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.
(L1) **245458**

2.STATE VENDOR OR MEDICAID NO.
(L2) **936325400**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH VIRGINIA CARE CENT**
(L4) **901 9TH STREET NORTH**
(L5) **VIRGINIA, MN** (L6) **55792**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2013**

6. DATE OF SURVEY **09/26/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **90** (L18)

13.Total Certified Beds **90** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Patricia Halverson, Unit Supervisor 10/01/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 10/10/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS
Posted 10/13/2014 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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 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

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245458	A. Building B. Wing	9/26/2014

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA HEALTH VIRGINIA CARE CENT	901 9TH STREET NORTH VIRGINIA, MN 55792

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
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(l** LSC	Correction Completed **09/16/2014**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **09/16/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **09/16/2014**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **09/16/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/16/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/16/2014**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **09/16/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **09/16/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **09/16/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/16/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **09/16/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PLH/mm	10/01/2014	12835	09/26/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/15/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to 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**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: P40F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00603

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(L1) **245458**
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(L2) **936325400**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH VIRGINIA CARE CENT**
(L4) **901 9TH STREET NORTH**
(L5) **VIRGINIA, MN** (L6) **55792**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2013**
6. DATE OF SURVEY **08/15/2014** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **90** (L18)
13.Total Certified Beds **90** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room
X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Chris Elmgren, HFE NEII 09/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 09/29/2014 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 10/13/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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:

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

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

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

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

Informal Dispute Resolution - 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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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:

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,

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 5458s14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245458	A. BUILDING _____ B. WING _____	08/15/2014

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 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. 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. On August 11-15, 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245458	A. BUILDING _____ B. WING _____	08/15/2014

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

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F 000	Continued From page 1 after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		9/16/14

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	245458	A. BUILDING _____ B. WING _____	08/15/2014

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

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F 156	Continued From page 2 and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification	F 156		

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F 156	Continued From page 3 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced 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, and discharged in 5/2014, for 11 days of stay in the facility, and was receiving treatment following a hip joint replacement due to osteoarthrosis.	F 156	1. Residents #31 and #14 were discharged in April and May 2014. 2. All residents could be affected by the deficient practice. Residents will be evaluated during their intake screening for Medicare coverage using Medicare coverage guidelines. During their stay continued coverage will be reviewed with input from nursing and therapy to determine ongoing coverage appropriateness. 3. As soon as a decision is made that Medicare Part A will be ending the MDS nurse will initiate denial letters to resident or responsible party. At least 48 hours before Medicare stay ends the resident or responsible party will be given letters. Nurse will either speak to resident face to	

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F 156	Continued From page 4 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 and Appeal Rights forms. RN-D further stated the 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 DON verified the lack of evidence to indicate the liability notices were provided for R31 and R14. A policy on Notice of Medicare Non-Coverage was requested and none was provided.	F 156	face if they are the responsible party and get signature after the resident states understanding of the form, or responsible party will be called. Per responsible parties request either the form will be mailed or it will be available for them to sign at EHVCC. The denial letters will be scanned into the Matrix system under Medicare and a progress note will be written stating the letter was delivered. The Medicare policy was reviewed and revised as neccesary. All RN's were educated on Medicare coverage quidelines and Medicare coverage policy. 4. Denial letter audit will be added to the admission and discharge checklists. Audits will be done weekly to ensure denial letters are in the residents chart. The audit results will be reported to the quarterly QI team which will make reccomendations for ongoing monitoring.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess safety for self administration of medications for 2 of 2 residents (R54, R43) observed to self administer medications.	F 176	1. A self-administration of medications was completed for residents #54 and #43. Care plans were updated. 2. All residents could be affected by the deficient practice. All residents are	9/16/14

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F 176	Continued From page 5 Findings include: R54 was not observed during self administration of medications despite being assessed as unsafe to self administer any medications. On 8/12/14, at 9:40 a.m. during an interview with R54, licensed practical nurse (LPN)-A placed a medication cup with approximately five or six pills on the overbed table. LPN- a briefly stood in the doorway and asked if R54 was taking his medications and then left. LPN-A left the area and returned at 9:48 a.m. to check if R54 took the medications. The Resident Administration Record dated 2/24/14, indicated R54's diagnoses included type two diabetes, spinal stenosis, esophageal reflux, glaucoma, hypertension, anxiety and pain. R54's psychosocial well being care plan dated 5/23/14, indicated R54 had memory problems related to cognitive deficits. R54 required reminders, cues and supervision for all activities of daily living, meals and daily routine. R54's quarterly minimum data set (MDS) indicated R54 was cognitively intact. The Self Administration of Medication Assessment (SAM) dated 8/3/14, indicated R54 did not want to SAM. R54 had moderately impaired decision making skills and had a history of noncompliance with medications and was not appropriate to SAM. On 8/13/14, at 1:35 p.m. LPN-A stated she leaves R54 with his medications, stays in the area and then "pops back in" to make sure he has taken	F 176	assessed upon admission for competency or desire to self-adminiater medications and/or treatments such as nebulizer treatments. Self- administraton of medications assessments are reviewed quarterly on all residents following the MDS schedule. 3. Audits will be done to observe that licensed staff follow residents plan of care for self-administering of medications and/or treatments. it is identified on the eMar and the careplan if the resident may self administer medications.Licensed staff will follow up with the resident to identify whether they completed the treatment or took their medications as identified. The self-administration of medication plicy was reviewed and revised as neccesary. Nursing staff were educated on self-administration of medications assessment and careplanning process. 4. Three audits will be done weekly for two months to ensure proper administration of medications and/or treatments. Ongoing audits will be completed based on the results of the audits. The audit results will be reported to the quarterly QI team which will make recommendations for ongoing monitoring.	

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F 176	Continued From page 6 them. On 8/14/14, at 9:44 a.m. registered nurse (RN)-A verified R54 was not to SAM and the nurse should wait and watch R54 take his medications. R43 was not assessed to be safe to self administer inhaled medications. On 8/13/14, at 1:19 p.m. R43 was observed alone in his room, seated in the recliner with a nebulizer treatment administered via face mask. At 1:30 p.m. LPN-B came down the hall from the nurses desk, removed the nebulizer mask and turned off the nebulizer machine. 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. On 8/13/14, at 1:43 p.m. LPN-B stated she leaves R43 alone to do the nebulizer and was told when R43 transferred from from the fourth floor he could be left alone with the nebulizer after it was set up. On 8/13/14, at 2:00 p.m. RN-B verified the SAM assessment indicated R43 was not to be left alone with the nebulizer. RN-B expected staff to stay with R43 while the nebulizer was running. The facility's Self Administration of Medications policy effective 9/24/10, indicated all residents would have a SAM observation completed upon admission, change in condition and as deemed	F 176		

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F 176	Continued From page 7 necessary. Residents who wished to SAM would be reviewed by the interdisciplinary team (IDT) to determine appropriateness.	F 176		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop comprehensive care plans for 1 of 3 residents (R52) for falls; for 1 of 1 residents (R3) reviewed for oxygen use; for 1 of 3 residents (R97) reviewed for oral hygiene; for 1 of 2 residents (R14) for skin conditions, and 1 of 5 residents (R43) for anticoagulant and pain medications.	F 279	1 Comprehensive care plans for residents #52, 97,14,43 and 3 were reviewed and revised to include falls,oxygen use, oral hygiene, skin conditions,pain and anticoagulatin medications. 2 All residents require comprehensive, individualized plans of care based on	9/16/14

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F 279	Continued From page 8 Findings include: R52's admission Minimum Data Set dated 6/5/14, indicated no falls prior to admission. The falls Care Area Assessment (CAA) dated 6/5/14, indicated R52 was at risk for falls related to decreased functional mobility secondary to recent left hip replacement, being non ambulatory and required the extensive assist of two staff for transfers. The CAA indicated a falls care plan was required with suggested interventions of call light and frequently used items within reach at all times and non-slip foot wear for all transfers. R52's care plan, dated 6/5/14, indicated diagnoses that included muscle weakness, osteoarthritis and generalized pain. The did not address the risk of falls or suggested interventions. The nurses aide worksheet directed extensive assistance for transfers and while walking with a walker, but did not address the risk of falls. R52's Fall risk assessment dated 8/11/14, indicated, "Resident is at risk for falls and has had 1 fall in the past quarter. Self-locking w/c put in place [sic] for resident safety and to prevent falls... Will continue to monitor for fall risk. Will continue current plan of care." Registered Nurse (RN)-B, interviewed on 8/14/14, at 12:15 p.m., verified the lack of care planning related to falls. R3's physician's orders dated 6/20/14, indicated diagnoses that included congestive heart failure, shortness of breath, pleural effusion, malaise and	F 279	needs identified during the assessment process. 3 The Care Planning Policy was reviewed and revised as neccesary. Nursing staff were educated on CAA's, care planning for all triggered problems that have been decided to be care planned, also any other problem that affects the residnet's 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 Coumadin use, pain, skin condition, oxygen, risk for falls and oral hygiene. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported to the quarterly QI team. The QI team will make recommendations for ongoing monitoring.	

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F 279	Continued From page 9	F 279		

fatigue. The orders included oxygen (O2) at 2.0 liters per minute during the night, day and evening.

R3's admission MDS, dated 6/9/14, indicated R3 utilized O2 prior to admission and in the facility.

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.

R3 was asleep in bed on 8/14/14, at 7:00 a.m. with nasal canulla for O2 connected to a portable tank on the wheel chair. The gauge on the O2 tank was pointing to the red area indicating the need for refill. The wall mounted O2 delivery system was not in use.

RN-C stated, on 8/14/14, at 8:40 a.m., the wall unit was functional and should be utilized for R3 in the room. RN-C stated care plan should address the use of O2 for R3.
R97 was observed, on 8/12/14, at 1:40 p.m. with large amount of white and pink colored debris around the bottoms of lower teeth. On 8/14/14, at 9:24 a.m., R97 was lying in bed and mouth was partially open. There was a thick coating on the lower teeth and between lips.

The annual MDS dated 7/16/14, indicated R97 had severe cognitive impairment and required extensive assistance of one staff for personal hygiene, bed mobility, transfers, locomotion, dressing, eating, and toilet use.

R97's care plan dated 5/24/14, directed extensive assist of one for grooming. The care plan lacked direction for oral hygiene or dental care. The nursing assistant care sheets lacked direction for

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F 279	Continued From page 10 care of teeth. RN-B, interviewed on 8/14/14, at 9:57 a.m. verified oral cares were not addressed in R97's care plan. R14 was observed to have three bruises on the top of the right hand on 8/11/14, at 6:56 p.m. R14 stated she was prone to bruising. R14's admission MDS dated 6/14/14, indicated moderate cognitive deficit and required extensive assistance of one staff for personal hygiene, bed mobility, transfers, locomotion in the wheelchair, dressing, and toilet 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. RN-B, interviewed on 8/13/14, at 1:25 p.m., stated that when residents were prone to bruising the care plan should address the problem and monitoring. Facility was unable to provide policy and procedure for care planning. R43's care plan did not address the use of Coumadin [an anticoagulant medication] and the use of a narcotic and non-narcotic pain medications. R43's signed Physician's Orders dated 6/19/14, included Coumadin (anticoagulant) 2 mg oral daily on Sunday, Tuesday, Thursday, and	F 279		

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Saturday, and 4 mg oral on Monday, Wednesday, and Friday; and Tylenol 325 mg oral every 4 hours as needed. R43's Physician's Orders dated 8/2/14, directed R43 to receive Norco 5.0/325 mg 1 tab oral every 6 hours prn [as needed].

R43's quarterly MDS dated 6/29/14, indicated R43's diagnoses included chronic obstructive pulmonary disease, congestive heart failure, and hypertension. The MDS further indicated R43 was cognitively intact and was receiving a scheduled pain medication.

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.

On 8/13/14, at 1:20 p.m. RN-B stated the facility had changed over to a new electronic medical record system earlier this year and the ETAR and care plan entries to address side effect monitoring were missed. RN-B stated R43's use of Coumadin should be care planned for the monitoring of adverse effects and side effects of the medication. RN-B further confirmed R43's care plan lacked a problem statement and approaches for R43's pain monitoring to include non-pharmacological interventions.

On 8/14/14, at 3:00 p.m. the director of nursing (DON) stated significant medications side effect monitoring should be care planned and included

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F 279	Continued From page 12 on the ETAR in the residents' electronic medical records. A Care Plan policy revised 12/3/13, indicated a resident's plan of care would be initiated in the electronic system and would address care areas such as clinical issues and treatments.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop temporary care plans for 1 of 3 residents (R142) for pressure ulcers and for 1 of 1 residents (R144)	F 280	1. Resident #142's care plan was revised to address pressure ulcers. Resident #144's careplan was revised to address isolation precautions.	9/16/14

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F 280	Continued From page 13 for contact precautions. Findings include: A temporary care plan was not developed to address R142's pressure ulcer care. R142's admission Minimum Data Set (MDS) dated 8/12/14, indicated diagnoses that included a pressure ulcer on hip. The MDS further indicated R142 had moderate cognitive impairment, required extensive assistance with bed mobility and transfers, and was assessed to be at risk for the development of pressure ulcers. The MDS further indicated R142 was admitted with with 1 unstageable pressure ulcer with suspected deep tissue injury. The MDS described the pressure ulcer as measuring 6.5 cm in length by 9.9 cm in width, with eschar tissue present in the wound bed. The MDS also indicated R142's ulcer treatments included a pressure reducing device for the chair and bed, nutrition or hydration interventions to manage skin problems, pressure ulcer care, and the application of nonsurgical dressings. R142's Physician Order Report dated 8/5/14, directed to change the Aquacel dressing on right hip every 12 to 24 hours depending on the saturation level. On 8/14/14, at 2:15 p.m. registered nurse (RN)-C stated confirmed R142's care plan lacked a problem statement, goals, or any interventions related to R142's right hip pressure ulcer. RN-C stated R142's care plan should have addressed the pressure ulcer care. RN-C verified a temporary care plan could not be located.	F 280	2. All residents could be affected by the deficient practice. All residents will have temporary plans of care completed within 24 hours of admission. 3. The temporary care plan form will be put into all admission packets. The admitting nurse will complete the temporary care plan. The temporary care plan will be updated and revised prnuntil the comprehensive care plan is completed. The Care Planning Policy was reviewed and revised as appropriate. 4. The Nursing Manager will review all newly admitted residents to ensure that a temporary care plan is in place. A minimum of three audits will be done weekly to ensure compliance . Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported to the quarterly QI team. The QI team will make recommendations for the ongoing monitoring.	

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F 280	Continued From page 14 On 8/14/14, at 3:00 p.m. the director of nursing (DON) stated a temporary care plan needs to be developed within the first 24 hours upon admission to the facility and should include pressure ulcer care. A temporary care plan was not developed and in place to address R144's contact isolation precautions. R144's Resident Admission Record (undated) indicated R144's diagnoses included MRSA [Methicillin-resistant Staphylococcus Aureus] infection and toe cellulitis/abscess. R144's admission MDS dated 8/8/14, indicated R144 was cognitively intact and had an infection with applications of dressings to the feet. R144's Care Plan dated 8/4/14, to 8/14/14, did not indicate contact precautions for MRSA infection. On 8/14/14, at 2:15 p.m. RN-C confirmed the care plan lacked directions for R144's MRSA infection. On 8/14/14, at 3:00 p.m. the DON confirmed the care plan should include information and direction for the infection and contact precautions, and the care plan information should be communicated to staff. On 8/15/14, at approximately 3:00 p.m. copies of R144's and R142's temporary care plans were requested, but was not provided. The facility's Care Plan policy revised 12/3/13, indicated a temporary care plan would be	F 280		

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F 280	Continued From page 15 completed and in place within 24 hours for newly admitted residents.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the use of oxygen (O2) was not provided appropriately for one of three residents (R3) observed for the use of O2; and hospice services were not coordinated for 1 of 1 residents (R42) reviewed for hospice. Findings include: R3's physician orders dated 6/20/14, indicated diagnoses that included congestive heart failure, shortness of breath, pleural effusion, malaise and fatigue. The orders included O2 at 2.0 liters per minute, every shift, nights, days and evenings. R3 was observed on 8/14/14, at 7:00 a.m. asleep in her bed with a nasal cannula for O2 connected to an O2 tank on the wheel chair. The gauge on the oxygen tank was pointing in the red area and noted, "Refill." R3 appeared in no acute distress. The wall mounted O2 delivery system was not in use and there was no humidifying "bubbler"	F 309	1 Resident #3 is deceased. Resident #42's hospice services were discontinued and her care plan was reviewed and revised. 2 All residents using oxygen or Hospice services have the potential to be effectedd by the deficient practice. 3 Policies and procedures for oxygen use have been reviewed and revised. The eMar will now have a task scheduled to monitor oxygen tanks. A meeting was held with Hospice Services to plan better communication between our facilities. The Hospice policy was reviewed. Nursing staff were educated on the oxygen and Hospice policies and where to find information regarding hospice residents. 4 Three audits will be done weekly for two months to ensure on-going compliance with oxygen use and tank replacement. Staff will be re-educated on an ongoing basis as needed based on the audit	9/16/14

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F 309	Continued From page 16 attached to the wall. On 8/14/14, at 8:31 a.m., R3 stated she was not feeling well and wished to remain in bed. Licensed practical nurse (LPN)-C entered the room, and when asked about the wall O2, stated she did not know why the wall was not used. LPN-C went to obtain tubing and a bubbler and connected R3 to the wall mounted O2 supply. When the portable O2 tank was removed from the wheel chair, the pressure gauge did not move when removed from the tank, indicating no pressure. The admission minimum Data Set, dated 6/9/14, indicated R3 utilized O2 prior to admission and in the facility. Nursing assistant (NA)- H, interviewed on 8/14/14, at 8:37 a.m., stated the nurse would be notified when a resident's O2 tank was near empty. Registered nurse (RN)-C stated, at 8:40 a.m., the wall unit was available for R3 and should automatically be used when R3 was in bed. The Director of Nursing stated, on 8/14/14 at 11:53 a.m., there was no formal monitoring of the O2 tank levels, but all staff should be checking it. R42's Admission Record dated 5/20/14, indicated diagnoses included subdural hemorrhage and chronic pain. R42's admission Minimum Data Set (MDS) dated 5/27/14, indicated R42 had short- and long- term memory deficits, had symptoms of delirium including continuous inattention and fluctuating	F 309	results. The monitoring results will be reported to the quarterly QI team. The QI team will make recommendations for ongoing monitoring.	

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F 309	Continued From page 17 disorganized thinking, was always incontinent of bowel and bladder, and was totally dependent in all activities of daily living (ADL's). The MDS further indicated R42 was not receiving scheduled or as needed [prn] pain medications, had no non-verbal indicators of pain, and was on hospice care. R42's care plan dated 5/22/14, indicated hospice services for end of life care related to subdural hemorrhage; comfort measurers as condition was irreversible and comfort was requested by patient and family. The goal was to be pain free and have good quality of life. R42's care plan approaches included provide pain medication as needed and/or requested, rest periods as needed and/or requested, nutrition and liquids for meals and snacks, turn and reposition every 2 hours and prn, spiritual care as requested and/or needed, anticipate grief and provide support to patient and family. R42's Hospice Team Care Plan dated 5/22/14, and printed 8/8/14, indicated the following hospice provider visits: * SN [Skilled Nursing]: 2 to 4 times per month for 3 months with 3 prn visits for symptom management. * MSS [Medical Social Services]: 3 prn visits for supportive care. * SCC [Spiritual Care Coordinator]: 3 prn visits for spiritual care. * BC [Bereavement Care]: 3 prn visits for grief support * AID [Hospice Aid]: 1 to 2 visits per week for 5 weeks and 3 prn visits for personal cares. * VO [Volunteer]: 1 to 4 times per month for 3 months.	F 309		

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F 309	Continued From page 18	F 309		

R42' Hospice Facility Contact forms (undated) were observed to be located on a clip board in the nurse manager's office on the third floor of the facility. The Contact forms indicated R42 had received no Hospice Aid visits in June, 2014, and 1 Hospice Aid visit on 7/28/14, 8/5/14, and 8/11/14. No Volunteer visits were indicated on the Contact forms from 5/23/14, to 8/14/14.

Home Health Aide Care Plan Tasks dated 7/16/14, 7/25/14, and 7/28/14, were provided by the facility upon request of the Hospice. The forms indicated R42 had received a Hospice Aid visit on those dates, but did not indicate the activity provided.

During the survey week of 8/11/14, through 8/14/14, R42 was observed on multiple occasions in the room and in the dining room of the facility.

On 8/13/14, at 2:00 p.m. licensed practical nurse (LPN)-D stated hospice does not come to the facility to visit R42 very often. LPN-D further stated she does not know if/when Hospice staff visit or what service was provided for R42

On 8/13/14, at 2:15 p.m. nursing assistant (NA)-A stated he was not aware of any hospice aide services having been provided for R42. NA-A further stated he thought R42 was no longer on Hospice.

On 8/14/14, at approximately 2:30 p.m. registered nurse (RN)-A stated Hospice coordination of care had improved in the facility. RN-A further stated Hospice staff and nursing home staff should be communicating when hospice is in the building. RN-A also stated R42 did not have a specific

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F 309	Continued From page 19 Hospice volunteer assigned to provide support. On 8/14/14, at 3:00 p.m. the director of nursing (DON) stated the coordination of care for Hospice services could be better. The DON further stated the nursing home staff should be aware what kind of hospice services were scheduled and what care was provided. An updated policy for Hospice process guidelines for LTC [long term care] and AL [assisted living] facilities was provided and indicated a Hospice communication sheet was to be kept in the patient closet. The policy further indicated hospice staff were to write on the communication sheet when visits were made. The policy also indicated hospice team member's progress notes for each visit would be faxed or delivered to the facility at least one time per week.	F 309		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329		9/16/14

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F 329	Continued From page 20 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide side effects monitoring of psychotherapeutic medications and anticoagulant medications or establish parameters for use of as needed pain medications for 4 of 5 residents (R73, R106, R54, R43) reviewed for unnecessary medications. Findings include: R73's Physician's Order Report signed on 8/13/14, included Tylenol Extra Strength 500 milligrams (mg) as needed twice a day for generalized pain and Tylenol 650 mg every four hours as needed, both without parameters for use. , and Seroquel 12.5 mg by mouth every day. R73's Resident Admission Record dated 6/17/14, dated 12/30/11, indicated diagnoses that included dementia with behavioral disturbances, paranoid state, anxiety, muscle spasm, falls and pain. The Minimum Data Set (MDS) dated 6/22/14, indicated R73 had severe cognitive impairment. R73's care plan did not address the use or monitoring side effects or effectiveness for Seroquel.	F 329	1 #73's order for Tylenol were reviewed and now include parameters for use. Her care plan was updated to include side effect monitoring and effectiveness of Seroquel. Resident #106's care plan was updated to include side effect monitoring and effectiveness and potential adverse effects related to use of Seroquel and Ativan. Resident # 54's care plan was updated to include Ativan, Celexa and Insulin use and monitoring for side effets and adverse effects. Resident #43's physicial orders and eMar were reviewed to ensure they are included all orders.Tylenol and Norco orders now include parameters for use. His care plan was updated to include the use of Coumadin, Tylenol and pain medications, effectiveness and side effect monitoring. 2 All residents recieving medications have have the potential to be impacted by a deficient practice in this area. 3 Nursing staff will work in collaberation with pharmcy and Nursing Unit Clerks to ensure parameters are included in orders	

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F 329	Continued From page 21 On 8/14/14, at 1:37 p.m. registered nurse (RN)-A verified the lack of parameters for use of Tylenol and that monitoring for side effects and effectiveness of Seroquel should be included on the care plan. R106's Physician's Order Report signed on 8/7/14, included Seroquel 12.5 mg by mouth daily and Ativan 0.5 mg by mouth every four hours as needed for anxiety. The Resident Admission Record dated 6/17/14, indicated diagnoses that included a hip fracture, malaise/fatigue, dementia with depression and anxiety. R106's care plan did not address use/monitoring for effectiveness and potential adverse effects related to use of Seroquel and Ativan. On 8/14/14, at 1:33 p.m. RN-A verified 106's care plan should address Seroquel or Ativan. R54 R54's Physician's Order Report signed on 7/10/14, included Ativan 0.5 mg by mouth once a morning and 1 mg by mouth at bedtime for anxiety. Celexa (antidepressant medication) 10 mg by mouth once a day, and Lantus insulin 8 units subcutaneous at bedtime. The Resident Admission Record dated 2/24/14, indicated R54's diagnoses included type two diabetes and anxiety. R106's care plan lacked Ativan, Celexa and insulin use, monitoring for effectiveness and side effects. On 8/14/14, at 1:46 p.m. RN-A verified the care plan did not address the use of Ativan, Celexa and insulin.	F 329	for medications which require parameters.Nursing stass will review care plans, observations and progress notes to ensure psychoactive medications are addressed.Medication monitoring policy was reviewed and revised as necessary. Nursing staff were educated on medication administration and monitoring policies. 4 Three eMars and care plans will be audited each week to ensure compliance. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported to the quarterly QIteam. The QI team will make recommendations fo ongoing monitoring.	

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F 329	Continued From page 22 R43's signed Physician's Orders dated 6/19/14, included Coumadin (anticoagulant) 2 mg oral daily on Sunday, Tuesday, Thursday, and Saturday, and 4 mg oral on Monday, Wednesday, and Friday; and Tylenol 325 mg oral every 4 hours as needed. R43's Physician's Orders dated 8/2/14, directed R43 to receive Norco 5.0/325 mg 1 tab oral every 6 hours prn [as needed]. R43's quarterly MDS dated 6/29/14, indicated R43's diagnoses included chronic obstructive pulmonary disease, congestive heart failure, and hypertension. The MDS further indicated R43 was cognitively intact and was receiving a scheduled pain medication. 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. On 8/13/14, at 1:20 p.m. RN-B stated the facility had changed over to a new electronic medical record system earlier this year and the ETAR and care plan entries to address side effect monitoring were missed. RN-B stated R43's use of Coumadin should be care planned for the monitoring of adverse effects and side effects of the medication. RN-B further confirmed R43's care plan lacked a problem statement and approaches for R43's pain monitoring to include non-pharmacological interventions.	F 329		

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F 329	Continued From page 23 On 8/14/14, at 3:00 p.m. the director of nursing (DON) stated significant medications side effect monitoring should be care planned and included on the ETAR in the residents' electronic medical records. A Care Plan policy revised 12/3/13, indicated a resident's plan of care would be initiated in the electronic system and would address care areas such as clinical issues and treatments.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the	F 334		9/16/14

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F 334	Continued From page 24 influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334		

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F 334	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a pneumococcal vaccine (for pneumonia) was administered to 1 of 5 residents (R77) reviewed for vaccines. Findings included: The annual Minimum Data Set (MDS) dated 7/17/14, indicated R77 had not received a pneumococcal vaccine because it was not offered. The MDS also indicated R77 was cognitively intact, was able to communicate clearly, understand others, and did not reject care. The face sheet updated on 7/2/14, indicated R77 had diagnoses including anemia (low hemoglobin/iron), chronic pain, esophageal reflux (heartburn), allergic rhinitis due to pollen (allergies to pollen), and hypertension (high blood pressure). An authorization, consent and release form signed by R77 on 9/15/11, indicated R77 was provided the education on risks and benefits of a pneumococcal vaccine and consented to administration of the vaccine. The resident vaccination and mantoux record initiated on 9/13/11, lacked evidence that R77 had received a pneumococcal vaccine. During an interview on 8/14/14, at 1:00 p.m. the infection control coordinator (ICC) stated she tracked resident vaccines and provided an infection control status record that did not indicate	F 334	1 Resident #77 was interviewed and asked if she wanted a pneumococcal vaccination. Vaccinationwas given per her wishes. Tuberculosis baseline symptoms screenings were completed for residents #8,77,102,97 and 43. 2 All residents have the potential to be impacted by a deficient practice in this area. 3 Influenza and Pneumococcal vaccination policy was reviewed. All nursing staff were re-educated on the policy. 4 Three chart audits will be completed each week to ensure ongoing compliance. The monitoring results will be reported to the quarterly QI team. The QI team will make recommendations for ongoing monitoring.	

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F 334	Continued From page 26 R77 had received a pneumococcal vaccine. The ICC verified R77 had not received a pneumococcal vaccine. The facility failed to provide a policy and procedure for immunizations for residents.	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356		9/16/14

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F 356	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to post the correct facility census number along with the actual hours worked for both licensed and unlicensed staff on the daily nurse staffing posting. This had the potential to affect all of the 80 residents residing in the facility, as well as family members, and any visitors who may have chosen to view the information. Findings include: During the initial tour of the facility on 8/12/14, at 1:45 p.m. the facility's nurse staff posting was observed to be located tacked to a bulletin board on the wall near the entrance to both the third and fourth floor resident areas. The Report of Nursing Staffing Directly Responsible for Resident Care form from both the third floor posting and the fourth Floor posting was observed to document the resident census as a total of 82, 50 residents on the third floor and 32 residents on the fourth floor. The Report form was further observed to contain no actual hours worked for the RN's (registered nurses), LPN's (licensed practical nurses), or NAR's (nursing assistants - registered). On 8/13/14, at 2:10 p.m. the director of nursing (DON) stated the resident census on 8/11/14, was 79 plus one resident on a bed hold for hospitalization for a total of 80 total. The DON confirmed she had said the resident census on the survey entrance date of 8/12/14, was 80. The DON further stated the staffing coordinator	F 356	1 The Posted Nurse Staffing information form has bveen revised to include actual hours worked for licensed and unlicensed staff. 2 All residents, family and visitors could be affected by the deficient practice. 3 A policy for Nurse Staffinf Posting has been created. The night staff will complete the daily posting form using the census of the facility at midnight. The form will be updated as necesasary by the staffing coordinator or supervisor based on staffing changes during the day.All staff were educated on the new policy and updated poasting form. 4 Audits will be completed three times per week to check the accuracy of the daily posting form.Staff will be re-educated as needed based on the results of the sudits. The monitoring results will be reported tot he quarterly QI team who will make recommendations for ongoing compliance.	

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F 356	Continued From page 28 completes the nurse staff posting for the next day and the night shift is responsible for actually putting the posting information on the walls designated on both the third and fourth floors of the facility. The DON also stated she was not aware the actual hours worked of the licensed and unlicensed staff needed to be posted. The DON further stated the facility used to post the actual hours worked, along with total hours at one time. On 8/14/14, at approximately 10:30 a.m. the DON stated the resident census on 8/12/14, should have been 81. The DON further stated the facility had the one bed hold as a resident went to the hospital that morning,, and another two residents had been admitted during the day and one had been discharged. not 82. The DON confirmed residents on a bed hold should be included in facility census. The DON reported the facility did not have a policy on the nurse staffing posting. On 8/14/14, at 3:00 p.m. the staffing coordinator (SC)-F stated she was not aware the actual hours worked by licensed and unlicensed staff needed to be included on the nurse staffing posting. The SC-F further stated the actual hours worked used to be included on the posting however had not been included for quite some time.	F 356		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431		9/16/14

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F 431	Continued From page 29 controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This 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	F 431	1 The medication label was correctly labeled for resident #24's insulin. 2 All residents could be affected by the deficient practice. 3 The medication Administration policy was reviewed and revised as necessary. The pharmacy staff were consulted on correct process for label changes. All nursing staff were educated on the	

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F 431	Continued From page 30 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 the label on the insulin. The LPN stated there was no other way to indicate when an order was changed, just call the pharmacy to change the label. The Physician's Orders signed 7/29/14, indicated the Novolog insulin order was changed from Novolog insulin 30 u sq three times a day to Novolog insulin 30 u sq twice a day and Novolog insulin 25 u with the evening meal. On 8/14/14, at 9:49 a.m. registered nurse (RN)-A stated the pharmacy would get the order change through the facility's computer system. The pharmacy usually would send up a new label for the medication.	F 431	Medication Administration Policy. 4 monitoring will be done by completing three audits weekly to check for accuracy of labels, medications and physician orders. Nursing staff will be re-educated as needed based on the results of the audits. The internal eMar process was also reviewed relating to orders sent to the pharmacy. The monitoring results will be reported to the QI team who will make recommendations for ongoing compliance.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		9/16/14

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F 441	Continued From page 31 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow infection control standards during dressing changes for 2 of 2 residents (R142, R144) observed for wound care; during blood glucose monitoring procedures for 1 of 1 residents (R147) observed during blood glucose monitoring; and during provision of care for 1 of 1 residents (R144) with isolation precautions. In addition, influenza immunization	F 441	1 The direst caregiver responsible for resident #142's dressing changes was re-educated on proper infection control techniue related to changing gloves and washing hands between changes of gloves. Resident 3 144's comprehensive care planwas updated to include contact isolation precautions.	

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F 441	Continued From page 32 education was not provided for 5 of 5 residents (R97, R102, R43, R8, R77) whose immunizations were reviewed. Findings include: R142's pressure ulcer dressing change procedure was not completed using appropriate infection control standards. R142's admission Minimum Data Set (MDS) dated 8/12/14, indicated diagnoses that included a pressure ulcer on hip. The MDS further indicated R142 had moderate cognitive impairment, required extensive assistance with bed mobility and transfers, and was assessed to be at risk for the development of pressure ulcers. The MDS further indicated R142 was admitted with with 1 unstageable pressure ulcer with suspected deep tissue injury. The MDS described the pressure ulcer as measuring 6.5 cm in length by 9.9 cm in width, with eschar tissue present in the wound bed. The MDS also indicated R142's ulcer treatments included a pressure reducing device for the chair and bed, nutrition or hydration interventions to manage skin problems, pressure ulcer care, and the application of nonsurgical dressings. R142's Physician Order Report dated 8/5/14, directed to change the Aquacel dressing on right hip every 12 to 24 hours depending on the saturation level. On 8/14/14, at 10:26 a.m. licensed practical nurse (LPN)-C was observed to provide pressure ulcer dressing change to R142's right hip. LPN-C applied blue, disposable gloves to her hands and knelt down on the floor facing R142's bedside.	F 441	Resident #147's nurses were re-educated on proper procedure for glucometer checks. Residents # 97.102,43,77 and 8 will recieve influenza education next month when influenza vaccines are given. Consent forms will be scanned into all residents medical records. 2 All residents have the potential to be effected by a break in infection control practices and lack of influenza education. 3 The infection Control Policy for handwashing and glove use was reviewed. The Policy for Blood Glucose monitoring was reviewed. The Policy for Isolation Presuations was reviewed. All staff were educated on handwashing, isolation precautions and blood glucose monitoring policies. 4 Observational monitoring will be completed to ensure ongoing compliance with infection control techniques. A minimum of four observational audits will be completed weekly at varius times to ensure ongoing compliance. Staff will be re-educated as needed based on the results of the audits. The monitoring results will be reported tot he quarterly QI team. The QI team will make recommendations for ongoing compliance.	

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LPN-C removed the soiled dressing noted to contain a moderate amount of yellow-tan colored drainage. LPN-C wrapped soiled dressing inside of disposable gloves as she removed them from her hands, and disposed of soiled dressing and gloves in a nearby garbage can. LPN-C applied new gloves to her hands and proceeded to measure the pressure ulcer wound bed. Upon completion of the ulcer measuring, LPN-C was observed to remove the gloves, and apply new gloves. LPN-C then cleansed the ulcer with a spray of clear solution and wiped the ulcer wound bed with a clean gauze sponge. LPN-C removed the used gloves and immediately applied new gloves. LPN-C opened the new dressing packages and applied the dressings to the ulcer and taped the dressing edges down. LPN-C removed the gloves and stored the dressing change supplies. LPN-C applied new gloves, finished putting away the rest of the dressings and supplies, gathered up the garbage bag, and then removed the gloves. LPN-C was observed to wash her hands in R142's bathroom sink at 10:41 a.m.

On 8/14/14, at approximately 2:00 p.m. LPN-C stated she washed her hands before beginning the dressing change procedure and then again when the procedure was complete. LPN-C further stated she was not aware she should have washed her hands after removing the soiled dressings and with glove changes. LPN-C stated she should not have knelt on the floor and instead should have raised the bed to a working height.

On 8/14/14, at 2:15 p.m. registered nurse (RN)-C stated hands should be washed when gloves are changed as well as between soiled and clean procedures. RN-C further stated the bed should

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be raised to working height when performing wound/ulcer care to a resident at the bedside.

On 8/14/14, at 3:00 p.m. the director of nursing (DON) stated hands should be washed/sanitized when old dressings are removed, before new gloves are applied. The DON further stated the bed should be raised to a working height and kneeling on floor avoided when performing ulcer care at the bedside.

The facility's Safety - Infection Prevention Policy and Procedure reviewed and revised 12/2012, directed routine hand hygiene was indicated at times before and after touching a patient, before performing a clean/aseptic technique, and before and after glove use. A Dressing Technique policy dated 7/2010, directed contaminated gloves should be removed after removing an old dressing and to wash hands between glove changes.

R144's contact isolation precautions were not followed during the provision of cares.

R144's Resident Admission Record (undated) indicated R144's diagnoses included MRSA [Methicillin-resistant Staphylococcus Aureus] infection and toe cellulitis/abscess.

R144's admission MDS dated 8/8/14, indicated R144 was cognitively intact and had an infection with applications of dressings to the feet.

R144's Care Plan dated 8/4/14, to 8/14/14, did not indicate contact precautions for MRSA infection.

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F 441	Continued From page 35 On 8/15/14, at approximately 3:00 p.m. copies of R144's temporary care plan were requested, but was not provided. On 8/11/14, at 1:45 p.m. during the initial tour of the facility, a large, light yellow colored metal dresser containing gloves on the top was observed to be located in the hall way outside of R144's room. There was no sign on the door to indicate precautions or that visitors should see licensed staff before entering the room. On 8/12/14, at approximately 9:00 a.m. registered nurse (RN)-F stated R144 was on contact precautions for a MRSA infection, meaning gowns and gloves to be worn in R144 when providing direct care. RN-F further stated there was usually a sign on the door for visitors to check with the nurse before entering R144's room. RN-F was observed to pull a sign out of the top drawer of the yellow cart outside of R144's room and place the sign on R144's room door. 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	F 441		

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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 done with contact precautions/isolation as cart was not next to R144's room door and there was no sign on 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 washing their hands before leaving R144's room. RN-C confirmed the care plan lacked directions for R144's MRSA infection.

On 8/14/14, at 3:00 p.m. the DON stated contact precautions for MRSA should include using disposable gloves and wearing disposable gowns with cares, and washing hands before leaving the room. The DON further stated the door of a resident on contact precautions should have a sign posted for visitors and a cart with the needed isolation supplies should be outside of the room. The DON confirmed the care plan should include information and direction for the infection and contact precautions, and the care plan information should be communicated to staff.

The Facility's Isolation (Transmission-Based Precautions) policy reviewed/revised 1/2011, indicated an isolation sign should be placed on the door frame at the entrance to the patient's

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room. The Policy further indicated a MRSA infection would require contact precautions to include hand hygiene upon entering and exiting the resident's room and after contact with body fluids or resident environment; exam gloves prior to entering resident room with changing of gloves and sanitizing hands after contact with contaminated items or surfaces and removal of gloves and sanitizing hands upon exiting the resident room; and cover gown worn prior to entering a resident room.

On 8/14/14, 11:16 a.m.-C was observed preparing for a dressing change to R144's toe ulcer. R144's foot was air drying following a foot soak. At 11:31 a.m. LPN-C washed hands in the bathroom and donned gloves before cleansing the ulcer with alcohol. LPN-C changed gloves without hand sanitization, applied an ointment to the ulcer with the gloved finger of the right hand. LPN-C changed her gloves again without hand sanitization, applied a Band-Aid followed by paper tape. LPN-C again changed gloves without hand sanitization, knelt on the floor and assisted R144 with socks and shoes. LPN-C removed gloves, washed hands in R144's bathroom, gathered the trash and exited the room.

On 8/14/14, at 11:41 a.m. LPN-C stated R144 was on contact precautions for MRSA in the toe ulcer. LPN-C stated she wore gloves during dressing changes or bedding changes. LPN-C stated she does not wash or sanitize her hands between glove changes.

The facility's Dressing Techniques policy dated 7/10, directed staff to wash their hand between glove changes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245458	A. BUILDING _____ B. WING _____	08/15/2014

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 38	F 441		

R147 was observed on 8/14/14, at 11:33 a.m. during a glucometer (blood sugar) check. LPN-A sanitized hands and put on gloves, performed the blood sugar check, wiped the glucometer with a germicidal wipe, wrapped the glucometer with a germicidal wipe, removed gloves, documented on the computer, and then sanitized her hands. LPN-A verified she should have cleaned her hands after removing gloves and before touching the computer or other things.

R147's admission face sheet dated 8/1/14, included a diagnosis of diabetes. The Medication Administration Record for 8/14, indicated blood sugar checks were done three times daily.

On 8/14/14, at 1:00 p.m. the infection control coordinator (ICC) stated hands should be washed immediately after removing gloves. The ICC stated the staff do yearly online-training that includes infection control, including hand hygiene.

The facility policy and procedure for standard precautions and personal protective equipment revised 3/14, indicated hand hygiene is to be performed immediately after removing gloves.

The facility policy and procedure for hand hygiene revised 3/14, indicated hand hygiene is to be performed after glove use.

R97's chart lacked evidence that annual education of influenza education was provided. R97's vaccination and mantoux record, initiated on admission of 7/8/13, indicated R97 was offered and refused an influenza vaccine at another facility prior to admission. The documentation did not indicate that R97 was educated and offered the influenza vaccine at this

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F 441	Continued From page 39 facility. R102's chart lacked evidence that annual education of influenza education was provided. R43's chart lacked evidence that annual education of influenza education was provided. R77's chart lacked evidence that annual education of influenza education was provided. R8's chart lacked evidence that annual education of influenza education was provided. The ICC, interviewed on 8/14/14, at 1:00 p.m., stated the consent and educational forms were sent out and the vaccine was given to those residents whose consent forms were signed. The ICC stated the consent forms were not kept in the charts. Documentation if resident received the vaccine was documented on the resident vaccination and Mantoux record, but did not indicate education or consent. The facility policy and procedure for resident influenza vaccines was not provided.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 465	1 Rooms	9/16/14

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F 465	Continued From page 40 review, the facility failed to ensure resident rooms were maintained in a sanitary homelike manner in 11 of 76 resident rooms. (Rooms 324, 334, 338, 340, 346, 418, 422, 424, 426, 436, 437) Findings include: During an environmental tour on 8/14/14, at 12:00 p.m. with the secretary of facilities and environment services (SFES) the following was observed. Room 324, had a circular pink stain approximately four inches by three inches and a small orange stain in the carpet by window. Room 334, had large chips in the paint in the bathroom, inside doorway and on the opposite wall. Room 338, had wallpaper behind the head of the bed that was lifting at the seam and the edges and the paint underneath was stained. The paint inside bathroom entry was badly scraped and gouged. In Room 340, the wall at the head of the bed was scraped and had tape marks. The corner in entry of bathroom was badly gouged and the grab bar along side toilet was loose. Room 346, the wall inside the bathroom was scraped near the handrail and had black marks. Room 418, had scrapes on the bathroom wall on the left lower edge and had scrapes on the wall in the room behind the bed and under the television. In Room 422, the wall above the molding behind	F 465	324,334,338,340,346,418,422.424,426,436,437 were cleaned, repaired and painted. 2 All residents have the potential to be affected by the deficient practice. 3 Maintenance does a daily walk through of the facility. When areas are noted to need repair an online workorder is placed.The Maintanence department gets the work order and completes the repair based on priorities. They also have a schedule for routine maintenance. All staff are to report if there is a maintanence concern. Staff were educated on the online process for completing work orders.	

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	245458	A. BUILDING _____ B. WING _____	08/15/2014

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

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F 465	Continued From page 41 toilet and under the sink was water stained and the paint was bubbled up. Room 424, had several tan/rust colored stains on the ceiling tiles in the bedroom area. Room 426, had several stained ceiling tiles in the bedroom area. Room 436, had staining on ceiling tiles with stains on them. Room 437, had many scrapes on the bathroom walls. On 8/14/14, at 12:15 p.m. housekeeper-A stated she shampoos the stains in the carpets when she sees them. Had not seen the stains on the floor in room 324. On 8/14/14, at 1:00 p.m. the SFES stated the facility had an electronic preventive maintenance schedule system that directs staff on areas scheduled for preventive maintenance. Maintenance does a daily walk through of the facility and floor staff are to put in an online work order for areas needing repair. The facility's Day shift Rounds revised 12/24/13, directed staff to look for abnormal conditions and check all areas for wet or stained ceiling tiles.	F 465		

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	245458	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/13/2014**

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, 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. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

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

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.

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 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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00603	A. BUILDING: _____ B. WING _____	08/15/2014

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

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop comprehensive care plans for 1 of 3 residents (R52) for falls; for 1 of 1 residents (R3) reviewed for oxygen use; for 1 of 3 residents (R97) reviewed for oral hygiene; for 1 of 2 residents (R14) for skin conditions, and 1 of 5 residents (R43) for anticoagulant and pain medications. Findings include: R52's admission Minimum Data Set dated 6/5/14, indicated no falls prior to admission. The falls	2 560	1 Comprehensive care plans for residents #52, 97,14,43 and 3 were reviewed and revised to include falls,oxygen use, oral 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 reviewed and revised as neccesary. Nursing staff were educated on CAA's, care planning for all triggered problems that have been	9/16/14

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2 560	Continued From page 2 Care Area Assessment (CAA) dated 6/5/14, indicated R52 was at risk for falls related to decreased functional mobility secondary to recent left hip replacement, being non ambulatory and required the extensive assist of two staff for transfers. The CAA indicated a falls care plan was required with suggested interventions of call light and frequently used items within reach at all times and non-slip foot wear for all transfers. R52's care plan, dated 6/5/14, indicated diagnoses that included muscle weakness, osteoarthritis and generalized pain. The did not address the risk of falls or suggested interventions. The nurses aide worksheet directed extensive assistance for transfers and while walking with a walker, but did not address the risk of falls. R52's Fall risk assessment dated 8/11/14, indicated, "Resident is at risk for falls and has had 1 fall in the past quarter. Self-locking w/c put in place [sic] for resident safety and to prevent falls... Will continue to monitor for fall risk. Will continue current plan of care." Registered Nurse (RN)-B, interviewed on 8/14/14, at 12:15 p.m., verified the lack of care planning related to falls. R3's physician's orders dated 6/20/14, indicated diagnoses that included congestive heart failure, shortness of breath, pleural effusion, malaise and fatigue. The orders included oxygen (O2) at 2.0 liters per minute during the night, day and evening. R3's admission MDS, dated 6/9/14, indicated R3 utilized O2 prior to admission and in the facility.	2 560	decided to be care planned, also any other problem that affects the residnet's 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 Coumadin use, pain, skin condition, oxygen, risk for falls and oral hygiene. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported to the quarterly QI team. The QI team will make recommendations for ongoing monitoring.	

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2 560	Continued From page 3 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. R3 was asleep in bed on 8/14/14, at 7:00 a.m. with nasal canulla for O2 connected to a portable tank on the wheel chair. The gauge on the O2 tank was pointing to the red area indicating the need for refill. The wall mounted O2 delivery system was not in use. RN-C stated, on 8/14/14, at 8:40 a.m., the wall unit was functional and should be utilized for R3 in the room. RN-C stated care plan should address the use of O2 for R3. R97 was observed, on 8/12/14, at 1:40 p.m. with large amount of white and pink colored debris around the bottoms of lower teeth. On 8/14/14, at 9:24 a.m., R97 was lying in bed and mouth was partially open. There was a thick coating on the lower teeth and between lips. The annual MDS dated 7/16/14, indicated R97 had severe cognitive impairment and required extensive assistance of one staff for personal hygiene, bed mobility, transfers, locomotion, dressing, eating, and toilet use. R97's care plan dated 5/24/14, directed extensive assist of one for grooming. The care plan lacked direction for oral hygiene or dental care. The nursing assistant care sheets lacked direction for care of teeth. RN-B, interviewed on 8/14/14, at 9:57 a.m. verified oral cares were not addressed in R97's care plan.	2 560		

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2 560	Continued From page 4 R14 was observed to have three bruises on the top of the right hand on 8/11/14, at 6:56 p.m. R14 stated she was prone to bruising. R14's admission MDS dated 6/14/14, indicated moderate cognitive deficit and required extensive assistance of one staff for personal hygiene, bed mobility, transfers, locomotion in the wheelchair, dressing, and toilet 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. RN-B, interviewed on 8/13/14, at 1:25 p.m., stated that when residents were prone to bruising the care plan should address the problem and monitoring. Facility was unable to provide policy and procedure for care planning. R43's care plan did not address the use of Coumadin [an anticoagulant medication] and the use of a narcotic and non-narcotic pain medications. R43's signed Physician's Orders dated 6/19/14, included Coumadin (anticoagulant) 2 mg oral daily on Sunday, Tuesday, Thursday, and Saturday, and 4 mg oral on Monday, Wednesday, and Friday; and Tylenol 325 mg oral every 4 hours as needed. R43's Physician's Orders dated 8/2/14, directed R43 to receive Norco 5.0/325 mg 1 tab oral every 6 hours prn [as needed]. R43's quarterly MDS dated 6/29/14, indicated R43's diagnoses included chronic obstructive	2 560		

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2 560	Continued From page 5 pulmonary disease, congestive heart failure, and hypertension. The MDS further indicated R43 was cognitively intact and was receiving a scheduled pain medication. 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. On 8/13/14, at 1:20 p.m. RN-B stated the facility had changed over to a new electronic medical record system earlier this year and the ETAR and care plan entries to address side effect monitoring were missed. RN-B stated R43's use of Coumadin should be care planned for the monitoring of adverse effects and side effects of the medication. RN-B further confirmed R43's care plan lacked a problem statement and approaches for R43's pain monitoring to include non-pharmacological interventions. On 8/14/14, at 3:00 p.m. the director of nursing (DON) stated significant medications side effect monitoring should be care planned and included on the ETAR in the residents' electronic medical records. A Care Plan policy revised 12/3/13, indicated a resident's plan of care would be initiated in the electronic system and would address care areas such as clinical issues and treatments. Suggested methods of correction: The director of nurses or designee could review	2 560		

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2 560	Continued From page 6 and revise policies and procedures related to care planning, develop and provide staff training, and initiate monitoring systems to ensure compliance. Time period for correction: Twenty one (21) days.	2 560		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the use of oxygen (O2) was not provided appropriately for one of three residents (R3) observed for the use of O2; and hospice services were not coordinated for 1 of 1 residents (R42) reviewed for hospice. Findings include: R3's physician orders dated 6/20/14, indicated diagnoses that included congestive heart failure, shortness of breath, pleural effusion, malaise and	2 830	1 Resident #3 is deceased. Resident #42's hospice services were discontinued and her care plan was reviewed and revised. 2 All residents using oxygen or Hospice services have the potential to be effectedd by the deficient practice. 3 Policies and procedures for oxygen use have been reviewed and revised. The eMar will now have a task scheduled to monitor oxygen tanks. A meeting was held with Hospice Services to plan better	9/16/14

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2 830	Continued From page 7 fatigue. The orders included O2 at 2.0 liters per minute, every shift, nights, days and evenings. R3 was observed on 8/14/14, at 7:00 a.m. asleep in her bed with a nasal cannula for O2 connected to an O2 tank on the wheel chair. The gauge on the oxygen tank was pointing in the red area and noted, "Refill." R3 appeared in no acute distress. The wall mounted O2 delivery system was not in use and there was no humidifying "bubbler" attached to the wall. On 8/14/14, at 8:31 a.m., R3 stated she was not feeling well and wished to remain in bed. Licensed practical nurse (LPN)-C entered the room, and when asked about the wall O2, stated she did not know why the wall was not used. LPN-C went to obtain tubing and a bubbler and connected R3 to the wall mounted O2 supply. When the portable O2 tank was removed from the wheel chair, the pressure gauge did not move when removed from the tank, indicating no pressure. The admission minimum Data Set, dated 6/9/14, indicated R3 utilized O2 prior to admission and in the facility. Nursing assistant (NA)- H, interviewed on 8/14/14, at 8:37 a.m., stated the nurse would be notified when a resident's O2 tank was near empty. Registered nurse (RN)-C stated, at 8:40 a.m., the wall unit was available for R3 and should automatically be used when R3 was in bed. The Director of Nursing stated, on 8/14/14 at 11:53 a.m., there was no formal monitoring of the O2 tank levels, but all staff should be checking it.	2 830	communication between our facilities. The Hospice policy was reviewed. Nursing staff were educated on the oxygen and Hospice policies and where to find information regarding hospice residents. 4 Three audits will be done weekly for two months to ensure on-going compliance with oxygen use and tank replacement. Staff will be re-educated on an ongoing basis as needed based on the audit results. The monitoring results will be reported to the quarterly QI team. The QI team will make recommendations for ongoing monitoring.	

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2 830	Continued From page 8 R42's Admission Record dated 5/20/14, indicated diagnoses included subdural hemorrhage and chronic pain. R42's admission Minimum Data Set (MDS) dated 5/27/14, indicated R42 had short- and long- term memory deficits, had symptoms of delirium including continuous inattention and fluctuating disorganized thinking, was always incontinent of bowel and bladder, and was totally dependent in all activities of daily living (ADL's). The MDS further indicated R42 was not receiving scheduled or as needed [prn] pain medications, had no non-verbal indicators of pain, and was on hospice care. R42's care plan dated 5/22/14, indicated hospice services for end of life care related to subdural hemorrhage; comfort measurers as condition was irreversible and comfort was requested by patient and family. The goal was to be pain free and have good quality of life. R42's care plan approaches included provide pain medication as needed and/or requested, rest periods as needed and/or requested, nutrition and liquids for meals and snacks, turn and reposition every 2 hours and prn, spiritual care as requested and/or needed, anticipate grief and provide support to patient and family. R42's Hospice Team Care Plan dated 5/22/14, and printed 8/8/14, indicated the following hospice provider visits: * SN [Skilled Nursing]: 2 to 4 times per month for 3 months with 3 prn visits for symptom management. * MSS [Medical Social Services]: 3 prn visits for supportive care.	2 830		

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2 830	Continued From page 9 * SCC [Spiritual Care Coordinator]: 3 prn visits for spiritual care. * BC [Bereavement Care]: 3 prn visits for grief support * AID [Hospice Aid]: 1 to 2 visits per week for 5 weeks and 3 prn visits for personal cares. * VO [Volunteer]: 1 to 4 times per month for 3 months. R42' Hospice Facility Contact forms (undated) were observed to be located on a clip board in the nurse manager's office on the third floor of the facility. The Contact forms indicated R42 had received no Hospice Aid visits in June, 2014, and 1 Hospice Aid visit on 7/28/14, 8/5/14, and 8/11/14. No Volunteer visits were indicated on the Contact forms from 5/23/14, to 8/14/14. Home Health Aide Care Plan Tasks dated 7/16/14, 7/25/14, and 7/28/14, were provided by the facility upon request of the Hospice. The forms indicated R42 had received a Hospice Aid visit on those dates, but did not indicate the activity provided. During the survey week of 8/11/14, through 8/14/14, R42 was observed on multiple occasions in the room and in the dining room of the facility. On 8/13/14, at 2:00 p.m. licensed practical nurse (LPN)-D stated hospice does not come to the facility to visit R42 very often. LPN-D further stated she does not know if/when Hospice staff visit or what service was provided for R42 On 8/13/14, at 2:15 p.m. nursing assistant (NA)-A stated he was not aware of any hospice aide services having been provided for R42. NA-A further stated he thought R42 was no longer on Hospice.	2 830		

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2 830	Continued From page 10 On 8/14/14, at approximately 2:30 p.m. registered nurse (RN)-A stated Hospice coordination of care had improved in the facility. RN-A further stated Hospice staff and nursing home staff should be communicating when hospice is in the building. RN-A also stated R42 did not have a specific Hospice volunteer assigned to provide support. On 8/14/14, at 3:00 p.m. the director of nursing (DON) stated the coordination of care for Hospice services could be better. The DON further stated the nursing home staff should be aware what kind of hospice services were scheduled and what care was provided. An updated policy for Hospice process guidelines for LTC [long term care] and AL [assisted living] facilities was provided and indicated a Hospice communication sheet was to be kept in the patient closet. The policy further indicated hospice staff were to write on the communication sheet when visits were made. The policy also indicated hospice team member's progress notes for each visit would be faxed or delivered to the facility at least one time per week. Suggested methods of correction: The director of nursing or designee could review and revise policies and procedures related to monitoring and use of oxygen therapy. 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.	2 830		

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21375	Continued From page 11	21375		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow infection control standards during dressing changes for 2 of 2 residents (R142, R144) observed for wound care; during blood glucose monitoring procedures for 1 of 1 residents (R147) observed during blood glucose monitoring; and during provision of care for 1 of 1 residents (R144) with isolation precautions. In addition, influenza immunization education was not provided for 5 of 5 residents (R97, R102, R43, R8, R77) whose immunizations were reviewed. Findings include: R142's pressure ulcer dressing change procedure was not completed using appropriate infection control standards. R142's admission Minimum Data Set (MDS) dated 8/12/14, indicated diagnoses that included a pressure ulcer on hip. The MDS further indicated R142 had moderate cognitive impairment, required extensive assistance with bed mobility and transfers, and was assessed to be at risk for the development of pressure ulcers. The MDS further indicated R142 was admitted with with 1 unstageable pressure ulcer with suspected deep tissue injury. The MDS	21375	1 The direst caregiver responsible for resident #142's dressing changes was re-educated on proper infection control techniue related to changing gloves and washing hands between changes of gloves. Resident 3 144's comprehensive care planwas updated to include contact isolation precautions. Resident #147's nurses were re-educated on proper procedure for glucometer checks. Residents # 97.102,43,77 and 8 will recieve influenza education next month when influenza vaccines are given. Consent forms will be scanned into all residents medical records. 2 All residents have the potential to be effected by a break in infection control practices and lack of influenza education. 3 The infection Control Policy for handwashing and glove use was reviewed. The Policy for Blood Glucose monitoring was reviewed. The Policy for Isolation Presuations was reviewed. All staff were educated on handwashing, isolation precautions and blood glucose monitoring policies. 4 Observational monitoring will be	9/16/14

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21375	Continued From page 12 described the pressure ulcer as measuring 6.5 cm in length by 9.9 cm in width, with eschar tissue present in the wound bed. The MDS also indicated R142's ulcer treatments included a pressure reducing device for the chair and bed, nutrition or hydration interventions to manage skin problems, pressure ulcer care, and the application of nonsurgical dressings. R142's Physician Order Report dated 8/5/14, directed to change the Aquacel dressing on right hip every 12 to 24 hours depending on the saturation level. On 8/14/14, at 10:26 a.m. licensed practical nurse (LPN)-C was observed to provide pressure ulcer dressing change to R142's right hip. LPN-C applied blue, disposable gloves to her hands and knelt down on the floor facing R142's bedside. LPN-C removed the soiled dressing noted to contain a moderate amount of yellow-tan colored drainage. LPN-C wrapped soiled dressing inside of disposable gloves as she removed them from her hands, and disposed of soiled dressing and gloves in a nearby garbage can. LPN-C applied new gloves to her hands and proceeded to measure the pressure ulcer wound bed. Upon completion of the ulcer measuring, LPN-C was observed to remove the gloves, and apply new gloves. LPN-C then cleansed the ulcer with a spray of clear solution and wiped the ulcer wound bed with a clean gauze sponge. LPN-C removed the used gloves and immediately applied new gloves. LPN-C opened the new dressing packages and applied the dressings to the ulcer and taped the dressing edges down. LPN-C removed the gloves and stored the dressing change supplies. LPN-C applied new gloves, finished putting away the rest of the dressings and supplies, gathered up the garbage bag, and	21375	completed to ensure ongoing compliance with infection control techniques. A minimum of four observational audits will be completed weekly at varius times to ensure ongoing compliance. Staff will be re-educated as needed based on the results of the audits. The monitoring results will be reported tot he quarterly QI team. The QI team will make recommendations for ongoing compliance.	

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21375	Continued From page 13 then removed the gloves. LPN-C was observed to wash her hands in R142's bathroom sink at 10:41 a.m. On 8/14/14, at approximately 2:00 p.m. LPN-C stated she washed her hands before beginning the dressing change procedure and then again when the procedure was complete. LPN-C further stated she was not aware she should have washed her hands after removing the soiled dressings and with glove changes. LPN-C stated she should not have knelt on the floor and instead should have raised the bed to a working height. On 8/14/14, at 2:15 p.m. registered nurse (RN)-C stated hands should be washed when gloves are changed as well as between soiled and clean procedures. RN-C further stated the bed should be raised to working height when performing wound/ulcer care to a resident at the bedside. On 8/14/14, at 3:00 p.m. the director of nursing (DON) stated hands should be washed/sanitized when old dressings are removed, before new gloves are applied. The DON further stated the bed should be raised to a working height and kneeling on floor avoided when performing ulcer care at the bedside. The facility's Safety - Infection Prevention Policy and Procedure reviewed and revised 12/2012, directed routine hand hygiene was indicated at times before and after touching a patient, before performing a clean/aseptic technique, and before and after glove use. A Dressing Technique policy dated 7/2010, directed contaminated gloves should be removed after removing an old dressing and to wash hands between glove changes.	21375		

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21375	Continued From page 14 R144's contact isolation precautions were not followed during the provision of cares. R144's Resident Admission Record (undated) indicated R144's diagnoses included MRSA [Methicillin-resistant Staphylococcus Aureus] infection and toe cellulitis/abscess. R144's admission MDS dated 8/8/14, indicated R144 was cognitively intact and had an infection with applications of dressings to the feet. R144's Care Plan dated 8/4/14, to 8/14/14, did not indicate contact precautions for MRSA infection. On 8/15/14, at approximately 3:00 p.m. copies of R144's temporary care plan were requested, but was not provided. On 8/11/14, at 1:45 p.m. during the initial tour of the facility, a large, light yellow colored metal dresser containing gloves on the top was observed to be located in the hall way outside of R144's room. There was no sign on the door to indicate precautions or that visitors should see licensed staff before entering the room. On 8/12/14, at approximately 9:00 a.m. registered nurse (RN)-F stated R144 was on contact precautions for a MRSA infection, meaning gowns and gloves to be worn in R144 when providing direct care. RN-F further stated there was usually a sign on the door for visitors to check with the nurse before entering R144's room. RN-F was observed to pull a sign out of the top drawer of the yellow cart outside of R144's room and place the sign on R144's room door.	21375		

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21375	Continued From page 15 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 done with contact precautions/isolation as cart was not next to R144's room door and there was no sign on 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 washing their hands before leaving R144's room. RN-C confirmed the care plan lacked directions for R144's MRSA infection. On 8/14/14, at 3:00 p.m. the DON stated contact precautions for MRSA should include using	21375		

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21375	Continued From page 16	21375		

disposable gloves and wearing disposable gowns with cares, and washing hands before leaving the room. The DON further stated the door of a resident on contact precautions should have a sign posted for visitors and a cart with the needed isolation supplies should be outside of the room. The DON confirmed the care plan should include information and direction for the infection and contact precautions, and the care plan information should be communicated to staff.

The Facility's Isolation (Transmission-Based Precautions) policy reviewed/revised 1/2011, indicated an isolation sign should be placed on the door frame at the entrance to the patient's room. The Policy further indicated a MRSA infection would require contact precautions to include hand hygiene upon entering and exiting the resident's room and after contact with body fluids or resident environment; exam gloves prior to entering resident room with changing of gloves and sanitizing hands after contact with contaminated items or surfaces and removal of gloves and sanitizing hands upon exiting the resident room; and cover gown worn prior to entering a resident room.

On 8/14/14, 11:16 a.m.-C was observed preparing for a dressing change to R144's toe ulcer. R144's foot was air drying following a foot soak. At 11:31 a.m. LPN-C washed hands in the bathroom and donned gloves before cleansing the ulcer with alcohol. LPN-C changed gloves without hand sanitization, applied an ointment to the ulcer with the gloved finger of the right hand. LPN-C changed her gloves again without hand sanitization, applied a Band-Aid followed by paper tape. LPN-C again changed gloves without hand sanitization, knelt on the floor and assisted R144 with socks and shoes. LPN-C removed

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21375	Continued From page 17 gloves, washed hands in R144's bathroom, gathered the trash and exited the room. On 8/14/14, at 11:41 a.m. LPN-C stated R144 was on contact precautions for MRSA in the toe ulcer. LPN-C stated she wore gloves during dressing changes or bedding changes. LPN-C stated she does not wash or sanitize her hands between glove changes. The facility's Dressing Techniques policy dated 7/10, directed staff to wash their hand between glove changes. R147 was observed on 8/14/14, at 11:33 a.m. during a glucometer (blood sugar) check. LPN-A sanitized hands and put on gloves, performed the blood sugar check, wiped the glucometer with a germicidal wipe, wrapped the glucometer with a germicidal wipe, removed gloves, documented on the computer, and then sanitized her hands. LPN-A verified she should have cleaned her hands after removing gloves and before touching the computer or other things. R147's admission face sheet dated 8/1/14, included a diagnosis of diabetes. The Medication Administration Record for 8/14, indicated blood sugar checks were done three times daily. On 8/14/14, at 1:00 p.m. the infection control coordinator (ICC) stated hands should be washed immediately after removing gloves. The ICC stated the staff do yearly online-training that includes infection control, including hand hygiene. The facility policy and procedure for standard precautions and personal protective equipment revised 3/14, indicated hand hygiene is to be performed immediately after removing gloves.	21375		

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21375	Continued From page 18 The facility policy and procedure for hand hygiene revised 3/14, indicated hand hygiene is to be performed after glove use. R97's chart lacked evidence that annual education of influenza education was provided. R97's vaccination and mantoux record, initiated on admission of 7/8/13, indicated R97 was offered and refused an influenza vaccine at another facility prior to admission. The documentation did not indicate that R97 was educated and offered the influenza vaccine at this facility. R102's chart lacked evidence that annual education of influenza education was provided. R43's chart lacked evidence that annual education of influenza education was provided. R77's chart lacked evidence that annual education of influenza education was provided. R8's chart lacked evidence that annual education of influenza education was provided. The ICC, interviewed on 8/14/14, at 1:00 p.m., stated the consent and educational forms were sent out and the vaccine was given to those residents whose consent forms were signed. The ICC stated the consent forms were not kept in the charts. Documentation if resident received the vaccine was documented on the resident vaccination and Mantoux record, but did not indicate education or consent. The facility policy and procedure for resident influenza vaccines was not provided.	21375		

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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.	21375		
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 be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure two-step mantouxs (skin	21426	1 Tuberculosis baseline symptoms screenings were completed for residents	9/16/14

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21426	Continued From page 20 test that screens for tuberculosis) were completed and recorded for 2 of 5 residents (R77, R102) and that baseline tuberculosis symptom screening was completed for 5 of 5 residents (R97, R102, R43, R77, R8) reviewed for tuberculosis screening. R77 was admitted to the facility on 12/28/12. R77's vaccination and mantoux record initiated 9/13/11, indicated the first step mantoux was given on 9/13/11. The record lacked documentation of results of the first step mantoux and lacked evidence that a second step mantoux was completed. R77's medical record lacked evidence that a baseline tuberculosis symptom screening was completed. R102 was admitted to the facility on 9/24/13. R102's vaccination and mantoux record initiated 9/24/13, indicated the first step mantoux had been given at the hospital, prior to admission, and the treatment record dated 9/13, indicated it was read at the facility. The treatment record and mantoux record lacked evidence that a second step mantoux was completed. R102's medical record lacked evidence that a baseline tuberculosis symptom screening was completed. R43 was admitted to the facility on 3/22/14. R43's medical record lacked evidence that a baseline tuberculosis symptom screening was completed. R97 was admitted to the facility on 7/8/13. R97's medical record lacked evidence that a baseline tuberculosis symptom screening was completed. R8 was admitted to the facility on 3/25/04. R8's medical record lacked evidence that a baseline tuberculosis symptom screening was completed.	21426	#8,77,102,97 and 43. 2 All residents have the potential to be impacted by a deficient practice in this area. 3 Tuberculin policy was reviewed. All nursing staff were re-educated on the policy. 4 Three chart audits will be completed each week to ensure ongoing compliance. The monitoring results will be reported to the quarterly QI team. The QI team will make recommendations for ongoing monitoring.	

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21426	Continued From page 21 During an interview with the infection control coordinator (ICC) on 8/14/14, at 1:00 p.m. she verified two-step mantouxs are to be done on all residents upon admission to the facility, and indicated documentation of mantouxs has not been consistent. In addition, the ICC verified the baseline tuberculosis symptom screening had not been initiated or completed for residents. The facility's policy and procedure for tuberculosis screening of residents dated 7/13/90, directed a two-step mantoux would be administered to all residents upon admission unless they have documentation of a previous positive mantoux. The policy and procedure lacked direction for baseline tuberculosis symptom screening.	21426		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment	21540		9/16/14

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21540	Continued From page 22 (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide side effects monitoring of psychotherapeutic medications and anticoagulant medications or establish parameters for use of as needed pain medications for 4 of 5 residents (R73, R106, R54, R43) reviewed for unnecessary medications. Findings include: R73's Physician's Order Report signed on 8/13/14, included Tylenol Extra Strength 500 milligrams (mg) as needed twice a day for generalized pain and Tylenol 650 mg every four hours as needed, both without parameters for use. , and Seroquel 12.5 mg by mouth every day. R73's Resident Admission Record dated 6/17/14, dated 12/30/11, indicated diagnoses that included dementia with behavioral disturbances, paranoid state, anxiety, muscle spasm, falls and pain. The Minimum Data Set (MDS) dated 6/22/14, indicated R73 had severe cognitive impairment. R73's care plan did not address the use or monitoring side effects or effectiveness for Seroquel. On 8/14/14, at 1:37 p.m. registered nurse (RN)-A verified the lack of parameters for use of Tylenol and that monitoring for side effects and effectiveness of Seroquel should be included on	21540	1 #73's order for Tylenol were reviewed and now include parameters for use. Her care plan was updated to include side effect monitoring and effectiveness of Seroquel. Resident #106's care plan was updated to include side effect monitoring and effectiveness and potential adverse effects related to use of Seroquel and Ativan. Resident # 54's care plan was updated to include Ativan, Celexa and Insulin use and monitoring for side effets and adverse effects. Resident #43's physicial orders and eMar were reviewed to ensure they are included all orders.Tylenol and Norco orders now include parameters for use. His care plan was updated to include the use of Coumadin, Tylenol and pain medications, effectiveness and side effect monitoring. 2 All residents recieving medications have have the potential to be impacted by a deficient practice in this area. 3 Nursing staff will work in collaberation with pharmcy and Nursing Unit Clerks to ensure parameters are included in orders for medications which require parameters.Nursing stass will review care plans, observations and progress notes to ensure psychoactive medications are addressed.Medication monitoring policy	

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21540	Continued From page 23 the care plan. R106's Physician's Order Report signed on 8/7/14, included Seroquel 12.5 mg by mouth daily and Ativan 0.5 mg by mouth every four hours as needed for anxiety. The Resident Admission Record dated 6/17/14, indicated diagnoses that included a hip fracture, malaise/fatigue, dementia with depression and anxiety. R106's care plan did not address use/monitoring for effectiveness and potential adverse effects related to use of Seroquel and Ativan. On 8/14/14, at 1:33 p.m. RN-A verified 106's care plan should address Seroquel or Ativan. R54 R54's Physician's Order Report signed on 7/10/14, included Ativan 0.5 mg by mouth once a morning and 1 mg by mouth at bedtime for anxiety. Celexa (antidepressant medication) 10 mg by mouth once a day, and Lantus insulin 8 units subcutaneous at bedtime. The Resident Admission Record dated 2/24/14, indicated R54's diagnoses included type two diabetes and anxiety. R106's care plan lacked Ativan, Celexa and insulin use, monitoring for effectiveness and side effects. On 8/14/14, at 1:46 p.m. RN-A verified the care plan did not address the use of Ativan, Celexa and insulin. R43's signed Physician's Orders dated 6/19/14, included Coumadin (anticoagulant) 2 mg oral daily on Sunday, Tuesday, Thursday, and Saturday, and 4 mg oral on Monday, Wednesday, and Friday; and Tylenol 325 mg oral every 4	21540	was reviewed and revised as necessary. Nursing staff were educated on medication administration and monitoring policies. 4 Three eMars and care plans will be audited each week to ensure compliance. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported to the quarterly QIteam. The QI team will make recommendations fo ongoing monitoring.	

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21540	Continued From page 24 hours as needed. R43's Physician's Orders dated 8/2/14, directed R43 to receive Norco 5.0/325 mg 1 tab oral every 6 hours prn [as needed]. R43's quarterly MDS dated 6/29/14, indicated R43's diagnoses included chronic obstructive pulmonary disease, congestive heart failure, and hypertension. The MDS further indicated R43 was cognitively intact and was receiving a scheduled pain medication. 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. On 8/13/14, at 1:20 p.m. RN-B stated the facility had changed over to a new electronic medical record system earlier this year and the ETAR and care plan entries to address side effect monitoring were missed. RN-B stated R43's use of Coumadin should be care planned for the monitoring of adverse effects and side effects of the medication. RN-B further confirmed R43's care plan lacked a problem statement and approaches for R43's pain monitoring to include non-pharmacological interventions. On 8/14/14, at 3:00 p.m. the director of nursing (DON) stated significant medications side effect monitoring should be care planned and included on the ETAR in the residents' electronic medical records.	21540		

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21540	Continued From page 25 A Care Plan policy revised 12/3/13, indicated a resident's plan of care would be initiated in the electronic system and would address care areas such as clinical issues and treatments. Suggested methods of correction: The director of nursing or designee could review and revise policies and procedures related to monitoring and use of medications. 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.	21540		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess safety for self administration of medications for 2 of 2 residents (R54, R43) observed to self administer medications. Findings include:	21565	1. A self-administration of medications was completed for residents #54 and #43. Care plans were updated. 2. All residents could be affected by the deficient practice. All residents are assessed upon admission for competency or desire to self-adminiater medications and/or treatments such as nebulizer	9/16/14

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21565	Continued From page 26 R54 was not observed during self administration of medications despite being assessed as unsafe to self administer any medications. On 8/12/14, at 9:40 a.m. during an interview with R54, licensed practical nurse (LPN)-A placed a medication cup with approximately five or six pills on the overbed table. LPN- a briefly stood in the doorway and asked if R54 was taking his medications and then left. LPN-A left the area and returned at 9:48 a.m. to check if R54 took the medications. The Resident Administration Record dated 2/24/14, indicated R54's diagnoses included type two diabetes, spinal stenosis, esophageal reflux, glaucoma, hypertension, anxiety and pain. R54's psychosocial well being care plan dated 5/23/14, indicated R54 had memory problems related to cognitive deficits. R54 required reminders, cues and supervision for all activities of daily living, meals and daily routine. R54's quarterly minimum data set (MDS) indicated R54 was cognitively intact. The Self Administration of Medication Assessment (SAM) dated 8/3/14, indicated R54 did not want to SAM. R54 had moderately impaired decision making skills and had a history of noncompliance with medications and was not appropriate to SAM. On 8/13/14, at 1:35 p.m. LPN-A stated she leaves R54 with his medications, stays in the area and then "pops back in" to make sure he has taken them. On 8/14/14, at 9:44 a.m. registered nurse (RN)-A verified R54 was not to SAM and the nurse	21565	treatments. Self- administraton of medications assessments are reviewed quarterly on all residents following the MDS schedule. 3. Audits will be done to observe that licensed staff follow residents plan of care for self-administering of medications and/or treatments. it is identified on the eMar and the careplan if the resident may self administer medications.Licensed staff will follow up with the resident to identify whether they completed the treatment or took their medications as identified. The self-administration of medication plicy was reviewed and revised as neccesary. Nursing staff were educated on self-administration of medications assessment and careplanning process. 4. Three audits will be done weekly for two months to ensure proper administration of medications and/or treatments. Ongoing audits will be completed based on the results of the audits. The audit results will be reported to the quarterly QI team which will make recommendations for ongoing monitoring.	

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21565	Continued From page 27 should wait and watch R54 take his medications. R43 was not assessed to be safe to self administer inhaled medications. On 8/13/14, at 1:19 p.m. R43 was observed alone in his room, seated in the recliner with a nebulizer treatment administered via face mask. At 1:30 p.m. LPN-B came down the hall from the nurses desk, removed the nebulizer mask and turned off the nebulizer machine. 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. On 8/13/14, at 1:43 p.m. LPN-B stated she leaves R43 alone to do the nebulizer and was told when R43 transferred from from the fourth floor he could be left alone with the nebulizer after it was set up. On 8/13/14, at 2:00 p.m. RN-B verified the SAM assessment indicated R43 was not to be left alone with the nebulizer. RN-B expected staff to stay with R43 while the nebulizer was running. The facility's Self Administration of Medications policy effective 9/24/10, indicated all residents would have a SAM observation completed upon admission, change in condition and as deemed necessary. Residents who wished to SAM would be reviewed by the interdisciplinary team (IDT) to determine appropriateness. SUGGESTED METHOD OF CORRECTION:	21565		

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21565	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	21565		
21620	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 the label on the insulin. The LPN stated there was no other way to indicate when an order was	21620	1 The medication label was correctly labeled for resident #24's insulin. 2 All residents could be affected by the deficient practice. 3 The medication Administration policy was reviewed and revised as necessary. The pharmacy staff were consulted on correct process for label changes. All nursing staff were educated on the Medication Administration Policy. 4 monitoring will be done by completing three audits weekly to check for accuracy of labels, medications and physician orders. Nursing staff will be re-educated as needed based on the results of the audits. The internal eMar process was also reviewed relating to orders sent to the pharmacy. The monitoring results will be reported to the QI team who will make recommendations for ongoing compliance.	9/16/14

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21620	Continued From page 29 changed, just call the pharmacy to change the label. The Physician's Orders signed 7/29/14, indicated the Novolog insulin order was changed from Novolog insulin 30 u sq three times a day to Novolog insulin 30 u sq twice a day and Novolog insulin 25 u with the evening meal. On 8/14/14, at 9:49 a.m. registered nurse (RN)-A stated the pharmacy would get the order change through the facility's computer system. The pharmacy usually would send up a new label for the medication. Suggested methods of correction: The director of nursing or designee could review and revise policies and procedures related to monitoring for accurage medication labeling. 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.	21620		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.	21695		9/16/14

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	00603	A. BUILDING: _____ B. WING _____	08/15/2014

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 30 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident rooms were maintained in a sanitary homelike manner in 11 of 76 resident rooms. (Rooms 324, 334, 338, 340, 346, 418, 422, 424, 426, 436, 437) Findings include: During an environmental tour on 8/14/14, at 12:00 p.m. with the secretary of facilities and environment services (SFES) the following was observed. Room 324, had a circular pink stain approximately four inches by three inches and a small orange stain in the carpet by window. Room 334, had large chips in the paint in the bathroom, inside doorway and on the opposite wall. Room 338, had wallpaper behind the head of the bed that was lifting at the seam and the edges and the paint underneath was stained. The paint inside bathroom entry was badly scraped and gouged. In Room 340, the wall at the head of the bed was scraped and had tape marks. The corner in entry of bathroom was badly gouged and the grab bar along side toilet was loose. Room 346, the wall inside the bathroom was scraped near the handrail and had black marks. Room 418, had scrapes on the bathroom wall on the left lower edge and had scrapes on the wall in the room behind the bed and under the television.	21695	1 Rooms 324,334,338,340,346,418,422.424,426,436,437 were cleaned, repaired and painted. 2 All residents have the potential to be affected by the deficient practice. 3 Maintenance does a daily walk through of the facility. When areas are noted to need repair an online workorder is placed.The Maintanence department gets the work order and completes the repair based on priorities. They also have a schedule for routine maintenance. All staff are to report if there is a maintanence concern. Staff were educated on the online process for completing work orders.	

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21695	Continued From page 31 In Room 422, the wall above the molding behind toilet and under the sink was water stained and the paint was bubbled up. Room 424, had several tan/rust colored stains on the ceiling tiles in the bedroom area. Room 426, had several stained ceiling tiles in the bedroom area. Room 436, had staining on ceiling tiles with stains on them. Room 437, had many scrapes on the bathroom walls. On 8/14/14, at 12:15 p.m. housekeeper-A stated she shampoos the stains in the carpets when she sees them. Had not seen the stains on the floor in room 324. On 8/14/14, at 1:00 p.m. the SFES stated the facility had an electronic preventive maintenance schedule system that directs staff on areas scheduled for preventive maintenance. Maintenance does a daily walk through of the facility and floor staff are to put in an online work order for areas needing repair. The facility's Day shift Rounds revised 12/24/13, directed staff to look for abnormal conditions and check all areas for wet or stained ceiling tiles. Suggested methods of correction: The environmental services director or designee could review and revise policies and procedures related to repair and maintenance of resident care areas. Staff could be provided education related to the policies and a monitoring system could be initiated to ensure compliance.	21695		

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21695	Continued From page 32 Time period for correction: Twenty one (21) days.	21695		
21800	MN St. Statute144.651 Subd. 4 Patients & 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 Requirement is not met as evidenced	21800		9/16/14

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21800	Continued From page 33 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, and discharged 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 and Appeal Rights forms. RN-D further stated the 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 DON verified the lack of evidence to indicate the liability notices were provided for R31 and R14. A policy on Notice of Medicare Non-Coverage	21800	1. Residents #31 and #14 were discharged in April and May 2014. 2. All residents could be affected by the deficient practice. Residents will be evaluated during their intake screening for Medicare coverage using Medicare coverage guidelines. During their stay continued coverage will be reviewed with input from nursing and therapy to determine ongoing coverage appropriateness. 3. As soon as a decision is made that Medicare Part A will be ending the MDS nurse will initiate denial letters to resident or responsible party. At least 48 hours before Medicare stay ends the resident or responsible party will be given letters. Nurse will either speak to resident face to face if they are the responsible party and get signature after the resident states understanding of the form, or responsible party will be called. Per responsible parties request either the form will be mailed or it will be available fr them to sign at EHVCC. The denial letters will be scanned into the Matrix system under Medicare and a progress note will be writtenstating the letter was delivered. The Medicare policy was reviewed and revised as neccesary. All RN's were educated on Medicare coverage quidelines and Medicare coverage policy. 4. Denial letter audit will be added to the admission and discharge checklists. Audits will be done weekly to ensure denial letters are in the residents chart. The audit results will be reported to the quarterly QI team which will make reccomendations for ongoing monitoring.	

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21800	Continued From page 34 was requested and none was provided. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents receive the required Medicare denial and appeal rights notices; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21800		