#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

#### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: P40F PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00603 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 7 (L8) (L3) ESSENTIA HEALTH VIRGINIA CARE CENT (L1)245458 1. Initial 2. Recertification (L4) 901 9TH STREET NORTH 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 55792 936325400 (L2)(L5) VIRGINIA, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7)8. Full Survey After Complaint (L9) 01/01/2013 05 HHA 13 PTIP 01 Hospital 09 ESRD 22 CLIA 6. DATE OF SURVEY 09/26/2014 (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC (L10) 12 RHC 12/31 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 16 HOSPICE 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: **X** A. In Compliance With And/Or Approved Waivers Of The Following Requirements: From (a): Program Requirements 2. Technical Personnel 6. Scope of Services Limit To (b): Compliance Based On: 3. 24 Hour RN \_\_\_7. Medical Director 12. Total Facility Beds 4. 7-Day RN (Rural SNF) (L18)\_1. Acceptable POC 8. Patient Room Size 90 5. Life Safety Code \_\_\_ 9. Beds/Room B. Not in Compliance with Program 90 (L17) 13. Total Certified Beds Requirements and/or Applied Waivers: (L12)\* Code: A 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15)90 (L37)(L38)(L39)(L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE Date: 18. STATE SURVEY AGENCY APPROVAL Date: Mark Weath Patricia Halverson, Unit Supervisor 10/01/2014 Enforcement Specialist 10/10/2014 (L19) (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: Ownership/Control Interest Disclosure Stmt (HCFA-1513) X 1. Facility is Eligible to Participate 3. Both of the Above: \_\_\_\_ 2. Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE VOLUNTARY INVOLUNTARY 04/01/1987 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L25) (141)(L24)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (L44) (L27) B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 03001 Posted 10/13/2014 Co. (L28) (1.31)31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE

(L33)

**DETERMINATION APPROVAL** 

(L32)



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5458

October 1, 2014

Ms. Linda Bump, Administrator Essentia Health Virginia Care Cent 901 9th Street North Virginia, MN 55792

Dear Ms. Bump:

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

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

Effective September 16, 2014 the above facility is certified for or recommended for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

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

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Form Approved OMB NO. 0938-0390

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

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245458	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/26/2014
Nam	Name of Facility		Street Address, City, State, Zip Code	
ES	SSENTIA HEALTH VIRGINIA CARE C	ENT	901 9TH STREET NORTH	

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

(Y4) Item		(Y5) Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
	F0156 483.10(b)(5) - (1		d ID Prefix Reg. #	F0176 483.10(n)		Correction Completed 09/16/2014			F0279 483.20(d), 483		Correction Completed 09/16/2014
ID Prefix Reg. # LSC	483.20(d)(3), 483	Correction Completed 09/16/2014 3.10(k)(2)	d 4 ID Prefix	F0309 483.25		Correction Completed 09/16/2014			F0329 483.25(I)		Correction Completed 09/16/2014
ID Prefix Reg. # LSC	483.25(n)	Correction Completee 09/16/2014	d 4 ID Prefix	F0356 483.30(e)		Correction Completed 09/16/2014			F0431 483.60(b), (d),		Correction Completed 09/16/2014
ID Prefix Reg. # LSC	F0441 483.65	Correction Completee 09/16/201	d ID Prefix Reg. #	F0465 483.70(h)		Correction Completed 09/16/2014					
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Reviewed E	ByRe	viewed By	Date:	Signatu	re of Sur	veyor:				Date:	
State Agen	cy ]	PLH/mm	10/01/20	14	12	2835				09/	26/2014
Reviewed E	Ву   Re	viewed By	Date:	Signatui	re of Sur	veyor:				Date:	
Followup t	o Survey Compl 8/15/20				•				Summary of the Facility?	YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered October 1, 2014

Ms. Linda Bump, Administrator Essentia Health Virginia Care Cent 901 9th Street North Virginia, Minnesota 55792

RE: Project Number S5458023

Dear Ms. Bump:

On August 26, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 15, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On September 26, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 15, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 16, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 15, 2014, effective September 16, 2014 and therefore remedies outlined in our letter to you dated August 26, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697 5458r14epoc

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: P40F

#### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00603 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 2 (L8) (L3) ESSENTIA HEALTH VIRGINIA CARE CENT (L1)1. Initial 2. Recertification (L4) 901 9TH STREET NORTH 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 55792 936325400 (L2)(L5) VIRGINIA, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7)8. Full Survey After Complaint (L9) 01/01/2013 05 HHA 13 PTIP 01 Hospital 09 ESRD 22 CLIA 6. DATE OF SURVEY 08/15/2014 (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC (L10) 12 RHC 12/31 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 16 HOSPICE 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: And/Or Approved Waivers Of The Following Requirements: A. In Compliance With From (a): Program Requirements 2. Technical Personnel 6. Scope of Services Limit To (b): Compliance Based On: 3. 24 Hour RN 7. Medical Director 12. Total Facility Beds 4. 7-Day RN (Rural SNF) (L18)\_1. Acceptable POC 8. Patient Room Size 90 \_\_\_ 9. Beds/Room 5. Life Safety Code X B. Not in Compliance with Program (L17) 13. Total Certified Beds Requirements and/or Applied Waivers: (L12)\* Code:  $\mathbf{R}^*$ 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID (L15)1861 (e) (1) or 1861 (j) (1): 90 (L37)(L38)(L39)(L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 18. STATE SURVEY AGENCY APPROVAL 17. SURVEYOR SIGNATURE Date: Date: Mark Chris Elmgren, HFE NEII 09/15/2014 Enforcement Specialist 09/29/2014 (L19) (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: Ownership/Control Interest Disclosure Stmt (HCFA-1513) X 1. Facility is Eligible to Participate 3. Both of the Above: Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE VOLUNTARY INVOLUNTARY 04/01/1987 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L25) (141)(L24)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (L44) (L27) B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 03001 Posted 10/13/2014 Co. (L28) (1.31)31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE

(L33)

**DETERMINATION APPROVAL** 

(L32)



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered August 26, 2014

Ms. Linda Bump, Administrator Essentia Health Virginia Care Cent 901 9th Street North Virginia, Minnesota 55792

RE: Project Number S5458023

Dear Ms. Bump:

On August 15, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

#### DEPARTMENT CONTACT

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

Patricia Halverson, Unit Supervisor Duluth Survey Team Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Patricia.halverson@state.mn.us

Phone: (218) 302-6151 Fax: (218) 723-2359

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

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 24, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

#### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

#### Original deficiencies not corrected

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

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

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

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

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

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

If substantial compliance with the regulations is not verified by November 15, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 15, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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:

5458s14

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division pat.sheehan@state.mn.us Telephone: (651) 201-7205

Fax: (651) 215-0525

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

Sincerely,

Mart Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

PRINTED: 09/28/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
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ADODATOD	<u> </u>	n violation of the state statute	LATURE	TITLE		(X6) DATE

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

(X6) DATE

**Electronically Signed** 

09/05/2014

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG			
		245458	B. WING		08/	15/2014	
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F 156 SS=D	evidence by." Followare the Suggested Time period for Con PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO RECOPLAN OF CORRECOMINNESOTA STAT 483.10(b)(5) - (10), RIGHTS, RULES, Some the facility must also provide (if any) of the suggested facility must also provide (if any) of the suggested facility must also provide (if any) of the suggested facility must also provide (if any) of the suggested facility must also provide (if any) of the suggested facility must also provide (if any) of the suggested facility must also provide (if any) of the suggested facility must also provide (if any) of the suggested facility must also provide (if any) of the suggested facility must also provide (if any) of the suggested facility must also provide facility must also provide suggested facil	"This Rule is not met as wing the surveyors findings Method of Correction and rection."  IRD THE HEADING OF THE WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.  QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.  483.10(b)(1) NOTICE OF SERVICES, CHARGES  form the resident both orally anguage that the resident or her rights and all rules and ang resident conduct and ang the stay in the facility. The ovide the resident with the extate developed under act. Such notification must be on admission and during the ceipt of such information, and of it, must be acknowledged in form each resident who is a benefits, in writing, at the time nursing facility or, when the eligible for Medicaid of the that are included in nursing facility or, when the eligible for Medicaid of the that are included in nursing facility or, when the eligible for Medicaid of the that are included in nursing facility or, when the eligible for Medicaid of the that are included in nursing facility or, when the eligible for Medicaid of the that are included in nursing facility or, when the eligible for Medicaid of the that are included in nursing facility or, when the eligible for Medicaid of the that are included in nursing facility or, when the eligible for Medicaid of the that are included in nursing facility or, when the eligible for Medicaid of the that are included in nursing facility or, when the eligible for Medicaid of the that are included in nursing facility or, when the eligible for Medicaid of the that are included in nursing facility or, when the eligible for Medicaid of the that are included in nursing facility or, when the eligible for Medicaid of the that are included in nursing facility or, when the eligible for Medicaid of the that are included in nursing facility or, when the eligible for Medicaid of the that are included in nursing facility or the that are	F 1			9/16/14	
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-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245458	B. WING			08/ <sup>-</sup>	15/2014
	PROVIDER OR SUPPLIER	CARE CENT		901	EET ADDRESS, CITY, STATE, ZIP CODE  9TH STREET NORTH  GINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	and for which the retthe amount of charginform each resider the items and service (i)(A) and (B) of this The facility must infat the time of admiss the resident's stay, facility and of chargincluding any chargincluding any charging under Medicare or Items of the facility must full legal rights which in A description of the funds, under paraginal A description of the for establishing eligithe right to request 1924(c) which dete non-exempt resour institutionalization a spouse an equitable cannot be consider toward the cost of timedical care in his down to Medicaid exposure of all pertigroups such as the agency, the State life ombudsman program advocacy network, unit; and a stateme	esident may be charged, and ges for those services; and at when changes are made to ces specified in paragraphs (5) is section.  orm each resident before, or esion, and periodically during of services available in the es for those services, es for services not covered by the facility's per diem rate.  Thish a written description of cludes:  manner of protecting personal raph (c) of this section;  requirements and procedures ibility for Medicaid, including an assessment under section rmines the extent of a couple's ces at the time of and attributes to the community e share of resources which ed available for payment the institutionalized spouse's or her process of spending	F 1	56			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245458	B. WING		08/15/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉT	
F 156	agency concerning misappropriation of facility, and non-codirectives requirem.  The facility must in name, specialty, an physician responsion.  The facility must puritten information applicants for adminformation about Medicare and Medicare	resident abuse, neglect, and f resident property in the mpliance with the advance	F 156			
	by: Based on interview facility failed to proper residents (R31, R1 and appeal rights.  Findings include: R31's electronic mR31 was admitted discharged in 4/20 occupational therator from pneumonia. R14's EMR, indicate facility in 5/2014, and 11 days of stay in the same facility facility in the same fac	NT is not met as evidenced w and document review, the vide liability notices for 2 of 4 4) reviewed for liability notices  edical record (EMR), indicated to the facility in 3/2014, and 14, and receiving physical and py services due to weakness  ted R14 was admitted to the and discharged in 5/2014, for he facility, and was receiving a hip joint replacement due to		1. Residents #31 and #14 were discharged in April and May 2014. 2. All residents could be affected by deficient practice. Residents will be evaluated during their intake screer Medicare coverage using Medicare coverage guidelines. During their st continued coverage will be reviewe input from nursing and therapy to determine ongoing coverage appropriateness. 3. As soon as a decision is made the Medicare Part A will be ending the I nurse will initiate denial letters to refor responsible party. At least 48 ho before Medicare stay ends the residence will either speak to resident for the side of the side	ning for cay d with mat MDS sident urs dent or	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION (X	X3) DATE SURVEY COMPLETED
		245458	B. WING		08/15/2014
	PROVIDER OR SUPPLIER  A HEALTH VIRGINIA	CARE CENT	9	STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 156 F 176 SS=D	and R14's Notices were requested fro 2:50 p.m. registere was not able to local Liability Notices and further stated the Light filed in the resident and signed by either representative.  On 8/14/14, at 3:00 (DON) stated she will liability notices coulfurther stated the splaced in the back DON verified the lall liability notices were A policy on Notice was requested and 483.10(n) RESIDE DRUGS IF DEEME An individual reside the interdisciplinary §483.20(d)(2)(ii), his practice is safe.  This REQUIREMED by: Based on observa	roximately 10:30 a.m. R31's of Medicare Non-Coverage m the facility. On 8/13/14, at d nurse (RN)-D stated she ate either R31's or R14's d Appeal Rights forms. RN-D iability Notices were usually s' medical records when given er the resident or the resident's op.m. the director of nursing was aware R31's and R14's ld not be located. The DON igned notices were usually of the resident's charts. The ck of evidence to indicate the e provided for R31 and R14.	F 156	face if they are the responsible party get signature after the resident states understanding of the form, or responsible parties request either the form will be mailed or it will be available for them sign at EHVCC. The denial letters wi scanned into the Matrix system under Medicare and a progress note will be written stating the letter was delivere. The Medicare policy was reviewed a revised as neccesary. All RN's were educated on Medicare coverage quidelines and Medicare coverage quidelines and Medicare coverage quidelines and discharge checklists. Audits will be done weekly to ensure denial letters are in the residents charten and the results will be reported to the quarterly QI team which will make reccomendations for ongoing monitors.	s sible to III be er ed to III
		edications for 2 of 2 residents ed to self administer		Care plans were updated.  2. All residents could be affected by deficient practice. All residents are	the

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		08/	15/2014	
NAME OF I	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIF	•		
ESSENT	IA HEALTH VIRGINI	A CARE CENT		901 9TH STREET NORTH VIRGINIA, MN 55792			
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F 176	of medications de to self administer  On 8/12/14, at 9:4 R54, licensed pra medication cup w on the overbed ta a briefly stood in t was taking his meleft the area and r R54 took the medication to the Resident Adr 2/24/14, indicated two diabetes, spir glaucoma, hyperter R54's psychosoci 5/23/14, indicated related to cognitive reminders, cues a of daily living, meaquarterly minimum was cognitively in  The Self Administration	erved during self administration espite being assessed as unsafe any medications.  40 a.m. during an interview with ectical nurse (LPN)-A placed a ith approximately five or six pills ble. LPN-the doorway and asked if R54 edications and then left. LPN-A returned at 9:48 a.m. to check if dications.  Ininistration Record dated IR54's diagnoses included type hal stenosis, esophageal reflux, ension, anxiety and pain.  al well being care plan dated IR54 had memory problems re deficits. R54 required and supervision for all activities als and daily routine. R54's m data set (MDS) indicated R54	F 1		n for competency er medications is nebulizer traton of its are reviewed following the observe that ents plan of care nedications entified on the the resident may ins. Licensed staff dent to identify the treatment or identified. The dication plicy was neccesary. Ited on dications in the per ions and/or its will be results of the will be reported to ch will make		
	impaired decision of noncompliance appropriate to SA On 8/13/14, at 1:3 R54 with his med	AM. R54 had moderately making skills and had a history with medications and was not M.  85 p.m. LPN-A stated she leaves ications, stays in the area and n" to make sure he has taken					

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 176	them.  On 8/14/14, at 9:44 verified R54 was no should wait and was R43 was not assess administer inhaled.  On 8/13/14, at 1:19 in his room, seated treatment administ p.m. LPN-B came desk, removed the the nebulizer mach. R43's Self Administ Assessment (SAM did not want to SA moderately impaire would set up and a The assessment for properly dispense.  On 8/13/14, at 1:43 R43 alone to do th R43 transferred from could be left alone set up.  On 8/13/14, at 2:00 assessment indicated alone with the neb.	4 a.m. registered nurse (RN)-A of to SAM and the nurse atch R54 take his medications. Seed to be safe to self medications.  9 p.m. R43 was observed alone in the recliner with a nebulizer fered via face mask. At 1:30 down the hall from the nurses nebulizer mask and turned off nine.  Stration of Medication  1) dated 6/25/14, indicated R43 M medications. R43 had ed cognition and the nurse administer R43's medications. Lurther indicated R43 could not	F 17	6		
	policy effective 9/2 would have a SAM	administration of Medications 4/10, indicated all residents dobservation completed upon e in condition and as deemed				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER	CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792	
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F 176 F 279	be reviewed by the determine appropria	nts who wished to SAM would interdisciplinary team (IDT) to ateness.	F 17		9/16/14
SS=E	A facility must use to develop, review a comprehensive plate.  The facility must deplan for each reside objectives and time medical, nursing, a	CARE PLANS the results of the assessment and revise the resident's			
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident'	t describe the services that are ttain or maintain the resident's physical, mental, and being as required under ervices that would otherwise 3483.25 but are not provided as exercise of rights under the right to refuse treatment.).			
	by: Based on observative review, the facility for comprehensive car (R52) for falls; for 1 for oxygen use; for reviewed for oral hy (R14) for skin conditions.	NT is not met as evidenced tion, interview, and document ailed to develop e plans for 1 of 3 residents of 1 residents (R3) reviewed 1 of 3 residents (R97) regiene; for 1 of 2 residents itions, and 1 of 5 residents lant and pain medications.		1 Comprehensive care plans for residents #52, 97,14,43 and 3 wer reviewed and revised to include falls,oxygen use, oral hygiene, skir conditions,pain and anticoagulatin medications.  2 All residents require comprehensindividualized plans of care based	n sive,

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COME	SURVEY PLETED
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	PROVIDER OR SUPPLIER	CARE CENT	9	STREET ADDRESS, CITY, STATE, ZIP CODE 101 9TH STREET NORTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 279	Findings include:  R52's admission Mindicated no falls programmed for the care Assessmindicated R52 was decreased function left hip replacement required the extensitransfers. The CAA was required with slight and frequently times and non-slip R52's care plan, dadiagnoses that inclusted extensive while walking with a the risk of falls.  R52's Fall risk assess indicated, "Resider had 1 fall in the passin place [sic] for resfalls Will continue continue current place at 12:15 p.m., verificated to falls.  R3's physician's ordiagnoses that including services and	inimum Data Set dated 6/5/14, rior to admission. The falls nent (CAA) dated 6/5/14, at risk for falls related to al mobility secondary to recent t, being non ambulatory and sive assist of two staff for a indicated a falls care plan suggested interventions of call used items within reach at all foot wear for all transfers.  Atted 6/5/14, indicated uded muscle weakness, reneralized pain. The did not falls or suggested nurses aide worksheet assistance for transfers and a walker, but did not address resement dated 8/11/14, at is at risk for falls and has at quarter. Self-locking w/c put sident safety and to prevent et to monitor for fall risk. Will	F 279	needs identified during the assess process.  3 The Care Planning Policy was reand revised as neccesary. Nursing were educated on CAA's, care plat for all triggered problems that have decided to be care planned, also a other problem that affects the resid well-being and overall cares.  4 Three residents care plans will be audited per week for two months to assure they are to assure they are comprehensive, including Coumac pain, skin condition, oxygen, risk for and oral hygiene. Staff will be reed on an ongoing basis as needed bathe results of the audits. The monit results will be reported to the quart team. The QI team will make recommendations for ongoing more	viewed staff nning been ny dnet's e o lin use, or falls ducated sed on toring erly QI	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				MPLETED	
		245458	B. WING		08	3/15/2014	
245458  B. WING  STREET ADDRESS, CITY, ST  901 9TH STREET NORTH  VIRGINIA, MN 55792  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  A. BUILDING  B. WING  901 9TH STREET NORTH  VIRGINIA, MN 55792  ID PROVIDER'S PL  PREFIX (EACH CORRECTION OF CORPECTION OF CORRECTION OF CORPECTION OF CORPE							
PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 279	fatigue. The orders liters per minute du evening.  R3's admission MD utilized O2 prior to R3's care plan, datuse of 02, how much by what route.  R3 was asleep in bowith nasal canulla frank on the wheel of tank was pointing to need for refill. The system was not in considered for refill.	included oxygen (O2) at 2.0 uring the night, day and OS, dated 6/9/14, indicated R3 admission and in the facility.  ed 6/19/14, did not address the ch 02 was to be delivered, or ed on 8/14/14, at 7:00 a.m. for O2 connected to a portable chair. The gauge on the O2 the red area indicating the wall mounted O2 delivery use.  14/14, at 8:40 a.m., the wall and should be utilized for R3 stated care plan should O2 for R3.  To no 8/12/14, at 1:40 p.m. with hite and pink colored debris of lower teeth. On 8/14/14, at 13 lying in bed and mouth was are was a thick coating on the tween lips.  ated 7/16/14, indicated R97 or impairment and required the of one staff for personal ity, transfers, locomotion,	F 2	79			

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 _		08	/15/2014
	PROVIDER OR SUPPLIER	CARE CENT		STREET ADDRESS, CITY, STATE, ZIP COI 901 9TH STREET NORTH VIRGINIA, MN 55792		
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F 279		age 10 on 8/14/14, at 9:57 a.m. were not addressed in R97's	F 27	79		
	top of the right han stated she was pro R14's admission M moderate cognitive assistance of one s	IDS dated 6/14/14, indicated e deficit and required extensive staff for personal hygiene, bed locomotion in the wheelchair,				
	the potential for ble R14's medical con- RN-B, interviewed stated that when re the care plan shou monitoring.	ted 6/20/14, did not address reding or bruising related to dition or medication.  on 8/13/14, at 1:25 p.m., residents were prone to bruising lid address the problem and reto provide policy and planning.				
	Coumadin [an anti- use of a narcotic a medications. R43's signed Phys included Coumadir	d not address the use of coagulant medication] and the nd non-narcotic pain ician's Orders dated 6/19/14, a (anticoagulant) 2 mg oral uesday, Thursday, and				

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR  (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AR DEFICIENCY)	HOULD E	BE	(X5) COMPLETION DATE
F 279	and Friday; and Tylhours as needed. I dated 8/2/14, direct 5.0/325 mg 1 tab or needed].  R43's quarterly MD R43's diagnoses in pulmonary disease hypertension. The was cognitively inta scheduled pain med R43's Care Plan (un Treatment Administ 7/15/14, to 8/14/14, Coumadin, Tylenol During the survey w 8/14/14, R43 was owith no evidence of Coumadin; and R43 On 8/13/14, at 1:20 had changed over the record system earlicate plan entries to monitoring were mit of Coumadin should monitoring of adverthe medication. RN care plan lacked a approaches for R43 non-pharmacologic On 8/14/14, at 3:00 (DON) stated signif	oral on Monday, Wednesday, enol 325 mg oral every 4 R43's Physician's Orders ed R43 to receive Norco ral every 6 hours prn [as all every 6 hours prn	F 2	79			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792		
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F 280 SS=D	records.  A Care Plan policy resident's plan of care electronic system a such as clinical issues 483.20(d)(3), 483.1 PARTICIPATE PLATE PLATE The resident has the incompetent or other incapacitated under participate in plannic changes in care and A comprehensive as interdisciplinary tear physician, a register for the resident, and disciplines as deter and, to the extent put the resident, the resident in the resi	residents' electronic medical revised 12/3/13, indicated a are would be initiated in the nd would address care areas us and treatments.  0(k)(2) RIGHT TO NNING CARE-REVISE CP e right, unless adjudged erwise found to be the laws of the State, to ng care and treatment or	F 28			9/16/14
	This REQUIREMENT by: Based on observative review, the facility for a care plans for 1 of 3	NT is not met as evidenced cion, interview, and document ailed to develop temporary 3 residents (R142) for d for 1 of 1 residents (R144)		Resident #142's care plan was to address pressure ulcers. Resident #144's careplan was revised to addisolation precautions.	ent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245458	B. WING		08/1	5/2014
	PROVIDER OR SUPPLIER	CARE CENT	g	STREET ADDRESS, CITY, STATE, ZIP CODE 001 9TH STREET NORTH /IRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 280	address R142's pres R142's admission M dated 8/12/14, indic a pressure ulcer on indicated R142 had impairment, require bed mobility and tra be at risk for the de The MDS further in with with 1 unstage suspected deep tist described the press cm in length by 9.9 tissue present in th indicated R142's ul pressure reducing on nutrition or hydratio skin problems, pres application of nonse R142's Physician C directed to change hip every 12 to 24 h saturation level.  On 8/14/14, at 2:15 stated confirmed R problem statement, related to R142's care the pressure ulcer of	lan was not developed to essure ulcer care.  Minimum Data Set (MDS) cated diagnoses that included hip. The MDS further I moderate cognitive ed extensive assistance with ansfers, and was assessed to evelopment of pressure ulcers. dicated R142 was admitted able pressure ulcer with sue injury. The MDS sure ulcer as measuring 6.5 cm in width, with eschar e wound bed. The MDS also cer treatments included a device for the chair and bed, in interventions to manage ssure ulcer care, and the	F 280	2. All residents could be affected by deficient practice. All residents will temporary plans of care completed 24 hours of admission.  3. The temporary care plan form wo put into all admission packets. The admitting nurse will complete the temporary care plan. The temporary plan will be updated and revised puthe comprehensive care plan is completed. The Care Planning Poloreviewed and revised as appropriated. The Nursing Manager will review newly admitted residents to ensure temporary care plan is in place. A minimum of three audits will be doweekly to ensure compliance. Stare-educated on an ongoing basis aneeded based on the results of the The monitoring results will be reported the quarterly QI team. The QI team make recommendations for the onmonitoring.	have I within ill be ry care rountil icy was te. v all that a ne ff will be as a audits. rted to n will	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG			E SURVEY PLETED
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F 280	(DON) stated a term developed within the admission to the far pressure ulcer care. A temporary care piplace to address Reprecautions.  R144's Resident Admidicated R144's dia [Methicillin-resistant infection and toe center of the content of the infection.  R144's admission of R144's Care Plan of the indicate contact infection.  On 8/14/14, at 2:15 care plan lacked dia infection.  On 8/14/14, at 3:00 care plan should infection.  On 8/14/14, at 3:00 care plan information staff.  On 8/15/14, at approximate staff.  On 8/15/14, at approximate staff.  The facility's Care Figure 1.	p.m. the director of nursing porary care plan needs to be efirst 24 hours upon cility and should include.  Ian was not developed and in 144's contact isolation  Imission Record (undated) agnoses included MRSA to Staphylococcus Aureus] Illulitis/abscess.  IDS dated 8/8/14, indicated ally intact and had an infection dressings to the feet.  Iated 8/4/14, to 8/14/14, did precautions for MRSA  p.m. RN-C confirmed the rections for R144's MRSA  p.m. the DON confirmed the clude information and direction dressings to the contact precautions, and the on should be communicated to coximately 3:00 p.m. copies of temporary care plans were	F 2	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION (X:	(X3) DATE SURVEY COMPLETED	
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F 280 F 309 SS=D	admitted residents	olace within 24 hours for newly . CARE/SERVICES FOR	F 280		9/16/14
	provide the necess or maintain the hig mental, and psycho	t receive and the facility must eary care and services to attain hest practicable physical, osocial well-being, in e comprehensive assessment			
	by: Based on observative review, the use of appropriately for or observed for the use were not coordinate reviewed for hospide.  R3's physician ordediagnoses that includes shortness of breath fatigue. The orders minute, every shift, R3 was observed on her bed with a national control of the oxygen tank was noted, "Refill." R3 and The wall mounted of the oxygen tank was noted, "Refill." R3 and The wall mounted of the oxygen tank was noted.	NT is not met as evidenced tion, interview and document oxygen (O2) was not provided ne of three residents (R3) se of O2; and hospice services ed for 1 of 1 residents (R42) ce.  ers dated 6/20/14, indicated uded congestive heart failure, n, pleural effusion, malaise and included O2 at 2.0 liters per nights, days and evenings.  on 8/14/14, at 7:00 a.m. asleep asal cannula for O2 connected ne wheel chair. The gauge on as pointing in the red area and appeared in no acute distress. O2 delivery system was not in no humidifying "bubbler"		1 Resident #3 is deceased. Resident #42's hospice services were discontin and her care plan was reviewed and revised.  2 All residents using oxygen or Hospic services have the potential to be effect by the deficient practice.  3 Policies and procedures for oxygen have been reviewed and revised. The eMar will now have a task scheduled monitor oxygen tanks. A meeting was with Hospice Services to plan better communication between our facilities. Hospice policy was reviewed. Nursing staff were educated on the oxygen an Hospice policies and where to find information regarding hospice resider 4 Three audits will be done weekly for months to ensure on-going compliance with oxygen use and tank replaceme Staff will be re-educated on an ongoin basis as needed based on the audit	tued  ce ctedd  use to held  The d  ds. two ce nt.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245458	B. WING			08/	15/2014
	PROVIDER OR SUPPLIER			901 97	T ADDRESS, CITY, STATE, ZIP CODE TH STREET NORTH INIA, MN 55792	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	feeling well and will Licensed practical room, and when as she did not know v LPN-C went to ob connected R3 to the When the portable the wheel chair, the when removed from pressure.  The admission minimidicated R3 utilizes the facility.  Nursing assistant (8/14/14, at 8:37 a.motified when a resempty.  Registered nurse (wall unit was availa automatically be used to be considered	_	F3	re: re; tea	sults. The monitoring results will ported to the quarterly QI team. am will make recommendations agoing monitoring.	The QI	

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			08/	15/2014
	PROVIDER OR SUPPLIER	CARE CENT		901	REET ADDRESS, CITY, STATE, ZIP CODE  9TH STREET NORTH RGINIA, MN 55792		
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F 309	disorganized thinking bowel and bladder, all activities of daily further indicated R4 scheduled or as ne had no non-verbal inhospice care.  R42's care plan data services for end of hemorrhage; comfoirreversible and corrand family. The goad have good quality of approaches include needed and/or requineeded and/or requineeded, anticipate patient and family.  R42's Hospice Tear and printed 8/8/14, hospice provider visting for 3 months with 3 management.  * SN [Skilled Nursi for 3 months with 3 management.  * MSS [Medical Sosupportive care.  * SCC [Spiritual Cafor spiritual care.  * BC [Bereavement support  * AID [Hospice Aid weeks and 3 prn visting schedules and spiritual care.	and was totally dependent in and was totally dependent in alliving (ADL's). The MDS 42 was not receiving eded [prn] pain medications, and was on a feed 5/22/14, indicated hospice life care related to subdural out measurers as condition was an affort was requested by patient all was to be pain free and a fife. R42's care plan and provide pain medication as a fested, rest periods as a fested, nutrition and liquids for turn and reposition every 2 tual care as requested and/or grief and provide support to	F 3	609			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NG		(X3) DATE SURVEY COMPLETED		
		245458	B. WING		0	8/15/2014
	PROVIDER OR SUPPLIER	CARE CENT		STREET ADDRESS, CITY, STATE, Z 901 9TH STREET NORTH VIRGINIA, MN 55792		9,10,2011
(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 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 309	were observed to be nurse manager's of facility. The Contact received no Hospica 1 Hospice Aid visit 8/11/14. No Volume the Contact forms of Home Health Aide 7/16/14, 7/25/14, at the facility upon received forms indicated R4 visit on those dates activity provided.  During the survey v8/14/14, R42 was of in the room and in the room a	ty Contact forms (undated) e located on a clip board in the fice on the third floor of the et forms indicated R42 had e Aid visits in June, 2014, and on 7/28/14, 8/5/14, and heter visits were indicated on rom 5/23/14, to 8/14/14.  Care Plan Tasks dated and 7/28/14, were provided by fuest of the Hospice. The 2 had received a Hospice Aid and but did not indicate the  week of 8/11/14, through beserved on multiple occasions the dining room of the facility.  p.m. licensed practical nurse pice does not come to the very often. LPN-D further t know if/when Hospice staff et was provided for R42  p.m. nursing assistant (NA)-A aware of any hospice aide en provided for R42. NA-A ought R42 was no longer on  coximately 2:30 p.m. registered d Hospice coordination of care et facility. RN-A further stated hursing home staff should be en hospice is in the building. 42 did not have a specific	F 3	09		

PRINTED: 09/28/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245458	B. WING			08/	15/2014
	PROVIDER OR SUPPLIER	CARE CENT		STREET ADDRESS, CITY, STATE, 901 9TH STREET NORTH VIRGINIA, MN 55792	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 329 SS=E	On 8/14/14, at 3:00 (DON) stated the conservices could be but the nursing home is of hospice services care was provided.  An updated policy from the LTC [long term of facilities was provided communication she patient closet. The hospice staff were the sheet when visits with indicated hospice the for each visit would facility at least one 483.25(I) DRUG REUNNECESSARY DEACH TEACH TEA	p.m. the director of nursing pordination of care for Hospice etter. The DON further stated taff should be aware what kind were scheduled and what or Hospice process guidelines care] and AL [assisted living] led and indicated a Hospice set was to be kept in the policy further indicated to write on the communication ere made. The policy also seam member's progress notes be faxed or delivered to the time per week.  EGIMEN IS FREE FROM RUGS  g regimen must be free from an An unnecessary drug is any excessive dose (including or for excessive duration; or ionitoring; or without adequate se; or in the presence of inces which indicate the dose or discontinued; or any	F3				9/16/14

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION  NG		E SURVEY MPLETED
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ESSENT	IA HEALTH VIRGINIA	CARE CENT		901 9TH STREET NORTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 329	drugs receive grade behavioral interven	ge 20 ts who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these	F 3	29		
	by: Based on observar review, the facility f monitoring of psych anticoagulant medi parameters for use medications for 4 o R43) reviewed for u  Findings include:  R73's Physician's 0 8/13/14, included T milligrams (mg) as generalized pain ar hours as needed, b use., and Seroque  R73's Resident Adr dated 12/30/11, ind dementia with beha state, anxiety, muse Minimum Data Set indicated R73 had s  R73's care plan did			1 #73's order for Tylenol and now include paramet care plan was updated to effect monitoring and effect monitoring and effect seroquel.  Resident #106's care plan include side effect monitoring effectiveness and potentic effects related to use of Stativan.  Resident # 54's care plan include Ativan, Celexa and monitoring for side effects effects.  Resident #43's physicial were reviewed to ensure all orders. Tylenol and Not include parameters for us was updated to include the Coumadin, Tylenol and peffectiveness and side effectiveness and side eff	ters for use. Her o include side ectiveness of an was updated to oring and al adverse. Seroquel and an was updated to ad Insulin use and and adverse orders and eMarthey are included roo orders now se. His care plan he use of ain medications, fect monitoring. medications have mpacted by a area. In collaberation g Unit Clerks to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED			
		245458	B. WING _		08/	15/2014
	PROVIDER OR SUPPLIER	CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 329	verified the lack of and that monitoring effectiveness of Set the care plan.  R106's Physician's 8/7/14, included Set and Ativan 0.5 mg needed for anxiety. Record dated 6/17 included a hip fract with depression an R106's care plan d for effectiveness are related to use of Set On 8/14/14, at 1:33 plan should address R54 R54's Physicia 7/10/14, included A morning and 1 mg anxiety. Celexa (armg by mouth once units subcutaneous Admission Record diagnoses included anxiety.  R106's care plan latinsulin use, monito effects.  On 8/14/14, at 1:46	7 p.m. registered nurse (RN)-A parameters for use of Tylenol g for side effects and croquel should be included on Order Report signed on croquel 12.5 mg by mouth daily by mouth every four hours as The Resident Admission (14, indicated diagnoses that cure, malaise/fatigue, dementiad anxiety.	F 32	for medications which require parameters. Nursing stass will replans, observations and progress ensure psychoactive medications addressed. Medication monitoring was reviewed and revised as new Nursing staff were educated on medication administration and mapolicies.  4 Three eMars and care plans waudited each week to ensure constaff will be re-educated on an obasis as needed based on the rethe audits. The monitoring result reported to the quarterly Qlteam team will make recommendation ongoing monitoring.	s notes to s are g policy cessary. onitoring ill be mpliance. ngoing sults of s will be The QI	

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245458	B. WING _		08	/15/2014	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 329	included Coumadir daily on Sunday, To Saturday, and 4 mg and Friday; and Tyl hours as needed. dated 8/2/14, direct 5.0/325 mg 1 tab oneeded].  R43's quarterly MD R43's diagnoses in pulmonary disease hypertension. The was cognitively intascheduled pain me R43's Care Plan (uTreatment Adminis 7/15/14, to 8/14/14 Coumadin, Tylenol During the survey w8/14/14, R43 was owith no evidence of Coumadin; and R4  On 8/13/14, at 1:20 had changed over record system earlicare plan entries to monitoring were miof Coumadin shoul monitoring of adverthe medication. Ricare plan lacked a	cian's Orders dated 6/19/14, a (anticoagulant) 2 mg oral uesday, Thursday, and g oral on Monday, Wednesday, enol 325 mg oral every 4 R43's Physician's Orders and every 6 hours prn [as a see of	F 32	9			

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 329 F 334 SS=D	(DON) stated signiful monitoring should be on the ETAR in the records.  A Care Plan policy resident's plan of celectronic system as such as clinical issess. 483.25(n) INFLUEN IMMUNIZATIONS  The facility must dethat ensure that (i) Before offering the each resident, or the representative receivements and potential immunization; (ii) Each resident is immunization Octon annually, unless the contraindicated or immunized during the contraindicated or immunized during the contraindicated or immunization; and (iv) The resident's indocumentation that following:  (A) That the resider representative was	p.m. the director of nursing ficant medications side effect be care planned and included residents' electronic medical revised 12/3/13, indicated a fare would be initiated in the find would address care areas fues and treatments.  NZA AND PNEUMOCOCCAL evelop policies and procedures the influenza immunization, for resident's legal elives education regarding the final side effects of the coffered an influenza to the immunization is medically the resident has already been	F 3		DEFICIENCY)		9/16/14
	immunization; and (B) That the resid	ent either received the ation or did not receive the					

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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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE	(X5) COMPLETION DATE	
F 334	influenza immunizacontraindications of that ensure that (i) Before offering to immunization, each legal representative the benefits and poimmunization; (ii) Each resident is immunization; (iii) Each resident is immunization, unle medically contraind already been immunization; and (ivi) The resident or representative has immunization; and (iv) The resident's documentation that following:  (A) That the resid representative was the benefits and popneumococcal immunication or (v) As an alternative and practitioner reconstruction or the pneumococcal immunication, unle immunization, unle	ation due to medical or refusal.  evelop policies and procedures the pneumococcal or resident, or the resident's ereceives education regarding otential side effects of the soffered a pneumococcal est the immunization is dicated or the resident has unized; the resident's legal the opportunity to refuse the indicated, at a minimum, the ent or resident's legal sprovided education regarding otential side effects of munization; and ent either received the nunization or did not receive immunization due to medical refusal.  The pased on an assessment commendation, a second nunization may be given after 5 first pneumococcal ss medically contraindicated or resident's legal representative	F 334				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER	CARE CENT		90	TREET ADDRESS, CITY, STATE, ZIP CODE 01 9TH STREET NORTH IRGINIA, MN 55792		
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F 334	by: Based on interview facility failed to ensity failed to ensity failed to ensity facility failed to ensity for pneumonia) was residents (R77) revenue Findings included: The annual Minimu 7/17/14, indicated Finder for MDS cognitively intact, with clearly, understand care. The face sheet upout had diagnoses included had diagnoses included in the moglobin/iron), continuous for the face sheet upout had diagnoses included in the moglobin/iron), continuous for the face sheet upout had diagnoses included in the face sheet upout had diagnoses included in the moglobin/iron), continuous for the face sheet upout had diagnoses included in the face sheet upout had diagnoses included in the moglobin/iron), continuous face sheet upout had diagnoses included in the face sheet upout had diagnoses included in the moglobin/iron), continuous face sheet upout had diagnoses included in the face sheet upout had diagnoses incl	NT is not met as evidenced and document review, the ure a pneumococcal vaccine is administered to 1 of 5 iewed for vaccines.  Im Data Set (MDS) dated R77 had not received a cine because it was not also indicated R77 was as able to communicate others, and did not reject ated on 7/2/14, indicated R77 uding anemia (low hronic pain, esophageal reflux inhinitis due to pollen, and hypertension (high blood onsent and release form 19/15/11, indicated R77 was tion on risks and benefits of a cine and consented to e vaccine.	F3	34	1 Resident #77 was interviewed ar asked if she wanted a pneumocock vaccination. Vaccinationwas given wishes. Tuberculosis baseline sym screenings were completed for res #8,77,102,97 and 43.  2 All residents have the potential to impacted by a deficient practice in area.  3 Influenza and Pneumococcal vaccination policy was reviewed. A nursing staff were re-educated on policy.  4 Three chart audits will be comple each week to ensure ongoing complete monitoring results will be reported the quarterly QI team. The QI team make recommendations for ongoin monitoring.	per her ptoms idents be this little ted pliance. rted to will	

	OF DEFICIENCIES OF CORRECTION	· · ·			(X3) DATE SURVEY COMPLETED	
		245458	B. WING		08/	15/2014
	PROVIDER OR SUPPLIER	CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 334	R77 had received a ICC verified R77 had pneumococcal vacco	pneumococcal vaccine. The d not received a	F 3	34		
F 356 SS=C	483.30(e) POSTED INFORMATION		F 3	56		9/16/14
	a daily basis: o Facility name. o The current date. o The total number by the following catualicensed nursing resident care per shallow a Registered nu - Licensed pract	rses. tical nurses or licensed as defined under State law).				
	specified above on of each shift. Data o Clear and readab	ace readily accessible to				
	make nurse staffing	oon oral or written request, data available to the public not to exceed the community				
	staffing data for a m	aintain the posted daily nurse ninimum of 18 months, or as w, whichever is greater.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COMP		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 356	Continued From pa	nge 27	F 356				
	by: Based on observareview, the facility for census number alloworked for both lice the daily nurse staff potential to affect a in the facility, as we visitors who may har information.  Findings include:  During the initial tool 1:45 p.m. the facility observed to be located on the wall near the fourth floor resident Nursing Staffing Di Resident Care form posting and the four observed to docume total of 82, 50 residents on the forwas further observed worked for the RN's (licensed practical assistants - register on 8/13/14, at 2:10 (DON) stated the rewas 79 plus one rehospitalization for a confirmed she had the survey entrance.	tion, interview, and document ailed to post the correct facility on with the actual hours ensed and unlicensed staff on fing posting. This had the ll of the 80 residents residing all as family members, and any ave chosen to view the ll of the facility on 8/12/14, at y's nurse staff posting was ated tacked to a bulletin board a centrance to both the third and at areas. The Report of rectly Responsible for a from both the third floor with Floor posting was entent the resident census as a lents on the third floor and 32 with floor. The Report form ed to contain no actual hours is (registered nurses), LPN's nurses), or NAR's (nursing red).  In p.m. the director of nursing esident census on 8/11/14, sident on a bed hold for a total of 80 total. The DON said the resident census on ed date of 8/12/14, was 80. The the staffing coordinator		1 The Posted Nurse Staffing infor form has byeen revised to include hours worked for licensed and unlistaff.  2 All residents, family and visitors be affected by the deficient practic 3 A policy for Nurse Staffinf Postin been created. The night staff will of the daily posting form using the cethe facility at midnight. The form wupdated as necesasary by the staff coordinator or supervisor based or staffing changes during the day. All were educated on the new policy aupdated poasting form.  4 Audits will be completed three times to check the accuracy of the posting form. Staff will be re-educaneeded based on the results of the The monitoring results will be reported the quarterly QI team who will make recommendations for ongoing compliance.	actual censed could e. g has omplete nsus of ill be fing n staff and mes per daily ted as e sudits. rrted tot		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3  A. BUILDING		` '	X3) DATE SURVEY COMPLETED	
		245458	B. WING _		08/	15/2014	
	PROVIDER OR SUPPLIER	CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 356	and the night shift is putting the posting designated on both the facility. The DC aware the actual ho and unlicensed state DON further stated actual hours worke time.	e staff posting for the next day is responsible for actually information on the walls the third and fourth floors of DN also stated she was not ours worked of the licensed if needed to be posted. The the facility used to post the d, along with total hours at one	F 38	56			
	stated the resident have been 81. The had the one bed ho hospital that mornir had been admitted been discharged. n residents on a bed facility census. The	roximately 10:30 a.m. the DON census on 8/12/14, should a DON further stated the facility old as a resident went to the ng., and another two residents during the day and one had ot 82. The DON confirmed hold should be included in a DON reported the facility did in the nurse staffing posting.					
F 431 SS=D	(SC)-F stated she worked by licensed to be included on the SC-F further stated to be included on the been included for q 483.60(b), (d), (e) E		F 4:	31		9/16/14	
	a licensed pharmac of records of receip controlled drugs in accurate reconciliar	nploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	FIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	CARE CENT		STREET ADDRESS, CITY, STAT 901 9TH STREET NORTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 431	reconciled.  Drugs and biologic labeled in accordar professional principappropriate access instructions, and thapplicable.  In accordance with facility must store a locked compartme controls, and permanently affixe controlled drugs list Comprehensive Drugs Control Act of 1976 abuse, except whe package drug districts.	maintained and periodically  als used in the facility must be nee with currently accepted bles, and include the sory and cautionary ne expiration date when  State and Federal laws, the all drugs and biologicals in nts under proper temperature it only authorized personnel to nee keys.  Tovide separately locked, nd compartments for storage of ted in Schedule II of the rug Abuse Prevention and stand other drugs subject to on the facility uses single unit ibution systems in which the minimal and a missing dose can	F4	31		
	by: Based on observareview, the facility were labeled corre observed during multiple Findings include: R24 was observed	NT is not met as evidenced tion, interview and document failed to ensure medications ctly for 1 of 7 residents (R24) edication administration.  during medication medication t 9:00 a.m. Licensed practical		1 The medication lat labeled for resident # 2 All residents could deficient practice. 3 The medication Adi was reviewed and reviewed and reviewed and reviewed and reviewed pharmacy staff were the process for lanursing staff were ed	24's insulin. be affected by the ministration policy vised as necessary. vere consulted on abel changes. All	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		E SURVEY IPLETED
		245458	B. WING _		08/	15/2014
	PROVIDER OR SUPPLIER	CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 431	Novolog insulin to F was noted to direct (sq) three times a condition Administration Recodirected Novolog in 25 u sq once in the EMAR directed the be given twice a day call the pharmacy to the label on the insum no other way to independ to the directed to the label on the insum of the label on the label	observed to administer R24. The Novolog insulin label 30 units (u) subcutaneous day. The electronic Medication ord (EMAR) dated 7/29/14, isulin 30 u sq twice a day and evening. LPN-A verified the 30 u of Novolog insulin was to be a comparable to the 10 to have the pharmacy change ulin. The LPN stated there was icate when an order was the pharmacy to change the	F 43	Medication Administration Policy. 4 monitoring will be done by com three audits weekly to check for a of labels, medications and physic orders. Nursing staff will be reeas needed based on the results of audits. The internal eMar process also reviewed relating to orders state pharmacy. The monitoring rebe reported to the QI team who werecommendations for ongoing compliance.	pleting accuracy sian ducated of the s was sent to sults will	
F 441 SS=E	the Novolog insulin Novolog insulin 30 Novolog insulin 30 insulin 25 u with the On 8/14/14, at 9:49 stated the pharmacy through the facility's pharmacy usually with medication. 483.65 INFECTION SPREAD, LINENS  The facility must es Infection Control Prisafe, sanitary and control to help prevent the of disease and infection Control Control (a) Infection Control Cont	a.m. registered nurse (RN)-A cy would get the order change is computer system. The would send up a new label for in CONTROL, PREVENT stablish and maintain an rogram designed to provide a comfortable environment and development and transmission ction.	F 44	11		9/16/14

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING							
		245458	B. WING _		08/	/15/2014	
	PROVIDER OR SUPPLIER	CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792	iver responsible for ssing changes was per infection control changing gloves and ween changes of comprehensive care		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 441	in the facility; (2) Decides what p should be applied t (3) Maintains a recactions related to in (b) Preventing Spre (1) When the Infect determines that a reverse the spread isolate the resident (2) The facility must communicable disefrom direct contact direct contact will tr (3) The facility must hands after each dhand washing is incorressional practic (c) Linens Personnel must ha	rocedures, such as isolation, o an individual resident; and ord of incidents and corrective infections.  ead of Infection tion Control Program esident needs isolation to of infection, the facility must interpretate the prohibit employees with a ease or infected skin lesions with residents or their food, if transmit the disease. It require staff to wash their irect resident contact for which dicated by accepted	F 44	11			
	by: Based on observa review, the facility f standards during d residents (R142, R during blood glucos of 1 residents (R14 glucose monitoring for 1 of 1 residents	NT is not met as evidenced tion, interview, and document railed to follow infection control ressing changes for 2 of 2 144) observed for wound care; se monitoring procedures for 1 observed during blood; and during provision of care (R144) with isolation dition, influenza immunization		1 The direst caregiver responsive resident #142's dressing change re-educated on proper infection techniue related to changing gloves.  Resident 3 144's comprehensive planwas updated to include coisolation precautions.	ges was n control loves and ges of ve care		

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 _		08/	15/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792			
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F 441	(R97, R102, R43, were reviewed.  Findings include:  R142's pressure a procedure was not infection control so the second of the s	t provided for 5 of 5 residents R8, R77) whose immunizations alcer dressing change of completed using appropriate	F 4	Resident #147's nurses were re on proper procedure for glucom checks. Residents # 97.102,43,77 and a recieve influenza education new when influenza vaccines are givenessed forms will be scanned residents medical records.  2 All residents have the potentic effected by a break in infection practices and lack of influenza 3 The infection Control Policy of handwashing and glove use was reviewed. The Policy for Blood monitoring was reviewed. The Isolation Presuations was reviewed staff were educated on handwas isolation precautions and blood monitoring policies.  4 Observational monitoring will completed to ensure ongoing cwith infection control technique minimum of four observational be completed weekly at varius ensure ongoing compliance. Stre-educated as needed based or results of the audits. The monit results will be reported tot he que team. The QI team will make recommendations for ongoing compliance.	eter  B will t month ren. into all al to be control education. or s Glucose Policy for wed. All shing, glucose be compliance s. A audits will imes to aff will be on the oring		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	contain a moderat drainage. LPN-C of disposable glov her hands, and dis gloves in a nearby new gloves to her measure the press completion of the observed to remove gloves. LPN-C the spray of clear solubed with a clean gives. LPN-C oppackages and appand taped the dres removed the glove change supplies. finished putting awand supplies, gath then removed the to wash her hands 10:41 a.m.  On 8/14/14, at appstated she washed her hands dressing and with she should not have should have raised.  On 8/14/14, at 2:14.	ne soiled dressing noted to e amount of yellow-tan colored wrapped soiled dressing inside es as she removed them from sposed of soiled dressing and garbage can. LPN-C applied hands and proceeded to sure ulcer wound bed. Upon ulcer measuring, LPN-C was we the gloves, and apply new en cleansed the ulcer with a tion and wiped the ulcer wound auze sponge. LPN-C removed and immediately applied new ened the new dressing blied the dressings to the ulcer as and stored the dressing LPN-C applied new gloves, way the rest of the dressings ered up the garbage bag, and gloves. LPN-C was observed as in R142's bathroom sink at a proximately 2:00 p.m. LPN-C her hands before beginning ge procedure and then again are was complete. LPN-C was not aware she should have after removing the soiled and glove changes. LPN-C stated we knelt on the floor and instead at the bed to a working height.	F	141			
	changed as well a	Ild be washed when gloves are s between soiled and clean				ļ	

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		08	/15/2014	
	PROVIDER OR SUPPLIER	CARE CENT		STREET ADDRESS, CITY, STATE, ZIP C 901 9TH STREET NORTH VIRGINIA, MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 441	wound/ulcer care to On 8/14/14, at 3:00 (DON) stated hand when old dressings gloves are applied. bed should be raise kneeling on floor average at the bedside. The facility's Safety and Procedure revidirected routine hartimes before and after glove use dated 7/2010, directed routine hartimes before and after glove used dressing and to warchanges.  R144's contact isolofollowed during the R144's Resident Addindicated R144's di [Methicillin-resistant infection and toe certain the R144's admission of R144's Care Planton R144'	g height when performing a resident at the bedside.  I. p.m. the director of nursing s should be washed/sanitized are removed, before new The DON further stated the ed to a working height and voided when performing ulcer  I. Infection Prevention Policy ewed and revised 12/2012, and hygiene was indicated at feer touching a patient, before aseptic technique, and before  I. A Dressing Technique policy sted contaminated gloves after removing an old sh hands between glove  attion precautions were not provision of cares.  Idmission Record (undated) agnoses included MRSA t Staphylococcus Aureus]	F 4	41			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG	` '	TE SURVEY MPLETED
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F 441	R144's temporary was not provided.  On 8/11/14, at 1:45 the facility, a large, dresser containing observed to be locally as a large of the facility of the fac	roximately 3:00 p.m. copies of care plan were requested, but 5 p.m. during the initial tour of light yellow colored metal gloves on the top was ated in the hall way outside of re was no sign on the door to so or that visitors should see re entering the room.  roximately 9:00 a.m. registered d R144 was on contact IRSA infection, meaning to be worn in R144 when re. RN-F further stated there on the door for visitors to se before entering R144's observed to pull a sign out of the yellow cart outside of place the sign on R144's room	F 44	11		
	was observed to re NA-G did not apply entrance to R144's was observed to be already inside R14 oral cares at the bewere observed to be or gowns while ass 9:55 a.m. NA-H was room without wash On 8/14/14, at 2:00 and stated that NA	is a.m. nursing assistant (NA)-G espond to R144's call light. If gloves or a gown upon a room. In R144's room, NA-G e making the bed. NA-H was 4's room, assisting R144 to do edside. Neither NA-G or NA-H we wearing disposable gloves sisting R144. At approximately as observed to leave R144's ing or sanitizing her hands.  In p.m. NA-H was interviewed 's were instructed to use ns that meant washing hands				

-	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245458	B. WING			08/	15/2014
	PROVIDER OR SUPPLIER			901 97	T ADDRESS, CITY, STATE, ZIP CODE TH STREET NORTH INIA, MN 55792		
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F 441	direct contact with the use of standar contact precaution wear a gown for all contact precaution sanitized her hand and stated she bel acceptable. NA-G why R144 was on further stated she contact precaution to R144's room do R144's door.  On 8/14/14, at 2:15 be wearing gloves cares for R144. R be washing their hroom. RN-C confi directions for R144. On 8/14/14, at 3:05 precautions for Mf disposable gloves with cares, and waroom. The DON for resident on contact sign posted for visits isolation supplies of the DON confirment information and discontact precautions information should. The Facility's Isola Precautions) policy indicated an isolation supplied.	ares and to use gloves for the resident. NA-G confirmed d precautions for a resident on s, but was not instructed to by cares with a resident on s. NA-H stated she had s after leaving R144's room ieved the practice was stated she was not aware of precautions/isolation. NA-H thought R144 was done with s/isolation as cart was not next or and there was no sign on 5 p.m. RN-C stated staff should and gowns when providing N-C further stated staff should ands before leaving R144's rmed the care plan lacked the care plan lacked the care plan lacked the care plan lacked the door of a stated the door of a the care plan should have a store and a cart with the needed should be outside of the room. The care plan should include the care plan should be outside of the room. The care plan should be communicated to staff.	F 4	41			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245458	B. WING			08/	15/2014
	PROVIDER OR SUPPLIER	CARE CENT		901 9TH	ADDRESS, CITY, STATE, ZIP CODE STREET NORTH IIA, MN 55792	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 441	infection would requinclude hand hygier the resident's room fluids or resident er to entering resident and sanitizing hand contaminated items gloves and sanitizin resident room; and entering a resident  On 8/14/14, 11:16 a preparing for a dresulcer. R144's foot wook. At 11:31 a.m. bathroom and donn the ulcer with alcohwithout hand sanitization, applied paper tape. LPN-C hand sanitization, applied paper tape. LPN-C hand sanitization, kR144 with socks an gloves, washed ha gathered the trash and the sanitization on 8/14/14, at 11:4 was on contact preducer. LPN-C stated dressing changes of stated she does no between glove chart.	curther indicated a MRSA cuire contact precautions to the upon entering and exiting and after contact with body environment; exam gloves prior room with changing of gloves after contact with sor surfaces and removal of the gloves grown worn prior to room.  a.mC was observed saing change to R144's toe was air drying following a foot LPN-C washed hands in the field gloves before cleansing oil. LPN-C changed gloves exation, applied an ointment to coved finger of the right hand. In gloves again without hand a Band-Aid followed by again changed gloves without nelt on the floor and assisted and shoes. LPN-C removed ands in R144's bathroom, and exited the room.  1 a.m. LPN-C stated R144 cautions for MRSA in the toe of she wore gloves during or bedding changes. LPN-C the wash or sanitize her hands	F 4	41			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED			
		245458	B. WING _		08	/15/2014		
	PROVIDER OR SUPPLIER	CARE CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 441	during a glucometer sanitized hands and blood sugar check, germicidal wipe, with germicidal wipe, rethe computer, and LPN-A verified she hands after removitied the computer or other computer o	d on 8/14/14, at 11:33 a.m. er (blood sugar) check. LPN-A d put on gloves, performed the wiped the glucometer with a rapped the glucometer with a moved gloves, documented on then sanitized her hands. should have cleaned her ng gloves and before touching her things.  face sheet dated 8/1/14, is of diabetes. The Medication ord for 8/14, indicated blood done three times daily.  D.p.m. the infection control stated hands should be washed emoving gloves. The ICC yearly online-training that control, including hand hygiene. and procedure for standard ersonal protective equipment ated hand hygiene is to be ately after removing gloves.		.1				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245458	B. WING		08/	15/2014	
	PROVIDER OR SUPPLIER	CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 441		d evidence that annual	F 4	41			
	R43's chart lacked	evidence that annual nza education was provided.					
		evidence that annual nza education was provided.					
	R8's chart lacked e of influenza educat	vidence that annual education ion was provided.					
	stated the consent sent out and the va residents whose co ICC stated the cons charts. Documenta vaccine was docum	ed on 8/14/14, at 1:00 p.m., and educational forms were accine was given to those onsent forms were signed. The sent forms were not kept in the ation if resident received the mented on the resident antoux record, but did not or consent.					
F 465 SS=E	influenza vaccines 483.70(h)	nd procedure for resident was not provided.  AL/SANITARY/COMFORTABL	F 4	65		9/16/14	
		ovide a safe, functional, ortable environment for the public.					
	by:	NT is not met as evidenced tion, interview and document		1 Rooms			

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			08/ <sup>-</sup>	15/2014
	PROVIDER OR SUPPLIER	CARE CENT		90	TREET ADDRESS, CITY, STATE, ZIP CODE 01 9TH STREET NORTH 'IRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	review, the facility f were maintained in 11 of 76 resident ro 340, 346, 418, 422. Findings include:  During an environm p.m. with the secre environment service observed.  Room 324, had a capproximately four small orange stain.  Room 334, had larg bathroom, inside dowall.  Room 338, had was bed that was lifting and the paint under inside bathroom engouged.  In Room 340, the wascraped and had ta of bathroom was baalong side toilet was Room 346, the wall scraped near the had room behind the room behind the	ailed to ensure resident rooms a sanitary homelike manner in oms. (Rooms 324, 334, 338, 424, 426, 436, 437)  nental tour on 8/14/14, at 12:00 tary of facilities and es (SFES) the following was incular pink stain inches by three inches and a in the carpet by window.  ge chips in the paint in the porway and on the opposite  Ilpaper behind the head of the at the seam and the edges meath was stained. The paint try was badly scraped and  vall at the head of the bed was pe marks. The corner in entry adly gouged and the grab bar	F 4	.65	324,334,338,340,346,418,422.424 6,437 were cleaned, repaired and p 2 All residents have the potential to affected by the deficient practice. 3 Maintenance does a daily walk the form of the facility. When areas are not eneed repair an online workerder is placed. The Maintanence department the work order and completes the phased on priorities. They also have schedule for routine maintenance, are to report if there is a maintaner concern. Staff were educated on the online process for completing work orders.	painted. be be be be arough d to ant gets epair a All staff ace be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	CARE CENT		9	TREET ADDRESS, CITY, STATE, ZIP CODE 01 9TH STREET NORTH /IRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	Room 424, had seven the ceiling tiles in the Room 426, had seven bedroom area.  Room 436, had state on them.  Room 437, had may walls.  On 8/14/14, at 12:1 she shampoos the sees them. Had not room 324.  On 8/14/14, at 1:00 facility had an elect schedule system the scheduled for prevent maintenance does a facility and floor state order for areas nees.  The facility's Day state of the state of	sink was water stained and ed up.  reral tan/rust colored stains on the bedroom area.  reral stained ceiling tiles in the stains on the bedroom area.  reral stained ceiling tiles with stains on the stains on the bathroom  5 p.m. housekeeper-A stated stains in the carpets when she is seen the stains on the floor in the profice preventive maintenance at directs staff on areas entive maintenance.  a daily walk through of the ff are to put in an online work	F 4	.65			

Printed: 08/20/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIE	٤
AND PLAN OF CORRECTION	

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:** 

A BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245458

B. WING

08/13/2014

NAME OF PROVIDER OR SUPPLIER

#### **ESSENTIA HEALTH VIRGINIA CARE CENT**

STREET ADDRESS, CITY, STATE, ZIP CODE

#### 901 9TH STREET NORTH

	VIRGIN	IIA, MN 557	792	
(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	K 000		
	FIRE SAFETY			
	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Virginia Regional Medical Center C & NC was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.			
	Virginia Regional Medical Center is a 4-story building with 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 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 100 beds and had a census of 94 at the time of the survey.		(9))	
	The requirement at 42 CFR Subpart 483.70(a) is MET.			¥3.

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.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered August 26, 2014

Ms. Linda Bump, Administrator Essentia Health Virginia Care Cent 901 9th Street North Virginia, Minnesota 55792

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5458023

Dear Ms. Bump:

The above facility was surveyed on August 11, 2014 through August 15, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Essentia Health Virginia Care Cent August 26, 2014 Page 2

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Patricia Halverson at (218) 302-6151 or email: Patricia.Halverson@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

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

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

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PRINTED: 09/28/2014 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00603		B. WING		08/	15/2014
	PROVIDER OR SUPPLIER	CARE CENT	901 9TH 9	DRESS, CITY, S STREET NOF , MN 55792	STATE, ZIP CODE RTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC / MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 000 Initial Comments			2 000				
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION OF	RDER				
	In accordance with 144A.10, this correpursuant to a surve found that the defic herein are not correnot corrected shall with a schedule of the Minnesota Depart	ction order has been by. If, upon reinspectiency or deficiencie ected, a fine for each be assessed in according to the fines promulgated	en issued ection, it is es cited ch violation cordance				
	Determination of whe corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated ducorrected.	compliance with all a rule provided at the rule provided at the rule number indicate as several items, for the items will be concluded. Lack of complianing item of multi-passement of a fine eve	ne tag ed below. ailure to onsidered ce upon art rule will n if the item				
	You may request a that may result from orders provided that the Department with notice of assessment.	n non-compliance at a written request hin 15 days of rece	with these is made to eipt of a				
	INITIAL COMMENT You have agreed to receipt of State lice the Minnesota Depi Informational Bullet http://www.health.so obul.htm The Stat delineated on the a	participate in the onsure orders constantment of Health in 14-01, available tate.mn.us/divs/fpce licensing orders	at c/profinfo/inf are				

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

**Electronically Signed** 09/05/14

STATE FORM 6899 P40F11 If continuation sheet 1 of 35

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	OATE SURVEY OMPLETED		
		00603	B. WING		08/15/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY,	STATE, ZIP CODE	
ESSENT	IA HEALTH VIRGINIA	CARE CENT	TREET NOI MN 55792	RTH	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000 2 560	Department of Hea you electronically. is necessary for Sta enter the word "corn text. You must then State licensure procompletion date, the corrected prior to el Minnesota Department."	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the	2 000		9/16/14
	Plan of Care; Contents comprehensive plan objectives and time long- and short-term and mental and psy identified in the compassessment. The compassessment include the increquired by Minnes subdivision 14, para This MN Requirement by:  Based on observation review, the facility for comprehensive car (R52) for falls; for 1 for oxygen use; for reviewed for oral hy (R14) for skin cond (R43) for anticoaguit Findings include:	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, vchosocial needs that are aprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).		1 Comprehensive care plans for reside #52, 97,14,43 and 3 were reviewed and revised to include falls,oxygen use, ora hygiene, skin conditions,pain and anticoagulatin medications. 2 All residents require comprehensive, individualized plans of care based on needs identified during the assessment process. 3 The Care Planning Policy was review and revised as neccesary. Nursing staf were educated on CAA's, care planning for all triggered problems that have been	ed :

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00603	B. WING		08/15	5/2014
	PROVIDER OR SUPPLIER	CARE CENT 901 9TH S	DRESS, CITY, S STREET NOF , MN 55792	STATE, ZIP CODE 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
2 560	Care Area Assessmindicated R52 was decreased function left hip replacemen required the extens transfers. The CAA was required with slight and frequently times and non-slip R52's care plan, dadiagnoses that inclusted osteoarthritis and gaddress the risk of interventions. The directed extensive while walking with a the risk of falls.  R52's Fall risk asseindicated, "Residen had 1 fall in the pasin place [sic] for resfalls Will continue continue current place [sic] for resfalls Will continue current place [sic] for resfalls Will continue current place [sic] for resfalls Will continue current place [sic] for resfal	nent (CAA) dated 6/5/14, at risk for falls related to all mobility secondary to recent the being non ambulatory and ive assist of two staff for indicated a falls care plan uggested interventions of call used items within reach at all foot wear for all transfers.  ted 6/5/14, indicated uded muscle weakness, eneralized pain. The did not falls or suggested nurses aide worksheet assistance for transfers and a walker, but did not address essment dated 8/11/14, t is at risk for falls and has at quarter. Self-locking w/c put ident safety and to prevent to monitor for fall risk. Will	2 560	decided to be care planned, also problem that affects the residnet's well-being and overall cares.  4 Three residents care plans will a audited per week for two months they are to assure they are comprehensive, including Couma pain, skin condition, oxygen, risk and oral hygiene. Staff will be recon an ongoing basis as needed by the results of the audits. The mon results will be reported to the qual team. The QI team will make recommendations for ongoing more	din use, for falls educated ased on itoring rterly QI	

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '				) DATE SURVEY COMPLETED	
		00603	B. WING		08/1	5/2014	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S STREET NOF	STATE, ZIP CODE			
ESSENT	ESSENTIA HEALTH VIRGINIA CARE CENT VIRGINIA			Kin			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 560	Continued From pa	ige 3	2 560				
	R3's care plan, dated 6/19/14, did not address the use of 02, how much 02 was to be delivered, or by what route.						
	with nasal canulla f tank on the wheel of tank was pointing to	ed on 8/14/14, at 7:00 a.m. or O2 connected to a portable chair. The gauge on the O2 to the red area indicating the wall mounted O2 delivery use.					
	unit was functional	14/14, at 8:40 a.m., the wall and should be utilized for R3 stated care plan should O2 for R3.					
	large amount of wharound the bottoms 9:24 a.m., R97 was	on 8/12/14, at 1:40 p.m. with nite and pink colored debris of lower teeth. On 8/14/14, at slying in bed and mouth was re was a thick coating on the ween lips.					
	had severe cognitive extensive assistant	ated 7/16/14, indicated R97 ve impairment and required ce of one staff for personal ity, transfers, locomotion, and toilet use.					
	assist of one for gredirection for oral hy	ted 5/24/14, directed extensive coming. The care plan lacked rgiene or dental care. The are sheets lacked direction for					
		on 8/14/14, at 9:57 a.m. were not addressed in R97's					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00603	B. WING		08/	15/2014
	PROVIDER OR SUPPLIER	CARE CENT 901 9TH	STREET NOF	STATE, ZIP CODE RTH		
	0.0000000000000000000000000000000000000		, MN 55792	DD0//DDD0 D/ AN 05 00DD50	7.01	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 560	Continued From page 4					
		to have three bruises on the d on 8/11/14, at 6:56 p.m. R14 ne to bruising.				
	moderate cognitive assistance of one s	DS dated 6/14/14, indicated deficit and required extensive taff for personal hygiene, bed ocomotion in the wheelchair, use.				
	R14's care plan dated 6/20/14, did not address the potential for bleeding or bruising related to R14's medical condition or medication.					
	stated that when re	on 8/13/14, at 1:25 p.m., sidents were prone to bruising d address the problem and				
	Facility was unable procedure for care	to provide policy and planning.				
	Coumadin [an antic	not address the use of coagulant medication] and the donon-narcotic pain				
	included Coumadin daily on Sunday, Tu Saturday, and 4 mg and Friday; and Tyl- hours as needed. If dated 8/2/14, direct	cian's Orders dated 6/19/14, (anticoagulant) 2 mg oral lesday, Thursday, and g oral on Monday, Wednesday, enol 325 mg oral every 4 R43's Physician's Orders ed R43 to receive Norco ral every 6 hours prn [as				
		S dated 6/29/14, indicated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		00603	B. WING		08/	15/2014
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH VIRGINIA	CARE CENT	H STREET NOF IIA, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 560	pulmonary disease, hypertension. The was cognitively inta scheduled pain med R43's Care Plan (ur Treatment Administ 7/15/14, to 8/14/14, Coumadin, Tylenol During the survey w 8/14/14, R43 was owith no evidence of Coumadin; and R43 On 8/13/14, at 1:20 had changed over trecord system earlicare plan entries to monitoring were mi of Coumadin should monitoring of adverthe medication. RN care plan lacked a papproaches for R43 non-pharmacologic On 8/14/14, at 3:00 (DON) stated signiff monitoring should be on the ETAR in the records.  A Care Plan policy resident's plan of care plan of care plan of care plan policy resident's plan of care plan of care plan policy resident's plan of care plan policy plan plan of care plan policy plan plan plan plan plan plan plan plan	congestive heart failure, an MDS further indicated R43 ct and was receiving a dication.  Indated) and R43's electronic tration Record (ETAR) dated did not address the use of or Norco pain medications.  Index of 8/11/14, through observed on multiple occasion bruising or bleeding from 3 denied pain.  In p.m. RN-B stated the facility of a new electronic medical er this year and the ETAR are address side effect seed. RN-B stated R43's used be care planned for the rise effects and side effects of the further confirmed R43's problem statement and B's pain monitoring to include the seed of the	ns / nd e f	DEFICIENC	Y)	
	such as clinical issu Suggested method: The director of nurs		,			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
		00603	B. WING		08/15/2014		
NAME OF I	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
2 560	Continued From pa	ge 6	2 560				
	care planning, deve and initiate monitor compliance.	and procedures related to elop and provide staff training, ing systems to ensure rection: Twenty one (21) days.					
2 830	MN Rule 4658.0520 Proper Nursing Car	) Subp. 1 Adequate and e; General	2 830			9/16/14	
	receive nursing carcustodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident bed.					
	by: Based on observation review, the use of compropriately for on observed for the use were not coordinate reviewed for hospical Findings include: R3's physician order diagnoses that includes	ent is not met as evidenced on, interview and document oxygen (O2) was not provided e of three residents (R3) e of O2; and hospice services ed for 1 of 1 residents (R42) e.		1 Resident #3 is deceased. Reside #42's hospice services were discound her care plan was reviewed at revised. 2 All residents using oxygen or Hoservices have the potential to be eleby the deficient practice. 3 Policies and procedures for oxygen have been reviewed and revised. eMar will now have a task schedul monitor oxygen tanks. A meeting with Hospice Services to plan better.	ntinued and spice applied to spice appli		

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION :	(X3) DATE COMP	SURVEY LETED
		00603	B. WING		08/1	5/2014
	PROVIDER OR SUPPLIER	CARE CENT 901 9TH	DRESS, CITY, STREET NO 1, 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	fatigue. The orders minute, every shift, R3 was observed o in her bed with a nat to an O2 tank on the oxygen tank wanoted, "Refill." R3 a The wall mounted ouse and there was attached to the wall. On 8/14/14, at 8:31 feeling well and wis Licensed practical room, and when as she did not know w LPN-C went to obtaconnected R3 to the When the portable the wheel chair, the when removed from pressure.  The admission minimidicated R3 utilized the facility.  Nursing assistant (18/14/14, at 8:37 a.m. notified when a resign empty.  Registered nurse (Fwall unit was availa automatically be us The Director of Nur 11:53 a.m., there was a constant.	included O2 at 2.0 liters per nights, days and evenings.  n 8/14/14, at 7:00 a.m. asleep asal cannula for O2 connected e wheel chair. The gauge on as pointing in the red area and appeared in no acute distress. O2 delivery system was not in no humidifying "bubbler"	2 830	communication between our fa Hospice policy was reviewed. It staff were educated on the oxy Hospice policies and where to information regarding hospice 4 Three audits will be done were months to ensure on-going cor with oxygen use and tank replaystaff will be re-educated on an basis as needed based on the results. The monitoring results reported to the quarterly QI teat team will make recommendation ongoing monitoring.	Nursing gen and find residents. ekly for two npliance acement. ongoing audit will be m. The QI	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00603		B. WING		08/1	5/2014
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				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 8		2 830			
	R42's Admission Record dated 5/20/14, indicated diagnoses included subdural hemorrhage and chronic pain.						
	R42's admission M 5/27/14, indicated F memory deficits, ha including continuou disorganized thinking bowel and bladder, all activities of daily further indicated R4 scheduled or as ne had no non-verbal hospice care.	R42 had short- are ad symptoms of comments of comments and simple and was always in and was totally comments. The comments of	nd long- term delirium fluctuating acontinent of dependent in The MDS ing nedications,				
	R42's care plan data services for end of hemorrhage; comfoirreversible and cortand family. The goat have good quality of approaches include needed and/or required and snacks, hours and prn, spir needed, anticipate patient and family.	life care related to the measurers as infort was reques all was to be pain of life. R42's care at provide pain muested, rest periodicated, nutrition at turn and repositional care as requirements.	o subdural condition was ted by patient free and plan edication as ods as and liquids for on every 2 lested and/or				
	R42's Hospice Team Care Plan dated 5/22/14, and printed 8/8/14, indicated the following hospice provider visits:						
	* SN [Skilled Nursi for 3 months with 3 management. * MSS [Medical So supportive care.	prn visits for syn	nptom				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED		
		00603		B. WING		08/	15/2014
	PROVIDER OR SUPPLIER	CARE CENT	901 9TH S	DRESS, CITY, S STREET NOF , MN 55792	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCY MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	* SCC [Spiritual Ca for spiritual care.	are Coordinator]: 3 are Coordinator]: 3 at Care]: 3 prn visit ]: 1 to 2 visits per sits for personal ca 1 to 4 times per mo at Contact forms (ity Contact forms (ity Contact forms (ity Contact forms indicated ite Aid visits in June on 7/28/14, 8/5/14 atteer visits were indicated visits were indicated ite Aid visits in June on 7/28/14, 8/5/14 atteer visits were indicated ite Aid visits were indicated ite Aid visits in June on 7/28/14, 8/5/14 atteer visits were indicated ite Aid visits in June on 7/28/14, 8/5/14 atteer visits were indicated ite Aid visits in June on 7/28/14, 8/5/14 atteer visits were indicated in the Hospical in the Aid in the Hospical in the Hospi	ts for grief week for 5 ares. onth for 3  undated) board in the or of the R42 had e, 2014, and dicated on 14/14.  ated rovided by e. The dospice Aid ate the  rough le occasions the facility. ctical nurse ate to the further spice staff R42  stant (NA)-A ce aide 2. NA-A				

Minnesota Department of Health

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AND DIAN OF CODDECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00603	B. WING		08/1	5/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENT	IA HEALTH VIRGINIA	CARE CENT	STREET NOF , MN 55792	RTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES '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
2 830	Continued From pa	ge 10	2 830			
	nurse (RN)-A stated had improved in the Hospice staff and n communicating who RN-A also stated R Hospice volunteer a On 8/14/14, at 3:00 (DON) stated the conservices could be buthe nursing home s	roximately 2:30 p.m. registered d Hospice coordination of care a facility. RN-A further stated ursing home staff should be en hospice is in the building. 42 did not have a specific assigned to provide support.  p.m. the director of nursing pordination of care for Hospice etter. The DON further stated taff should be aware what kind were scheduled and what				
	for LTC [long term of facilities was provid communication she patient closet. The hospice staff were to sheet when visits would indicated hospice to facilities.]	or Hospice process guidelines care] and AL [assisted living] led and indicated a Hospice set was to be kept in the policy further indicated to write on the communication were made. The policy also seam member's progress notes be faxed or delivered to the time per week.				
	and revise policies monitoring and use be provided educat a monitoring system compliance.	s of correction: sing or designee could review and procedures related to of oxygen therapy. Staff could ion related to the policies and n could be initiated to ensure rection: Twenty one (21) days.				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	(X3) DATE SURVEY COMPLETED		
	00603		B. WING		08/15/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE	
COCENT	IA LIFALTIL VIDOINIA	901 9TH	STREET NO	RTH	
ESSENI	IA HEALTH VIRGINIA	VIRGINIA	, MN 55792		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
21375	Continued From pa	ge 11	21375		
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375		9/16/14
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.			
	by: Based on observatireview, the facility f standards during diresidents (R142, R during blood glucos of 1 residents (R14 glucose monitoring for 1 of 1 residents precautions. In addeducation was not (R97, R102, R43, F were reviewed.  Findings include: R142's pressure ule procedure was not infection control stated 8/12/14, indicated 8/12/14, indicated 8/12/14, indicated R142 had impairment, require bed mobility and trabe at risk for the detate MDS further in	on, interview, and document ailed to follow infection control ressing changes for 2 of 2 144) observed for wound care; se monitoring procedures for 17) observed during blood; and during provision of care (R144) with isolation dition, influenza immunization provided for 5 of 5 residents (R, R, R		1 The direst caregiver responsible for resident #142's dressing changes were-educated on proper infection contechniue related to changing gloves washing hands between changes of gloves.  Resident 3 144's comprehensive carplanwas updated to include contact isolation precautions.  Resident #147's nurses were re-edu on proper procedure for glucometer checks.  Residents # 97.102,43,77 and 8 will recieve influenza education next mowhen influenza vaccines are given.  Consent forms will be scanned into a residents medical records.  2 All residents have the potential to effected by a break in infection contrustices and lack of influenza education and washing and glove use was reviewed. The Policy for Blood Glucomonitoring was reviewed. The Policy Isolation Presuations was reviewed. staff were educated on handwashing isolation precautions and blood glucomonitoring policies.	as trol and  re acated  nth all be rol ation.  ose y for All g,

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00603	B. WING		08/15/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
ESSENT	ΓΙΑ HEALTH VIRGINIA	CARE CENT	STREET NO A, MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
21375	described the press cm in length by 9.9 tissue present in the indicated R142's ule pressure reducing on nutrition or hydration skin problems, pressure reducing on the indicated R142's Physician Consumplication of nonstructed to change hip every 12 to 24 has a turation level.  On 8/14/14, at 10:2 (LPN)-C was obserd dressing change to applied blue, dispossing the contain a moderate drainage. LPN-C work of disposable glove her hands, and dispute gloves in a nearby onew gloves to her hands, and dispute the pressure the pres	sure ulcer as measuring 6.5 cm in width, with eschar e wound bed. The MDS also cer treatments included a device for the chair and bed, n interventions to manage ssure ulcer care, and the		completed to ensure ongoing con with infection control techniques. minimum of four observational au be completed weekly at varius timensure ongoing compliance. Staff re-educated as needed based on results of the audits. The monitoring results will be reported to the quateam. The QI team will make recommendations for ongoing compliance.	A dits will nes to will be the ng	

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00603	B. WING		08/1	5/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	-	
ESSENT	IA HEALTH VIRGINIA	CARE CENT	STREET NOF , MN 55792	RTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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
21375	then removed the geto wash her hands 10:41 a.m.  On 8/14/14, at approved the dressing change when the procedure further stated she washed the dressings and with she should not have should have raised  On 8/14/14, at 2:15 stated hands should changed as well as procedures. RN-C feet be raised to working wound/ulcer care to the complete of the complet	lloves. LPN-C was observed in R142's bathroom sink at roximately 2:00 p.m. LPN-C her hands before beginning e procedure and then again e was complete. LPN-C was not aware she should have after removing the soiled glove changes. LPN-C stated e knelt on the floor and instead the bed to a working height.  p.m. registered nurse (RN)-C d be washed when gloves are between soiled and clean further stated the bed should g height when performing of a resident at the bedside.  p.m. the director of nursing is should be washed/sanitized are removed, before new The DON further stated the ed to a working height and roided when performing ulcer	21375			
		after removing an old sh hands between glove				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		SURVEY PLETED	
		00603		B. WING		08/	15/2014
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
ESSENT	IA HEALTH VIRGINIA	CARE CENT		TREET NOF MN 55792	RTH		
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21375	Continued From pa	ge 14		21375			
	followed during the R144's Resident Ad	lmission Record (undat	ed)				
		agnoses included MRS/ t Staphylococcus Aureu llulitis/abscess.					
	R144 was cognitive	MDS dated 8/8/14, indic ly intact and had an infe dressings to the feet.					
		ated 8/4/14, to 8/14/14, precautions for MRSA					
		oximately 3:00 p.m. cop care plan were requeste					
	the facility, a large, dresser containing observed to be loca R144's room. Ther indicate precautions	p.m. during the initial to light yellow colored met gloves on the top was ated in the hall way outs be was no sign on the do so or that visitors should be entering the room.	ide of oor to				
	nurse (RN)-F stated precautions for a M gowns and gloves t providing direct car was usually a sign of check with the nurs room. RN-F was of the top drawer of the	roximately 9:00 a.m. reg d R144 was on contact RSA infection, meaning o be worn in R144 when e. RN-F further stated to on the door for visitors to e before entering R144 beserved to pull a sign of the yellow cart outside of lace the sign on R144's	n there o 's ut of				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  B. WING	/2014
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	(X5)
	COMPLETE DATE
21375 Continued From page 15 21375	
On 8/14/14, at 9:45 a.m. nursing assistant (NA)-G was observed to respond to R144's call light. NA-G did not apply gloves or a gown upon entrance to R144's room. In R144's room, NA-G was observed to be making the bed. NA-H was already inside R144's room, assisting R144 to do oral cares at the bedside. Neither NA-G or NA-H were observed to be wearing disposable gloves or gowns while assisting R144. At approximately 9:55 a.m. NA-H was observed to leave R144's room without washing or sanitizing her hands.  On 8/14/14, at 2:00 p.m. NA-H was interviewed and stated that NA's were instructed to use standard precautions that meant washing hands before and after cares and to use gloves for direct contact with the resident. NA-G confirmed the use of standard precautions for a resident on contact precautions, but was not instructed to wear a gown for any cares with a resident on contact precautions. NA-H stated she had sanitized her hands after leaving R144's room and stated she believed the practice was acceptable. NA-G stated she was not aware of why R144 was on precautions/isolation. NA-H further stated she thought R144 was not next to R144's door.  On 8/14/14, at 2:15 p.m. RN-C stated staff should be wearing gloves and gowns when providing cares for R144. RN-C further stated staff should be wearing gloves and gowns when providing cares for R144. RN-C further stated staff should be wearing gloves and gowns when providing cares for R144. RN-C further stated staff should be wearing gloves and gowns when providing cares for R144. RN-C further stated staff should be wearing gloves and gowns when providing cares for R144. RN-C further stated staff should be wearing gloves and gowns when providing cares for R144. RN-C further stated staff should be wearing gloves and gowns when providing cares for R144. RN-C further stated staff should be wearing gloves and gowns when providing cares for R144. RN-C further stated staff should provided the sashing their hands before leaving R144's room and stated she governed the same provide	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
00603		B. WING		08/15/2014		
NAME OF PF	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ESSENTIA	A HEALTH VIRGINIA	CARE CENT	STREET NOF , MN 55792	RTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	with cares, and was room. The DON furesident on contact sign posted for visit isolation supplies slate DON confirmed information and direct precautions information should. The Facility's Isolat Precautions) policy indicated an isolatic the door frame at the common. The Policy furing the resident's room fluids or resident end sanitizing hand contaminated items gloves and sanitizing resident room; and centering a resident on 8/14/14, 11:16 apreparing for a dresulcer. R144's foot where the ulcer with alcohomy without hand sanitize the ulcer with the glater tape. LPN-C changed he sanitization, applied paper tape. LPN-C hand sanitization, k	and wearing disposable gowns shing hands before leaving the rther stated the door of a precautions should have a cors and a cart with the needed hould be outside of the room. If the care plan should include ection for the infection and so, and the care plan be communicated to staff.  It ion (Transmission-Based reviewed/revised 1/2011, on sign should be placed on the entrance to the patient's curther indicated a MRSA cuire contact precautions to the upon entering and exiting and after contact with body exironment; exam gloves prior aroom with changing of gloves as after contact with so or surfaces and removal of the glover gown worn prior to	21375			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00603	B. WING		08/	15/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH VIRGINIA	CARE CENT	STREET NOR A, MN 55792	RTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
21375	gloves, washed ha gathered the trash at On 8/14/14, at 11:4 was on contact predulcer. LPN-C stated dressing changes of stated she does not between glove chart. The facility's Dressi 7/10, directed staff glove changes.  R147 was observed during a glucomete sanitized hands and blood sugar check, germicidal wipe, wr germicidal wipe, rethe computer, and the LPN-A verified she hands after removing the computer or oth R147's admission frincluded a diagnosi Administration Received and the staff do yincludes infection of the facility policy at the facility policy at the staff do yincludes infection of the facility policy at the st	nds in R144's bathroom, and exited the room.  1 a.m. LPN-C stated R144 cautions for MRSA in the toe is she wore gloves during or bedding changes. LPN-C twash or sanitize her hands ages.  Ing Techniques policy dated to wash their hand between it on 8/14/14, at 11:33 a.m. In (blood sugar) check. LPN-A put on gloves, performed the wiped the glucometer with a moved gloves, documented on then sanitized her hands. In should have cleaned her ang gloves and before touching				
	revised 3/14, indica	ted hand hygiene is to be tely after removing gloves.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA				(3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
		00603	B. WING		08/1	5/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-		
ESSENT	IA HEALTH VIRGINIA	CARE CENT	TREET NOF	RTH			
	OLIMANA DV. OTA		, MN 55792	PROVIDENIA PLANTOS CORRECTIO		4.5	
(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 APPROFICIENCY)	D BE	(X5) COMPLETE DATE	
21375	Continued From pa	ge 18	21375				
		nd procedure for hand hygiene ted hand hygiene is to be ve use.					
	education of influen R97's vaccination a on admission of 7/8 offered and refused another facility prior documentation did	evidence that annual aza education was provided. and mantoux record, initiated 3/13, indicated R97 was an influenza vaccine at r to admission. The not indicate that R97 was ed the influenza vaccine at this					
	education of influen	d evidence that annual nza education was provided.					
		evidence that annual nza education was provided.					
		evidence that annual nza education was provided.					
	R8's chart lacked e of influenza educati	vidence that annual education ion was provided.					
	stated the consent sent out and the varesidents whose co ICC stated the conscharts. Documenta vaccine was docum vaccination and Maindicate education of						
	I he facility policy at influenza vaccines	nd procedure for resident was not provided.					

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NAME OF PROVIDER OR SUPPLIER  ESSENTIA HEALTH VIRGINIA CARE CENT  (X4) ID PREFEIX TAGK  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGK  TAGK  CONFIDENCY OR LISC IDENTIFYING INFORMATION)  21375  Continued From page 19  Suggested methods of correction: The director of nursing or designee could review and revise policies and procedures related to infection control practices. Staff could be provided education related to the policies and a monitoring system could be initiated to ensure compliance.  Time period for correction: Twenty one (21) days.  21426  MN St. Statute 144A,04 Subd. 4 Tuberculosis Prevention And Control  (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.  (b) Written compliance with this subdivision must be maintained by the nursing home.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  ESSENTIA HEALTH VIRGINIA CARE CENT  (X4) ID PREFIX TAG  (X4) ID PREFIX TAG  (X4) ID PREFIX TAG  (X5) ID PREFIX TAG  (X6) ID PREFIX TAG			00603	B. WING		08/15/2014
Continued From page 19   Suggested methods of correction: The director of nursing or designee could review and revise policies. Staff could be provided education related to the policies and a monitoring system could be initiated to ensure compliance.    21426	NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
PRÉÉIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21375  Continued From page 19  Suggested methods of correction: The director of nursing or designee could review and revise policies and procedures related to infection control practices. Staff could be provided education related to the policies and a monitoring system could be initiated to ensure compliance.  Time period for correction: Twenty one (21) days.  21426  MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control  (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control program according to the most current tuberculosis limitation, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.  (b) Written compliance with this subdivision must	ESSENT	IA HEALTH VIRGINIA	CARE CENT		RTH	
Suggested methods of correction: The director of nursing or designee could review and revise policies and procedures related to infection control practices. Staff could be provided education related to the policies and a monitoring system could be initiated to ensure compliance.  Time period for correction: Twenty one (21) days.  21426  MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control  (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.  (b) Written compliance with this subdivision must	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETE
Prevention And Control  (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.  (b) Written compliance with this subdivision must	21375	Suggested methods The director of nurs and revise policies infection control pra education related to system could be ini	s of correction: sing or designee could review and procedures related to actices. Staff could be provided the policies and a monitoring tiated to ensure compliance.			
This MN Requirement is not met as evidenced by:  Based on interview and document review, the facility failed to ensure two-step mantouxs (skin screenings were completed for residents	21426	(a) A nursing home maintain a compreh infection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volument to the shall provide regarding implement (b) Written compliable maintained by the This MN Requirements.	e provider must establish and nensive tuberculosis ogram according to the most is infection control guidelines d States Centers for Disease ation (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of extechnical assistance intation of the guidelines.  Ance with this subdivision must be nursing home.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00603	B. WING			08/15/2014	
	PROVIDER OR SUPPLIER	CARE CENT 901 9TH	DDRESS, CITY, STREET NO A, MN 55792				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21426	test that screens for completed and record (R77, R102) and the symptom screening residents (R97, R10) for tuberculosis screening residents (R97, R10) for tuberculosis screening was admitted to given on 9/13/11. It documentation of reand lacked evidence was completed. R7 evidence that a bas screening was common R102 was admitted R102's vaccination 9/24/13, indicated the treatment recorded at the facility. It mantoux record lacked evidentuberculosis symptom R43 was admitted to R43's medical record lacked evidentuberculosis symptom R43 was admitted to medical record lacked tuberculosis symptom R8 was admitted to medical record lacked to medical record lacked tuberculosis symptom R8 was admitted to medical record lacked tuberculosis symptom R8 was admitted to medical record lacked tuberculosis symptom R8 was admitted to medical record lacked tuberculosis symptom R8 was admitted to medical record lacked tuberculosis symptom R8 was admitted to medical record lacked tuberculosis symptom R8 was admitted to medical record lacked tuberculosis symptom R8 was admitted to medical record lacked tuberculosis symptom R8 was admitted to medical record lacked tuberculosis symptom R8 was admitted to medical record lacked tuberculosis symptom R8 was admitted to medical record lacked tuberculosis symptom R8 was admitted to medical record lacked tuberculosis symptom R8 was admitted to medical record lacked tuberculosis symptom R8 was admitted to medical record lacked tuberculosis symptom R8 was admitted to medical record lacked tuberculosis symptom R8 was admitted to medical record lacked tuberculosis symptom R8 was admitted to medical record lacked tuberculosis symptom R8 was admitted tuberculosis symptom	r tuberculosis) were orded for 2 of 5 residents at baseline tuberculosis was completed for 5 of 5 of 5 of 5, R43, R77, R8) reviewed eening.  o the facility on 12/28/12. Ind mantoux record initiated ne first step mantoux was the record lacked esults of the first step mantoux rethat a second step mantoux roll acked eeline tuberculosis symptom		#8,77,102,97 and 43.  2 All residents have the potential timpacted by a deficient practice in area.  3 Tuberculin policy was reviewed nursing staff were re-educated or policy.  4 Three chart audits will be compleach week to ensure ongoing con The monitoring results will be reported the quarterly QI team. The QI team make recommendations for ongoing monitoring.	n this I. All In the Ileted Inpliance. Input of tools and the tools are		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY	
	00603		B. WING		08/1	5/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
ESSENT	IA HEALTH VIRGINIA	CARE CENT	STREET NOF , MN 55792	Kin		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	During an interview coordinator (ICC) o verified two-step maresidents upon admindicated document been consistent. In baseline tuberculos been initiated or coordinated or coordinated two-step mantoux was residents upon admindicated tuberculos.  MN Rule 4658.1318 Usage; Monitoring Subp. 2. Monitoring Subp. 2. Monitoring Subp. 2. Monitoring Subp. 2. Monitoring The policies and pharmacist must represident attending physician does not home's recomment adequate justification believes the resident adversely affected, matter to the medicate in the subject of the medicate in the subject of the medicate in the subject of the subject of the medicate in the subject of the subject of the medicate in the subject of the	with the infection control n 8/14/14, at 1:00 p.m. she antouxs are to be done on all hission to the facility, and tation of mantouxs has not addition, the ICC verified the sis symptom screening had not impleted for residents.  and procedure for tuberculosis nts dated 7/13/90, directed a would be administered to all hission unless they have previous positive mantoux. Seedure lacked direction for his symptom screening.  5 Subp. 2 Unnecessary Drug  g. A nursing home must ent's drug regimen for usage, based on the nursing diprocedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist must refer the real director for review if the	21426			9/16/14
	the medical directo physician does not the order and if the change the order, the	not the attending physician. If r determines that the attending have adequate justification for attending physician does not he matter must be referred for y Assurance and Assessment				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			X3) DATE SURVEY COMPLETED		
				A. BUILDING:			
		00603		B. WING		08/15/2014	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH VIRGINIA	CARE CENT	901 9TH S	STREET NO	RTH		
ESSENT	IA NEALIN VIRGINIA	CARE CENT	VIRGINIA	, MN 55792			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	Continued From pa	age 22		21540			
	(QAA) committee r the attending phys the consulting phar directly to the QAA	equired by part ician is the me macist shall re	dical director,				
	This MN Requirem by: Based on observat review, the facility f monitoring of psychanticoagulant mediparameters for use medications for 4 or R43) reviewed for use medications for 4 or R43) reviewed for use medications include:  R73's Physician's (8/13/14, included T milligrams (mg) as generalized pain ar hours as needed, buse., and Seroque R73's Resident Addated 12/30/11, indicated 12/30/11, indicated R73's care plan did monitoring side effects on 8/14/14, at 1:37 verified the lack of	ion, interview a ailed to provide notherapeutic not cations or estate of as needed of 5 residents (Funnecessary management). Order Report sitylenol Extra Straneeded twice and Tylenol 650 ooth without particated diagnost avioral disturbatical spasm, falls (MDS) dated 6 severe cognitive and address the cets or effective or p.m. registere	and document e side effects nedications and blish pain R73, R106, R54, redications.  Igned on rength 500 a day for mg every four rameters for routh every day.  Id dated 6/17/14, es that included nces, paranoid and pain. The 6/22/14, re impairment.  The use or eness for each of the contract of the cont		1 #73's order for Tylenol were reviand now include parameters for u care plan was updated to include effect monitoring and effectiveness Seroquel. Resident #106's care plan was up include side effect monitoring and effectiveness and potential adverse effects related to use of Seroquel Ativan. Resident # 54's care plan was up include Ativan, Celexa and Insulin monitoring for side effets and adveffects. Resident #43's physicial orders a were reviewed to ensure they are all orders. Tylenol and Norco orderinclude parameters for use. His cawas updated to include the use of Coumadin, Tylenol and pain medieffectiveness and side effect mon 2 All residents recieving medication have the potential to be impacted deficient practice in this area. 3 Nursing staff will work in collabe with pharmcy and Nursing Unit Clensure parameters are included in for medications which require parameters. Nursing stass will reviplans, observations and progress	se. Her side s of dated to se and dated to use and erse and erse and erse so the side of the second	
	and that monitoring effectiveness of Se	for side effect	s and		ensure psychoactive medications addressed. Medication monitoring	are	

Minnesota Department of Health

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00603		B. WING		08/15/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH VIRGINIA	CARE CENT	STREET NOF MN 55792	RTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE COMPLETE	
21540	Continued From pa	ige 23	21540			
	the care plan.  R106's Physician's 8/7/14, included Se and Ativan 0.5 mg is needed for anxiety. Record dated 6/17/included a hip fractivity with depression and R106's care plan differ effectiveness ar related to use of Second 8/14/14, at 1:33 plan should addres R54 R54's Physicia 7/10/14, included A morning and 1 mg is anxiety. Celexa (an mg by mouth once units subcutaneous Admission Record	Order Report signed on croquel 12.5 mg by mouth daily by mouth every four hours as The Resident Admission 14, indicated diagnoses that ure, malaise/fatigue, dementiad anxiety.		was reviewed and revised as necestal Nursing staff were educated on medication administration and mopolicies.  4 Three eMars and care plans will audited each week to ensure com Staff will be re-educated on an one basis as needed based on the rest the audits. The monitoring results reported to the quarterly QIteam. Iteam will make recommendations ongoing monitoring.	nitoring  be pliance. going ults of will be Гhe QI	
	R106's care plan la	cked Ativan, Celexa and ring for effectiveness and side				
		p.m. RN-A verified the care s the use of Ativan, Celexa				
	included Coumadin daily on Sunday, Tu Saturday, and 4 mg	cian's Orders dated 6/19/14, (anticoagulant) 2 mg oral uesday, Thursday, and g oral on Monday, Wednesday, enol 325 mg oral every 4				

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			D. WING			
		00603	B. WING		08/1	5/2014
	PROVIDER OR SUPPLIER	901 9TH S	DRESS, CITY, S STREET NOF	STATE, ZIP CODE RTH		
ESSENT	IA HEALTH VIRGINIA	CARE CENT	, MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 24	21540			
	dated 8/2/14, direct	R43's Physician's Orders ed R43 to receive Norco ral every 6 hours prn [as				
	R43's diagnoses in pulmonary disease hypertension. The	S dated 6/29/14, indicated cluded chronic obstructive congestive heart failure, and MDS further indicated R43 ct and was receiving a dication.				
	R43's Care Plan (undated) and R43's electronic Treatment Administration Record (ETAR) dated 7/15/14, to 8/14/14, did not address the use of Coumadin, Tylenol or Norco pain medications.					
	During the survey week of 8/11/14, through 8/14/14, R43 was observed on multiple occasions with no evidence of bruising or bleeding from Coumadin; and R43 denied pain.					
	had changed over the record system earling care plan entries to monitoring were mind of Coumadin should monitoring of adverthe medication. RN care plan lacked a plan lack	p.m. RN-B stated the facility of a new electronic medical er this year and the ETAR and address side effect essed. RN-B stated R43's used be care planned for the se effects and side effects of I-B further confirmed R43's problem statement and B's pain monitoring to include all interventions.				
	(DON) stated signif monitoring should be	p.m. the director of nursing icant medications side effect be care planned and included residents' electronic medical				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '			(X3) DATE SURVEY COMPLETED	
7.1.12 . 2.11	o. co20		A. BUILDING:		30 22125	
		00603	B. WING		08/15/2014	
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 DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	resident's plan of ca electronic system a such as clinical issu	revised 12/3/13, indicated a are would be initiated in the and would address care areas ues and treatments.	21540			
	nursing or designed policies and proced use of medications education related to system could be ini	s of correction: The director of e could review and revise dures related to monitoring and . Staff could be provided to the policies and a monitoring tiated to ensure compliance.  Twenty one (21) days.				
21565	Subp. 4. Self-adm self-administer med resident assessmed care as required in 4658.0405 indicate is a written order from This MN Requirement	5 Subp. 4 Administration of dmin inistration. A resident may dications if the comprehensive nt and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician.	21565			9/16/14
	review, the facility fadministration of m	on, interview, and document ailed to assess safety for self edications for 2 of 2 residents ed to self administer		A self-administration of medicat was completed for residents #54 a Care plans were updated.     All residents could be affected be deficient practice. All residents are assessed upon admission for comor desire to self-adminiater medica and/or treatments such as nebuliz	oy the expetency ations	

winnesc	ita Department of He	eaith				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00603	B. WING		08/15/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ESSENT	IA HEALTH VIRGINIA	CARE CENT	STREET NOI , MN 55792	RTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CORRECTION (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE
21565	Continued From pa	ge 26	21565			
	R54 was not observed fredications despto self administer at On 8/12/14, at 9:40 R54, licensed pract medication cup with on the overbed table a briefly stood in the was taking his med left the area and reference R54 took the medication. The Resident Admi 2/24/14, indicated Ference two diabetes, spinal glaucoma, hyperter R54's psychosocial 5/23/14, indicated Ference to cognitive reminders, cues an of daily living, meals quarterly minimum was cognitively intained to SAM did not want to SAM impaired decision nof noncompliance wappropriate to SAM On 8/13/14, at 1:35 R54 with his medication in self-administration of the self-administration	ved during self administration pite being assessed as unsafe ny medications.  a.m. during an interview with tical nurse (LPN)-A placed a napproximately five or six pills le. LPN-e doorway and asked if R54 dications and then left. LPN-A turned at 9:48 a.m. to check if eations.  nistration Record dated R54's diagnoses included type I stenosis, esophageal reflux, asion, anxiety and pain.  well being care plan dated R54 had memory problems deficits. R54 required d supervision for all activities and daily routine. R54's data set (MDS) indicated R54 lct.  ation of Medication dated R54 had moderately naking skills and had a history with medications and was not		treatments. Self- administration of medications assessments are reviquarterly on all residents following MDS schedule.  3. Audits will be done to observe the licensed staff follow residents plant for self-administering of medication and/or treatments. It is identified to eMar and the careplan if the resident self administer medications. Licens will follow up with the resident to its whether they completed the treatments took their medications as identified self-administration of medication previewed and revised as neccesar Nursing staff were educated on self-administration of medications assessment and careplanning productions. Three audits will be done week months to ensure proper administ medications and/or treatments. Or audits will be completed based on results of the audits. The audit resident be reported to the quarterly QI tea will make recommendations for or monitoring.	the hat n of care ns n the ent may sed staff dentify hent or d. The olicy was y.  cess. y for two ration of ngoing the ults will m which	
		a.m. registered nurse (RN)-A of to SAM and the nurse				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00603	B. WING		08/	15/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH VIRGINIA	CARE CENT	STREET NOF A, MN 55792	RTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	R43 was not assess administer inhaled in On 8/13/14, at 1:19 in his room, seated treatment administed p.m. LPN-B came of	p.m. R43 was observed alone in the recliner with a nebulizer ered via face mask. At 1:30 down the hall from the nurses nebulizer mask and turned off				
	R43's Self Administration of Medication Assessment (SAM) dated 6/25/14, indicated R43 did not want to SAM medications. R43 had moderately impaired cognition and the nurse would set up and administer R43's medications. The assessment further indicated R43 could not properly dispense a nebulizer.					
	R43 alone to do the R43 transferred from	p.m. LPN-B stated she leaves e nebulizer and was told when m from the fourth floor he with the nebulizer after it was	<b>;</b>			
	assessment indicat alone with the nebu	p.m. RN-B verified the SAM ed R43 was not to be left lizer. RN-B expected staff to the nebulizer was running.				
	policy effective 9/24 would have a SAM admission, change necessary. Residen be reviewed by the determine appropria	dministration of Medications 4/10, indicated all residents observation completed upon in condition and as deemed at who wished to SAM would interdisciplinary team (IDT) to ateness.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		L COM			E SURVEY IPLETED	
		7.1. 20.2210				
	00603	B. WING		08/1	5/2014	
PROVIDER OR SUPPLIER						
IA HEALTH VIRGINIA	CARE CENT		КІН			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	D BE	(X5) COMPLETE DATE	
The director of nurs and revise policies assessemnt of self Staff could be prov systems could be in	ses or designee could review and procedures related to administration of medications. ided education and monitoring nitiated to ensure compliance.	21565				
Drugs used in the r in accordance with  This MN Requirem by: Based on observat review, the facility f were labeled correct observed during metals and the served pass on 8/12/14, at nurse (LPN)-A was Novolog insulin to f was noted to direct (sq) three times a condinistration Recondirected Novolog in 25 u sq once in the EMAR directed the	nursing home must be labeled part 6800.6300.  ent is not met as evidenced ion, interview and document ailed to ensure medications ctly for 1 of 7 residents (R24) edication administration.  during medication medication eg:00 a.m. Licensed practical observed to administer R24. The Novolog insulin label 30 units (u) subcutaneous day. The electronic Medication ord (EMAR) dated 7/29/14, isulin 30 u sq twice a day and evening. LPN-A verified the 30 u of Novolog insulin was to	21620	labeled for resident #24's insulin.  2 All residents could be affected by deficient practice.  3 The medication Administration powas reviewed and revised as nece The pharmacy staff were consulted correct process for label changes. nursing staff were educated on the Medication Administration Policy.  4 monitoring will be done by completinee audits weekly to check for accorders. Nursing staff will be re-educated as needed based on the results of audits. The internal eMar process also reviewed relating to orders seen as the service of the serv	by the colicy cassary. It is a color of the	9/16/14	
	PROVIDER OR SUPPLIER  IA HEALTH VIRGINIA  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From pa  The director of nurs and revise policies assessemnt of self Staff could be provisystems could be in  TIME PERIOD FOR (21) days  MN Rule 4658.134.  Drugs used in the rin accordance with  This MN Requirem by: Based on observat review, the facility f were labeled correct observed during modes  Findings include:  R24 was observed pass on 8/12/14, at nurse (LPN)-A was Novolog insulin to f was noted to direct (sq) three times a co Administration Rec directed Novolog in 25 u sq once in the EMAR directed the be given twice a da call the pharmacy t the label on the ins	OF CORRECTION  O0603  PROVIDER OR SUPPLIER  STREET AD  A HEALTH VIRGINIA CARE CENT  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 28  The director of nurses or designee could review and revise policies and procedures related to assessemnt of self administration of medications. Staff could be provided education and monitoring systems could be initiated to ensure compliance.  TIME PERIOD FOR CORRECTION: Twenty one (21) days  MN Rule 4658.1345 Labeling of Drugs  Drugs used in the nursing home must be labeled in accordance with part 6800.6300.  This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were labeled correctly for 1 of 7 residents (R24) observed during medication administration.  Findings include:  R24 was observed during medication medication pass on 8/12/14, at 9:00 a.m. Licensed practical nurse (LPN)-A was observed to administer Novolog insulin to R24. The Novolog insulin label was noted to direct 30 units (u) subcutaneous (sq) three times a day. The electronic Medication Administration Record (EMAR) dated 7/29/14, directed Novolog insulin 30 u sq twice a day and 25 u sq once in the evening. LPN-A verified the EMAR directed the 30 u of Novolog insulin was to be given twice a day. The LPN stated she would call the pharmacy to have the pharmacy change	OF CORRECTION DOMOS B. WING DO	PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  901 9TH STREET NORTH WIRGINIA, MN 55792  SLIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 28  The director of nurses or designee could review and revise policies and procedures related to assessment of self administration of medications. Staff could be initiated to ensure compliance.  TIME PERIOD FOR CORRECTION: Twenty one (21) days  MN Rule 4658.1345 Labeling of Drugs  Drugs used in the nursing home must be labeled in accordance with part 6800.6300.  This MN Requirement is not met as evidenced by:  Based on observation, interview and document review, the facility failed to ensure medications were labeled correctly for 1 of 7 residents (R24) observed during medication administration.  Findings include:  R24 was observed during medication medication pass on 81/12/14, a 9:00 a.m. Licensed practical nurse (LPN)-A was observed to administer Novolog insulin to R24. The Novolog insulin label was noted to direct 30 units (u) subcutaneous (sq) three times a day. The electronic Medication Administration Policy.  4 monitoring will be done by comp was reviewed and revised as neced thanged and procedure aday and 25 u sq once in the evening. LPN-A verified the EMAR directed the 30 u of Novolog insulin nations train or of labels, medications and physicia orders. Nursing staff will be re-edulated the EMAR directed the 30 u of Novolog insulin was to be given twice a day. The LPN stated she would call the pharmacy to have the pharmacy change the label on the insulin. The LPN stated there was serviced to the QI team who will mecommendations for orgoing	OF CORRECTION OBORS B. WING 08/1  PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  A HEALTH VIRGINIA CARE CENT OTH STREET NORTH VIRGINIA, MN 55792  B. WING PROVIDER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFYING INFORMATION)  Continued From page 28  The director of nurses or designee could review and revise policies and procedures related to assessement of self administration or medications. Staff could be provided education and monitoring systems could be initiated to ensure compliance.  TIME PERIOD FOR CORRECTION: Twenty one (21) days  MN Rule 4658.1345 Labeling of Drugs 21620  Drugs used in the nursing home must be labeled in accordance with part 6800,6300.  This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were labeled correctly for 1 of 7 residents (R24) beserved during medication administration.  Findings include:  R24 was observed during medication medication pass on 8/12/14, at 9:00 a.m. Licensed practical nurse (LPN)-A was observed to administer Novolog insulin 30 u sq twice a day and 25 u sq once in the evening. LPN-A verified the EMAR directed the 30 u of Novolog insulin 30 u sq twice a day and 25 u sq once in the evening. LPN-A verified the EMAR directed the 30 u of Novolog insulin was to be given twice a day. The LPN stated she would call the pharmacy to have th	

AND DIAN OF CORRECTION INTERPRETATION NUMBERS		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00603	B. WING		08/1	5/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AC	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	Continued From pa	ige 29	21620			
	changed, just call the label.	he pharmacy to change the				
	the Novolog insulin Novolog insulin 30 (	rders signed 7/29/14, indicated order was changed from u sq three times a day to u sq twice a day and Novolog e evening meal.				
	stated the pharmac through the facility's	a.m. registered nurse (RN)-A cy would get the order change s computer system. The would send up a new label for				
	Suggested methods	s of correction:				
	and revise policies a monitoring for accu could be provided e	sing or designee could review and procedures related to trage medication labeling. Staff education related to the itoring system could be compliance.				
	Time period for corr	rection: Twenty one (21) days.				
21695	MN Rule 4658.1415 Housekeeping, Ope	5 Subp. 4 Plant eration, & Maintenance	21695			9/16/14
	provide housekeepi necessary to mainta comfortable interior	eeping. A nursing home must ing and maintenance services ain a clean, orderly, and r, including walls, floors, fixtures, equipment, lighting,				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00603 B. WING			08/15/2014		
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/1	0/2014
	IA HEALTH VIRGINIA	CARE CENT 901 9TH S	STREET NOF , MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21695	This MN Requirements: Based on observation review, the facility of were maintained in 11 of 76 resident ro 340, 346, 418, 422. Findings include:  During an environment, with the secret environment service observed.  Room 324, had a capproximately four small orange stain.  Room 334, had large bathroom, inside downli.  Room 338, had was bed that was lifting and the paint under inside bathroom engouged.  In Room 340, the wascraped and had ta of bathroom was balong side toilet was Room 346, the wall scraped near the had room 418, had scraped left lower edge.	ent is not met as evidenced ion, interview and document ailed to ensure resident rooms a sanitary homelike manner in ioms. (Rooms 324, 334, 338, 424, 426, 436, 437)  nental tour on 8/14/14, at 12:00 tary of facilities and es (SFES) the following was ircular pink stain inches by three inches and a in the carpet by window.  ge chips in the paint in the porway and on the opposite  Ilpaper behind the head of the at the seam and the edges meath was stained. The paint try was badly scraped and  vall at the head of the bed was upe marks. The corner in entry adly gouged and the grab bar	21695	1 Rooms 324,334,338,340,346,418,422.42 6,437 were cleaned, repaired and 2 All residents have the potential affected by the deficient practice. 3 Maintenance does a daily walk of the facility. When areas are not need repair an online workorder is placed. The Maintanence departm the work order and completes the based on priorities. They also hav schedule for routine maintenance are to report if there is a maintane concern. Staff were educated on online process for completing work	to be through ted to seent gets repair re a . All staff ence the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		o	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00603	B. WING _		08/	15/2014
NAME OF	PROVIDER OR SUPPLIER	STI	REET ADDRESS, CITY	, STATE, ZIP CODE		
ESSENT	IA HEALTH VIRGINIA	CARF CENT	1 9TH STREET NO RGINIA, MN 5579			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULI SC IDENTIFYING INFORMATION		PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
21695	Continued From pa	ge 31	21695			
		vall above the molding be sink was water stained led up.				
	Room 424, had seven the ceiling tiles in the	veral tan/rust colored sta ne bedroom area.	ns on			
	Room 426, had sev bedroom area.	veral stained ceiling tiles	in the			
	Room 436, had star on them.	ining on ceiling tiles with	stains			
	Room 437, had ma walls.	ny scrapes on the bathro	oom			
	she shampoos the sees them. Had not room 324. On 8/14/14, at 1:00 facility had an elect schedule system th scheduled for prevention of the second sec	5 p.m. housekeeper-A sistains in the carpets when the stains on the first seen the stains on the first seen the SFES stated the tronic preventive mainternat directs staff on areas entive maintenance. In a daily walk through of the first seen to put in an online ding repair.	en she loor in he lance			
	directed staff to loo	nift Rounds revised 12/24 k for abnormal condition wet or stained ceiling tile	s and			
	could review and re related to repair and care areas. Staff co related to the policion	s of correction: services director or desi evise policies and proced d maintenance of resider ould be provided education es and a monitoring system of ensure compliance.	ures nt on			

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
7.1.12 1 2 111	o. co20		A. BUILDING:			
		00603	B. WING		08/1	5/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH VIRGINIA	CARECENT	TREET NOF MN 55792	RTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21695	Continued From pa	ge 32	21695			
	Time period for cor	rection: Twenty one (21) days.				
21800	• •	651 Subd. 4 Patients & ac.Bill of Rights	21800			9/16/14
	Residents of HC Fac.Bill of Rights  Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.					
	This MN Requireme	ent is not met as evidenced				

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792    Year   Description   PREETY   PROVIDER STATE ADDRESS, CITY, STATE, ZIP CODE 901 9TH STREET NORTH VIRGINIA, MN 55792    Year   Description   PREETY   PROVIDER STATE ADDRESS, CITY, STATE, ZIP CODE   Year   Description   PREETY   PREETY	-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
SUMMARY STATEMENT OF DEFICIENCIES   TAG			00603	B. WING	WING 08/		5/2014
CAN   ID   PROVIDER'S PLAN OF CORRECTION   CANCELLY	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
21800 Continued From page 33 by: Based on interview and document review, the facility failed to provide liability notices and appeal rights.  Findings include: Findings include:  Findi	ESSENT	IA HEALTH VIRGINIA	CARECENT		<b>RTH</b>		
by: Based on interview and document review, the facility failed to provide liability notices for 2 of 4 residents (R31, R14) reviewed for liability notices and appeal rights.  Findings include:  R31's electronic medical record (EMR), indicated R31 was admitted to the facility in 3/2014, and discharged in 4/2014, and receiving physical and occupational therapy services due to weakness from pneumonia.  R14's EMR, indicated R14 was admitted to the facility in 5/2014, for 11 days of stay in the facility, and was receiving treatment following a hip joint replacement due to osteoarthrosis.  On 8/13/14, at approximately 10:30 a.m. R31's and R14's Notices of Medicare Non-Coverage were requested from the facility. On 8/13/14, at 2:50 p.m. registered nurse (RN)-D stated she was not able to locate either R31's or R14's Liability Notices were usually filed in the residents' medical records when given and signed by either the resident or the resident's representative.  On 8/14/14, at 3:00 p.m. the director of nursing (DON) stated she was aware R31's and R14's liability notices could not be located. The DON further stated the signed notices were usually placed in the back of the resident's charts. The	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	COMPLETE
liability notices were provided for R31 and R14.  A policy on Notice of Medicare Non-Coverage  The audit results will be reported to the quarterly QI team which will make reccomendations for ongoing monitoring.	21800	by: Based on interview facility failed to prove residents (R31, R14 and appeal rights.  Findings include: R31's electronic me R31 was admitted to discharged in 4/201 occupational therapter from pneumonia. R14's EMR, indicate facility in 5/2014, and 11 days of stay in the treatment following osteoarthrosis.  On 8/13/14, at appear and R14's Notices of were requested from 2:50 p.m. registered was not able to local Liability Notices and further stated the Lifiled in the residents and signed by either representative.  On 8/14/14, at 3:00 (DON) stated she will liability notices could further stated the signal placed in the back of DON verified the late liability notices were	and document review, the vide liability notices for 2 of 4 d) reviewed for liability notices do the facility in 3/2014, and 4, and receiving physical and by services due to weakness and discharged in 5/2014, for the facility, and was receiving a hip joint replacement due to doximately 10:30 a.m. R31's of Medicare Non-Coverage on the facility. On 8/13/14, at did nurse (RN)-D stated she are either R31's or R14's did Appeal Rights forms. RN-D ability Notices were usually so medical records when given or the resident or the resident's did not be located. The DON gned notices were usually of the residence to indicate the exprovided for R31 and R14.	21800	1. Residents #31 and #14 were discharged in April and May 2014. 2. All residents could be affected the deficient practice. Residents will be evaluated during their intake screed Medicare coverage using Medicar coverage guidelines. During their continued coverage will be review input from nursing and therapy to determine ongoing coverage appropriateness. 3. As soon as a decision is made. Medicare Part A will be ending the nurse will initiate denial letters to ror responsible party. At least 48 he before Medicare stay ends the resident face if they are the responsible paget signature after the resident staunderstanding of the form, or responsible request either the form will be mai will be available fr them to sign at The denial letters will be scanned Matrix system under Medicare and progress note will be writtenstating letter was delivered. The Medicare was reviewed and revised as nece All RN's were educated on Medicare coverage quidelines and Medicare coverage policy. 4. Denial letter audit will be added admission and discharge checklis Audits will be done weekly to ensudenial letters are in the residents of The audit results will be reported to quarterly QI team which will make	e ening for re ening for re estay ed with that MDS esident ours esident or ers. I face to rty and ates ening for it EHVCC. Into the day the ening	

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			B. WING			
		00603	<u> </u>		08/1	5/2014
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S STREET NO!	STATE, ZIP CODE		
ESSENT	IA HEALTH VIRGINIA		, MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21800	Continued From pa	ge 34	21800			
	was requested and	none was provided.				
	SUGGESTED MET	HOD FOR CORRECTION:				
		sing (DON) or designee could nent policies and procedures				
	to ensure that resid	lents receive the required				
	Medicare denial an	d appeal rights notices; nen develop monitoring				
	systems to ensure	ongoing compliance and				
	report the findings to Committee.	to the Quality Assurance				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one				