow under R2's feet and left					
	director of nursing (not instituted and contreatment record and stated once the ord should have been in MD order and should stated new orders of plan so all staff knot confirmed the order	on 2/15/22, at 3:32 p.m. the (DON) stated the order was urrently was noted on the nd was not being done. She er was entered and verified it implemented immediately per ld be done. The DON also should be placed on the care with the intervention and reto offload heels and use we was not on R2's care plan.					
F 695 SS=D	Implementation of I revised 10/16/17, ic verified the RN was appropriate staff in	wledgement, Coordination and Physicians' Orders policy lentified once an order was to communicate orders to volved in patient's care. ostomy Care and Suctioning	F 69	95			3/24/22
	The facility must en needs respiratory of care and tracheal s care, consistent with practice, the compr	and tracheal suctioning. sure that a resident who are, including tracheostomy uctioning, is provided such h professional standards of ehensive person-centered ents' goals and preferences,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245458	B. WING_	B. WING		02/	16/2022
	PROVIDER OR SUPPLIER	CARE CENT		901	REET ADDRESS, CITY, STATE, ZIP CODE 9TH STREET NORTH RGINIA, MN 55792	, <u>, , , , , , , , , , , , , , , , , , </u>	
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	by: Based on observate review, the facility fatubing and oxygen I timely manner for 1 for respiratory care. Findings include: R6's Face Sheet prhad diagnoses which chronic condition in blood as well as it sobesity, and palliative R6's quarterly Mining 2/3/22, indicated R6 R6's care plan date required oxygen the Interventions including signs and symptom amount of oxygen roxygen saturation leand administer oxygorders. R6's Physician Orde 2/16/22, indicated F6 to five liters per nas started on 7/30/21. On 2/14/22, at 1:50 wheelchair in her recannula with humid	ion, interview, and document ailed to ensure the oxygen numidifier were changed in a of 1 residents (R6) reviewed inted on 2/16/22, indicated R6 in included heart failure (a which the heart doesn't pump hould), chronic pain, anxiety,	F 69		1. R6's oxygen tubing was change 2. Orders placed in EMAR for all re on oxygen to have tubing changed dated once weekly 3. Admission and order checklist up to include if a resident is on oxyger order to change and date tubing we 4. DON/Designee to complete 2 ra audits weekly for 2 months for com 5. Standard Work reviewed and up 6. All issues will be reported to administrator immediately for follow and brought to QAPI committee at quarterly	esidents and odated o to add eekly ndom pletion dated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING (X3)				
		245458	B. WING_		02/16/2022		
	ROVIDER OR SUPPLIER A HEALTH VIRGINIA	CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792			
(X4) I D PREF I X TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	D BE COMPLÉTION		
F 921 SS=D	stated he did not kn was changed, he say changed the tubing humidifier was almous needed to be changed humidifier and oxygstated there were noursing staff to change oxygen tubing. On 2/16/22, at 7:55 (DON) verified oxygstubing should be changed there was not ensure it was done. The facility Storage Oxygen policy date the frequency of repoxygen tubing. Safe/Functional/Sate (CFR(s): 483.90(i)) §483.90(i) Other Enthe facility must prosanitary, and comforces idents, staff and This REQUIREMENT by: Based on observatified to maintain gresidents living spareviewed for clean for the findings include:	p.m. registered nurse (RN)-B now when the oxygen tubing aid he thought maybe nights. RN-B verified the oxygen ost out of water and said it ged. RN-B verified the oxygen per tubing was undated. RN-B ot any nursing orders alerting nge the oxygen humidifier and a.m. the director of nursing gen humidifiers and oxygen hanged weekly. The DON not a process in place to and Handling of Supplies and d 4/5/19, lacked direction on placing oxygen humidifiers and mitary/Comfortable Environ environmental Conditions ovide a safe, functional, portable environment for the public. No in the public of the walls in the ce for 1 of 1 resident (R19)	F 69		and here or eep quests	/24/22	
	•						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245458	B. WING		02	/16/2022
	PROVIDER OR SUPPLIER IA HEALTH VIRGINIA	CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CO 901 9TH STREET NORTH VIRGINIA, MN 55792		
(X4) I D PREF I X TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 921	all activities of daily diagnoses list includementia. R19's care plan da required extensive of bilateral grab ba During observation bed had grab bars side of the upper p in the lowest positio but not touching the marks and chipped approximately 12 in the level where the During observation bed was elevated to pushed close to bur ound, black knob to the bed. The known was touching the word marks and chipped During an interview housekeeper (hskpthrough every room bathroom, mopped needed, swept and wiped down the tabs swept and mopped During an interview licensed practical in noticed a wall with the nurse manager	R19 required assistance with valiving (ADL's). R19's ded Alzheimer's disease and sted 1/20/22, identified R19 assist of one staff and the use rs for bed mobility. on 2/14/22, at 1:35 p.m. R19's attached to the frame on either ortion of the bed. The bed was on, pushed up next to the wall e wall. The wall had scuff I paint in an area aches wide x 18 inches high at grab bars where located. on 2/16/22, at 8:23 a.m. R19's o mid-thigh level and was to not touching the wall. A on the grab bars was attached ob on the left side of the bed wall at the level of the scuff	F 921	audits twice monthly for comthree months 5. Standard of Work general completion of routine checks 6. All issues will be reported adminstrator immediately for and brought to the QAPI conleast quarterly	ted for s to r follow up	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245458	B. WING	B. WING		02/	16/2022
	PROVIDER OR SUPPLIER	CARE CENT		9	TREET ADDRESS, CITY, STATE, ZIP CODE 01 9TH STREET NORTH 'IRGINIA, MN 55792	, 02.	
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 921	nursing assistant (N housekeepers woul general cleaning, d stains if needed. Mascrapes or tears in that needed to be d During an interview nursing (DON) on 2 stated the black know wall when the bed wup/down. The know wall and left marks the paint chips on the up and the wall in Frepaired.	on 2/16/22, at 11:53 a.m. NA)-A and NA-D stated Id mop the floors, complete ust, and take care of any aintenance would fix any the wallpaper or any painting	FS	921			



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

F5458033

PRINTED: 03/14/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION 6 01 - MAIN BUILDING 01		E SURVEY PLETED	
		245458	B. WING_			02/	16/2022
	PROVIDER OR SUPPLIER	CARE CENT		ç	STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs .	K 00	00			
	FIRE SAFETY						
	conducted on 02/16 Department of Publ Division. At the time Health Virginia Care compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F (NFPA) 101, Life Sa	y recertification survey was 6/2022 by the Minnesota dic Safety, State Fire Marshal e of this survey, Essentia e Center was found not in e requirements for participation and at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association afety Code (LSC), Chapter 19 and the 2012 edition of are Facilities Code.					
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.					
	ONSITE REVISIT (CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	PLEASE RETURN CORRECTION FOI DEFICIENCIES (K-	R THE FIRE SAFETY					
		IN THE E-POC PROCESS, A THE PLAN OF CORRECTION).					
LABORATOR`	L Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		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:		l ' '	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245458	B. WING		02	2/16/2022
	PROVIDER OR SUPPLIER IA HEALTH VIRGINIA	CARE CENT		STREET ADDRESS, CITY, STATE, Z 901 9TH STREET NORTH VIRGINIA, MN 55792		
(X4) I D PREF I X TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
K 000	Healthcare Fire Ins State Fire Marshal 445 Minnesota St., St. Paul, MN 5510 ^o By email to: FM.HC.Inspections THE PLAN OF CO DEFICIENCY MUSTFOLLOWING INFO 1. A detailed descritaken or planned to 2. Address the meato ensure the deficition. 3. Indicate how the performance to ensure the deficition. 4. Identify who is reactions and monito. 5. The actual or prother remedy. Essentia Health Virbuilding with a full by was constructed in 1970. The nursing home floors. A 3 story hot type adjoins the nurby a 2-hour fire-rate.	pections Division Suite 145 1-5145, OR S@state.mn.us RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: iption of the corrective action of correct the deficiency. asures that will be put in place iency does not reoccur. facility plans to monitor future sure solutions are sustained. esponsible for the corrective oring of compliance. poposed date for completion of rginia Care Center is a 4-story basement. The original building 1936, and additions and 1999, all of Type II(222). occupies the 3rd and 4th spital of the same construction irsing home and is separated ed barrier, with 1&1/2 hour loors. Therefore, the nursing	K			
	The building is fully	sprinkler protected. The				

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 03/14/2022 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245458 B. WING 02/16/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH **ESSENTIA HEALTH VIRGINIA CARE CENT** VIRGINIA, MN 55792 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 000 | Continued From page 2 K 000 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 712 Fire Drills K 712 3/24/22 SS=F 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 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: 1. Verify Fire Drill Schedule meets Based on a review of available documentation and staff interview, the facility failed to conduct compliance need fire drills per NFPA 101 (2012 edition). Life Safety 2. Review and Update Standard of Work Code, sections 19.7.1.2 and 19.7.1.4. These 3. Re-educate all Nurse Supervisors on deficient findings could have a widespread impact documentation expectation and procedure on the residents within the facility. 4. DON/Designee will audit compliance and proper documentation of all Fire Drills Findings include: and provide to Facilities and Emergency Preparedness Assistant for 3 months 1. On 02/16/2022, at 11:30 AM., during the review of all available fire drill documentation and

(X2) MULTIPLE CONSTRUCTION

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245458 B. WING 02/16/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH **ESSENTIA HEALTH VIRGINIA CARE CENT** VIRGINIA, MN 55792 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 712 | Continued From page 3 K 712 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 914 | Electrical Systems - Maintenance and Testing K 914 3/24/22 SS=F 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

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(X6) DATE

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00603	B. WING	B. WING		6/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	STATE, ZIP CODE	•	
ESSENT	IA HEALTH VIRGINIA	CARF CENT	STREET NOI A, MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 000 Initial Comments		2 000				
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber and mumber and mum	hether a violation has been				
	You may request a that may result from orders provided that the Department with	hearing on any assessments non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	INITIAL COMMENT On 2/14/22, through was conducted at y the Minnesota Depa facility was found N State Licensure and orders are issued. F	·				

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

03/09/22 **Electronically Signed**

TITLE

STATE FORM 6899 N1Z511 If continuation sheet 1 of 15 Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF COMPLETI				
		00603	B. WING		02/	16/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE ZIP CODE	·	
TO WILL OF	THOUBER OR SOLVER		STREET NOR	•		
ESSENT	IA HEALTH VIRGINIA	CARE CENT	A, MN 55792	•••		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
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2 000	Continued From pa	ge 1	2 000			
	these orders and identify the date when they will be completed.					
	the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state stalisted in the "Summ column and replace the correction order the findings which a statute after the stales as evidence by." For	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for the assigned tag number eff column entitled "ID Prefix attute/rule out of compliance is the "To Comply" portion of the "To Comply" portion of the state are in violation of the state attement, "This Rule is not met following the surveyors findings Method of Correction and crection.				
	receipt of State lice the Minnesota Depa Informational Bullet https://www.health.sn/infobulletins/ib14_orders are delineate Department of Hea you electronically. is necessary for State of text. You must then State licensure proceedings of the corrected prior to element of Minnesota Department of the Minnesota	state.mn.us/facilities/regulatio state.mn.us/facilities/regulatio _1.html The State licensing ed on the attached Minnesota lth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.				
	FOURTH COLUMN "PROVIDER'S PLA	ARD THE HEADING OF THE WHICH STATES, IN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SURVE COMPLETED			
		00603	B. WING	B. WING		16/2022
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
FSSENT	IA HEALTH VIRGINIA	CARE CENT 901 9T	H STREET NO	RTH		
LOOLINI	IATILALITI VIRGINIA	VIRGI	IIA, MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
2 000	Continued From page 2		2 000			
	IS NO REQUIREM CORRECTION FO	R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN O R VIOLATIONS OF E STATUTES/RULES.				
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment		e 2 540			3/24/22
	conduct a compreh resident's needs, w capability to perform significant impairments of the comprehensive resused to develop, recomprehensive plates 4658.0405. Subp. 2. Information comprehensive resinclude at least the A. medically demedical history; B. medical state C. physical and D. sensory and E. nutritional stares.	ion; ential; n potential; tus; r; and	A.			

Minnesota Department of Health

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00603	B. WING		02/1	6/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENT	IA HEALTH VIRGINIA	CARE CENT	STREET NOF , MN 55792	KIH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 540	Continued From pa	ge 3	2 540			
	by: Based on interview facility failed to com Data Set (MDS) as Resident Assessme for 1 of 2 resident (and document review, the aplete an admission Minimum sessment in accordance to the ent Instrument (RAI) manual R17) identified with incomplete I sections of the MDS.		corrected		
	Findings include:					
	(CMS) Long-Term (Assessment Instruit dated 10/2019, identification assessment tool where the control of the co	edicare and Medicaid Services Care Facility Resident ment (RAI) 3.0 User's Manual ntified the MDS as an nich facilities are required to rovided instructions to ensure lete coding for each section of follows:				
	intent of determinin orientation and abil information. These	ve Patterns," with a written g the residents attention, ity to register and recall new items were listed as "crucial e planning decisions."				
	addressing mood d "serious condition,"	with a written intent of istress which was labeled as a which was under-diagnosed n the nursing home setting.				
	2/4/22, identified R failure and hyperter patterns) and Sectirather each field wavalues recorded. Se signed by the MDS	num Data Set (MDS) dated 17's diagnoses included heart asion. Section C (cognitive on D (mood) were not coded as dashed or had no other ection Z of the MDS was coordinator and dated 2/8/22, assessment was complete.				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
00603			B. WING		02/1	6/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH VIRGINIA	CARE CENT	STREET NOF , MN 55792	RTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 540	Continued From pa	age 4	2 540			
	MDS coordinator, resident MDS assers R17's annual MDS MDS was missing and assessed or "darent Health Questool used to screen and severity of dep RN-A stated the MI responsibility at the assessments compothers completed by (SSD). However, Resident to ensure this information of the electronic medital in the the second of the second of the second of the second of the electronic medital in the second of the s	pleted by nursing staff and by the social services designee N-A stated he was responsible mation was entered into the the completion. RN-A stated cal record (EMR) would alert monetary penalty if the MDS mpleted and he was aware the				
	SSD stated she waresponsible for the Section D or the Ph MDS training and vistarting her role in became aware of his beginning of Februattempting to comp. During an interview 2:23 p.m. the direct she was aware RN the day prior, 2/15/2 extent or the correct	on 12/16/22, at 2:23 p.m. the is not aware she was completion of Section C, HQ-9, had not had any formal was "thrown into it" after November 2021. However, her responsibility at the ary 2022 and had been plete them since. on 2/16/22, at approximately tor of nursing (DON) stated -A submitted MDS corrections 22, but was unaware of the ctions needed. The DON is responsible for Section C,				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			SURVEY LETED
	00603		B. WING		02/1	6/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
ESSENT	IA HEALTH VIRGINIA	CARE CENT	TREET NOF MN 55792	RTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 540	further stated when would be alerted by "unable to validate" the sections not conshe provided the Stand she suspected these sections on pDON stated she wo staff for further detained on 2/16/22, at 3:09 SSD was completing the PHQ-9 on paper information into the "dash" to those section expected the MDS and to be notified on completion. The facility Minimal Assessment Comparties districted the register coordinator would expected the MDS and to be notified on completion. The facility Minimal Assessment Comparties districted the register coordinator would expected the policy coordinator would the coordinator would the sessment and we completion of the accoordinator would the sessments to CM SUGGESTED MET The Director of Nurricedures to ensure Set (MDS) is filled to submitting.	ete these as well. The DON a submitting a MDS, RN-A the system that a MDS was and RN-A would be aware of impleted. The DON also stated SD with informal MDS training the SSD was completing the SSD was completed the the SSD was not entering this the MDS and was adding a stions. The DON stated she assessments to be completed from the concerns with [sic] Data Set (MDS) Iletion policy dated 7/15/20, and the MDS in directed the RN MDS conduct or coordinate each could sign and certify the seessment. The RN MDS and the CONTROL of the completed MDS and the completed MDS and the quarterly Minimum Data and the quarterly Minimum Data could completely prior to	2 540	BEHOLENOTY		
	The Director of Nur	sing or designee could iate staff on the policies and				

Minnesota Department of Health

STATE FORM N1Z511 If continuation sheet 6 of 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00603	B. WING		02/1	6/2022
	PROVIDER OR SUPPLIER	CARE CENT 901 9TH S	DRESS, CITY, S STREET NOI , MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 540	develop monitoring compliance.	ge 6 sing or designee could systems to ensure ongoing R CORRECTION: Twenty-one	2 540			
2 550	Subp. 4. Review of home must examin quarterly and must comprehensive ass	O Subp. 4 Comprehensive ent; Review f assessments. A nursing e each resident at least revise the resident's essment to ensure the y of the assessment.	2 550			3/24/22
	by: Based on interview facility failed to com Minimum Data Sets	and document review, the aplete required quarterly (MDS) for 5 of 12 (R4, R2, reviewed for assessment		corrected		
	The Centers for Me (CMS) Long-Term (Assessment Instrur dated 10/2019, ider assessment tool whuse. The manual praccurate and comp the assessment as	edicare and Medicaid Services Care Facility Resident ment (RAI) 3.0 User's Manual ntified the MDS as an nich facilities are required to rovided instructions to ensure lete coding for each section of follows: we Patterns," with a written g the residents attention,				

Minnesota Department of Health

STATE FORM 6899 N1Z511 If continuation sheet 7 of 15

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				B. WING			4.0.40.00	
		00603				02/	16/2022	
NAME OF	PROVIDER OR SUPPLIER			DRESS, CITY, S STREET NOF	STATE, ZIP CODE			
ESSENT	IA HEALTH VIRGINIA	CARE CENT		, MN 55792	VIП			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
2 550	information. These factors in many car factors in many car "Section D: Mood," address mood distrunderdiagnosed an home and is assoc It is particularly impsymptoms of mood residents because can be treatable. "Section E: Behavioral sidentify behavioral distress to the residentify behavioral sidentify behavioral sidentify the care environmentation, and inaction unrecognized need Behaviors include the harmful to the resident and inaction of the behavioral symptom others is critical to constitute problems problematic. Once behavioral symptom follow-up evaluation can be developed the reduce their impact. R4's Quarterly Minimator in the problematic can be developed the reduce their impact.	ity to register and recapited as were listed as a planning decisions." with a written intent to ress, a serious condition of the did undertreated in the intent to identify signs of the serious and symptoms and symptoms that may capter, "with a written intersymptoms that may captent, or may be distress among nursifications and symptoms that may captent, or may be distress are sident, or may be distress are sidents, staff members, with these behaviors or at risk for injury, with and may also indies, preferences or illness that are potential lent himself or herself ying behaviors, which medical diagnosis. In the frequency and the imms on the resident and distinguish behaviors as from those that are resident are accurately detent and care plan intervals improve the symptonic intervals.	"crucial" on that is nursing norbidity. s and ing home of the storms on to see sing or pers or may cate iss. ally . The does not pact of don that not pact of ermined, entions ms or	2 550				
	disease, and insom	stinal bleeding, chroni nnia. Section C was no as dashed or had no c	ot coded					

Minnesota Department of Health

STATE FORM N1Z511 If continuation sheet 8 of 15

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00603	B. WING		02/1	6/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH VIRGINIA	CARE CENT	STREET NOF , MN 55792	RTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 550	signed by registere 2/7/22, which indicated complete. R2's quarterly MDS severe cognitive important term memory issued organized thinking. Alzheimer's diseased Section D had no expected only question one was two through eleven signed completed in R19's minimum dated identified R19 had alzheimer's diseased The assessment's question number of brief interview for mesection D: Mood identifying the reside should've been conquestions for both of answered or had a of the MDS was signed 12/30/21, which indicate the modern of the modern	ection Z of the MDS was d nurse (RN)-A and dated ated the assessment was a dated to a number of the control of the	2 550			
	R13's diagnoses in					

6899

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
ESSENT	ΓΙΑ HEALTH VIRGINIA	CARF CENT	I STREET NOR IA, MN 55792	тн		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 550	depression. Section C1310 of R13's MI no values were reconcerned policy of R13's MI no values were reconcerned policy of R13's MI no values were reconcerned policy of R13's Section on 1/21/22, and was MDS assessment paware the MDS was facility resident MD of R4's quarterly MI the MDS was missi assessed or "dashe explained this was completed on 1/21/assessment period stated the MDS was responsibility at the assessments compothers completed by RN-A stated he was information was enformation was not fully complexed was not fully com	n C, questions C0100 through DS were blank or dashed and orded. Section D, questions 600 were blank or dashed and orded. I on 2/16/22, at 1:34 p.m. IN)-A verified he had been the nace 2018, for the facility. RN-I C was completed "too early" is not conducted during the period. However, RN-A was as not completed correctly. It is responsible to complete the S assessments. Upon review DS dated 1/28/22, RN-A state of the section C-it was not ed" out. However, RN-A due to Section C being 22, which was not during the and was "unusable". RN-A is always a shared facility with some eleted by nursing staff and y social services. However, is responsible to ensure this tered into the MDS and "sign RN-A stated the electronic IR) would alert him if there nalty if the MDS was not and he was aware the MDS	d e A			

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Minnesota Department of Health

AND DIAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00603		B. WING		02/1	16/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENTIA HEALTH VIRGINIA CARE CENT			STREET NOF , MN 55792	RTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENC Y MUST BE PRECEDED E SC IDENTIFYING INFORI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRIES OF THE AP	ULD BE	(X5) COMPLETE DATE
2 550	Continued From parthe information entouent for a time perimonthswithout a subsessments for set of assessments for set of assessments for set of assessments for set of aware she was of Section C, had not raining and was "the role in November 2 aware of her response february 2022 and complete them since the management of the correct she was aware RN the day prior, 2/15/2 extent or the correct stated social service C, but nursing staff these as well. The submitting a complate the submitting a complate the system of the SSD was completed by the system of the SSD was completed the sections on paper. Stated she would not further details. On 2/16/22, at 3:09 SSD was completing paper. RN-A was not the MDS and was a sections. The DON	ered. RN-A stated to de-six months to resocial worker. During esponsible for compections C and D. If on 12/16/22, at 2:2 ignee (SSD) stated responsible for the ot had any formal forown into it" after so 021. However, she insibility at the begin had been attempting to a con 2/16/22, at appoint of nursing (DON-A submitted MDS-22, but was unaware tions needed. The less was responsible had the ability to con DON further stated eted MDS, RN-A was mould be aware of eted. The DON also with informal MDS to SSD was completing Because of this, the led to speak with he informations for ot entering this information adding a "dash" to the social state of the pont of the	prine and that time upleting the she was completion with the she was completion with the she was complete and the she was complete when could be "unable to the stated she raining, and the she constant of the she was a she with the was a she	2 550			

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
	00603		B. WING		02/1	6/2022
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	<u> </u>	OIZOZZ
	IA HEALTH VIRGINIA	901 9TH	STREET NOF			
LOOLINI		VIRGINIA	, MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 550	Continued From pa	ge 11	2 550			
	of any concerns wit	th completion.				
	Assessment Comp directed the registe coordinator would e care area assessm addition, the policy coordinator would of assessment and wo completion of the a	[sic] Data Set (MDS) letion policy dated 7/15/20, bred nurse (RN) MDS ensure timely completion of the ents (CAAs) and the MDS. In directed the RN MDS conduct or coordinate each ould sign and certify the ssessment. The RN MDS ransmit the completed MDS MS.				
	The Director of Nur develop, review, an procedures to ensu Set (MDS) is filled a submitting. The Director of Nur educate all appropriocedures. The Director of Nur develop monitoring compliance.	THOD OF CORRECTION: rsing or designee could ad/or revise policies and are the quarterly Minimum Data out completely prior to rsing or designee could riate staff on the policies and rsing or designee could systems to ensure ongoing R CORRECTION: Twenty-one				
21665	. , ,	0 Physical Environment	21665			3/24/22
21000	A nursing home mu functional, comforta environment, allowi personal belonging	ust provide a safe, clean, able, and homelike physical ing the resident to use s to the extent possible.	21000			JIZ41ZZ
	I IIIS IVIN Requireme	ent is not met as evidenced				

6899

Minnesota Department of Health STATE FORM

00603 B. WING 02/16/202	İ
	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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CON	(X5) COMPLETE DATE
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	

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21665 Continued From page 13 wiped down the tables. On bath days they also B. WING B. WING PREFIX (EACH DEFICIENCY VIRGINIA, MN 55792 ID PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21665 wiped down the tables. On bath days they also	STATEMENT OF DEFICIE AND PLAN OF CORRECT	
ESSENTIA HEALTH VIRGINIA CARE CENT 901 9TH STREET NORTH VIRGINIA, MN 55792 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21665 Continued From page 13 wiped down the tables. On bath days they also	00603	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21665 Continued From page 13 wiped down the tables. On bath days they also	NAME OF PROVIDER OF	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21665 Continued From page 13 wiped down the tables. On bath days they also	ESSENTIA HEALTH	
wiped down the tables. On bath days they also	PREFIX (EACH	
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.	wiped down swept and licensed proticed at the nurse fill out the it repaired. During an anursing an housekeet general contains if not scrapes of that need. During an anursing (I stated the wall where up/down. wall and I the paint up and the repaired. The Facil 2/1/19, discussed the state of the procedure develop, in procedure develop, in procedure educate at the swept in good the procedure of the procedure o	

Minnesota Department of Health

STATE FORM N1Z511 If continuation sheet 14 of 15

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00603	B. WING		02/1	6/2022
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET			STATE, ZIP CODE	-	
I ESSENTIA HEALTH VIRGINIA CARE CENT			TREET NOI , MN 55792	RTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 14	21665			
	develop monitoring compliance.	systems to ensure ongoing				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				