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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XJV8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00461

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245512**

2.STATE VENDOR OR MEDICAID NO.
(L2) **381347904**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH FOSSTON**
(L4) **900 HILLIGOSS BOULEVARD SOUTHEAST**
(L5) **FOSSTON, MN** (L6) **56542**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/16/2017** (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)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements

Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 10/17/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Speicalist 10/17/2017 (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
01/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/05/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245512

October 17, 2017

Mr. Kevin Gish, Administrator
Essentia Health Fosston
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

Dear Mr. Gish:

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 22, 2017 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 17, 2017

Mr. Kevin Gish, Administrator
Essentia Health Fosston
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

RE: Project Number S5512027

Dear Mr. Gish:

On September 14, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 30, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 16, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 25, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 30, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 22, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 30, 2017, effective September 22, 2017 and therefore remedies outlined in our letter to you dated September 14, 2017, 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.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 17, 2017

Mr. Kevin Gish, Administrator
Essentia Health Fosston
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

Re: Reinspection Results - Project Number S5512027

Dear Mr. Gish:

On October 16, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 16, 2017, with orders received by you on September 18, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: XJV8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00461

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245512**

2.STATE VENDOR OR MEDICAID NO.
(L2) **381347904**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH FOSSTON**
(L4) **900 HILLIGOSS BOULEVARD SOUTHEAST**
(L5) **FOSSTON, MN** (L6) **56542**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/30/2017** (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)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Theresa Gullingsrud, HFE-NE II 09/25/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 10/04/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(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 :
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22. ORIGINAL DATE OF PARTICIPATION
01/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
September 14, 2017

Mr. Kevin Gish, Administrator
Essentia Health Fosston
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

RE: Project Number S5512027

Dear Mr. Gish:

On August 30, 2017, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

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 October 9, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 9, 2017 the following remedy will be imposed:

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

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.

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 30, 2017 (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 March 1, 2018 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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 electronic 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH FOSSTON	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

(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 On 8/30/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's electronic Plan of Correction (ePoC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePoC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the PoC will be used as verification of compliance.	F 000		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that	F 279		9/22/17

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

Electronically Signed | 09/22/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH FOSSTON	**900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542**

(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 279	Continued From page 1	F 279		

includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) 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 §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record.

(iv)In consultation with the resident and the resident’s representative (s)-

(A) The resident’s goals for admission and desired outcomes.

(B) The resident’s preference and potential for future discharge. Facilities must document whether the resident’s desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH FOSSTON	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

(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 279	Continued From page 2 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop interventions for the use of insulin and anticoagulant medication (Coumadin) for 1 of 5 residents (R61) whose medication regimens were reviewed. Findings include: R61's admission Minimum Data Set (MDS) dated 7/12/17, indicated R61 was cognitively intact and had diagnoses which included atrial fibrillation fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and diabetes. The MDS also indicated R61 received insulin injections and anticoagulant medication (prevent or reduce coagulation of blood, prolonging the clotting time) 3 of 7 days during the assessment period. R61's Physician Order Report dated 7/23/17 - 8/23/17, included the following orders: -Coumadin 2.5 milligrams (mg) at bedtime on Monday, for atrial fibrillation -Coumadin 5 mg at bedtime on Sunday, Tuesday, Wednesday, Thursday, Friday and Saturday for atrial fibrillation -Tresiba FlexTouch U-200 insulin pen 200 units/milliliter (ml) 44 units subcutaneous at bedtime for Type 2 diabetes mellitus. -Novolog Flexpen insulin pen 100 units/ml 10	F 279	First Care Living Center policies require the development and implementation of a comprehensive person centered care plan for each resident. This includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. A. First Care Living Center policy for Care Planning review and revision to include baseline care plan implementation within first 48 hours of admission. B. Comprehensive assessment completed of resident R61 who is diagnosed with A-Fib and is taking an anticoagulant. Care plan updated for risk of bruising and bleeding on 8-30-17 by RN MDS Coordinator. Updates include individualized protocol for monitoring for potential adverse effects such as nosebleeds, bleeding gums, petechiae, blood in stools, etc. Monitor for unsafe activity which could increase risk of injury or bruising. The Coumadin Clinic in Fosston monitors the INR results from Lab & dictates the coumadin dosing. Coumadin Clinic & Provider updated for further interventions as necessary with signs/symptoms of bleeding or unusual bruising. C. Comprehensive assessment completed for resident R61 who is diagnosed with Diabetes and is taking	

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F 279	Continued From page 3 units subcutaneous three times a day before meals for Type 2 diabetes mellitus. R61's undated, Care Plan indicated R61 had diagnoses including atrial fibrillation and type 2 diabetes mellitus. The Care Plan identified R61 was at nutritional risk due to diabetes, however, lacked interventions related to the use of insulin and Coumadin and lacked interventions related to monitoring for potential adverse effects of the medications. On 8/30/17, at 12:36 p.m. registered nurse (RN)-B stated when she developed a care plan for a diabetic resident she would typically include a focus for diabetes and include monitoring for side effects related to the use of insulin such as hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar). She also indicated she often included a resident's use of Coumadin with the skin interventions to monitor for bruising. RN-B confirmed R61's care plan did not address the use of Coumadin or insulin or monitoring for adverse effects of the medications. On 8/30/17, at 12:58 p.m. the director of nursing (DON) confirmed she would have expected the care plan to address monitoring of bleeding with the use of Coumadin and high/low blood sugars for residents on insulin. The Care Planning policy dated 4/2017, indicated a comprehensive care plan must be developed for each resident that included measurable objectives and time tables to meet a resident's	F 279	insulin, an antidiabetic medication. Care plan updated for risk of low blood sugar (hypoglycemia) and high blood sugar (hyperglycemia) on 8-30-17 by RN MDS Coordinator. Updates include individualized protocol on the care plan to identify potential adverse effects of Hypoglycemia (BS<60mg/dl) including sweating, cold clammy skin, numbness of fingers, toes and mouth, rapid heartbeat, tremors, fainting, dizziness, etc. and Hyperglycemia (BS>140mg/dl) including increased thirst, increased urination, increased/decreased appetite, nausea/vomiting etc. The Facility's standing orders can be initiated and provider is updated as necessary for further interventions of resident not responding to regimen. D. All residents that are prescribed anticoagulant medications have had RN MDS Coordinator assessment and Care Plan review/updates. All new residents with anticoagulant medications and residents with a change in anticoagulant medication will have a RN assessment and update to their care plans implemented for risk of bleeding/ bruising/ and safety. E. All residents that are prescribed an antidiabetic medication have had RN MDS Coordinator reassessment and Care Plan review/updates. All new residents with antidiabetic medications and residents with a change in antidiabetic medication will have a RN assessment and update to their care plans for low blood sugar interventions and high blood sugar interventions.	

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F 279	Continued From page 4 medical, nursing, mental and psychosocial needs that had been identified in the comprehensive assessment.	F 279	F. All nursing staff educated for compliance with following care plan for signs/symptoms of risk of bleeding/bruising and following care plan for hypoglycemic/hyperglycemic signs and symptoms, and at Licensed Staff meeting 10-4-17 and NAR staff meeting 10-5-17. G. Staff not attending are provided written education on anticoagulant use and risk for bleeding/bruising and written education on antidiabetic medication use and signs of hypo/hyperglycemia and will document by signature they understand this information prior to their next scheduled shift and protocol included with all new employee orientation. H. DON or her designee audits care plans of all newly admitted residents with medication for diabetes or medication which puts resident at risk of bleeding. This will ensure all recently admitted residents have care plans for anticoagulant use and hypoglycemia/hyperglycemia weekly x 4 weeks, then random monthly audit thereafter and will document audit results. I. Compliance with audits reported to our QA program by DON and reported to QAPI meetings quarterly. J. Completion date 10-10-17.	
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--	F 329		9/22/17

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F 329	Continued From page 5 (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic 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 ensure resident drug regimens were free from excessive doses of acetaminophen for 1 of 5 residents (R61) whose drug regimens were reviewed.	F 329	First Care Living Center will ensure that each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose.	

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F 329	Continued From page 6 Findings include: R61's admission Minimum Data Set (MDS) dated 7/12/17, indicated R61 was cognitively intact and had diagnoses which included collapsed lumbar vertebra with subsequent encounter for fracture, gout, and arthritis. The MDS also indicated R61 received as needed pain (PRN) medication for occasional pain rated 4 on a 0-10 scale. R61's undated Care Plan indicated R61 had a potential for pain related to lumbar fracture, congestive heart failure, edema and generalized deconditioning. The Care Plan directed staff to administer medications as ordered, attempt non-pharmacological interventions prior to using medications for pain management, and attempt pain rating scale prior to intervention use and to use log roll technique for supine (lying face upward) to sit and getting out of bed, do not twist back. The Care Plan also directed staff standing orders were in place and to update MD [physician] and family as needed with changes in comfort level. R61's Physician Order Report dated 7/23/17 - 8/23/17, included the following orders: --acetaminophen 1000 milligrams (mg) every 4 hours as needed for fracture of third lumbar vertebra. The order start date was identified as 7/5/17. --May use standing orders. The order start date was identified as 7/5/17.	F 329	A. First Care Living Center policy for Consultant Pharmacy medication regimen reviewed 8/30/17. At least monthly review of medication regimen or a more frequent review if deemed necessary by prescriber, DON or other licensed nurse. B. RN MDS Coordinator review of R61 EMAR completed 8-30-17, attending Physician changed the order to acetaminophen 1000mg every 6 hours PRN with special MD instructions: Do not exceed 4000mg in 24 hours. C. RN MDS Coordinators reviewed all current residents orders 8/30/17 to ensure physician orders do not have acetaminophen (or any other medication that contains acetaminophen) which could be given in excess of 3000mg, or with physician discretion, 4000mg. D. DON or her designee will audit all new orders for acetaminophen or any other medication that contains acetaminophen weekly x 4 weeks, then random monthly audit thereafter and will document results. E. Consultant Pharmacy will review monthly all resident's medication orders to ensure they are free from unnecessary drugs, to document audit of acetaminophen orders, and to allow only maximum dose. F. At Licensed staff meeting on October 4, 2017 all licensed staff (RNs, LPNs, TMAs) will be verbally provided information on compliance for acetaminophen not to exceed 4000mg in 24 hours with discretion from physician. Acetaminophen 3000mg in 24 hours per standing orders of facility. Written education will include recommended	

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F 329	Continued From page 7 The Standing Orders of First Care Medical Services Nursing Home dated 5/20/13, directed Tylenol (acetaminophen) administration was not to exceed 3 grams (gm) daily. This included Tylenol in combination drugs. On 8/30/17, at 7:35 a.m. R61 was observed up and dressed, walking independently with a walker toward the dining room. Her gait was steady. She greeted staff members in the hall and the interactions were friendly and cordial. No mood or pain symptoms were observed. Review of R61's Medication Administration History dated 7/1/17 - 7/31/17, revealed on 7/13/17, R61 received 1000 mg of acetaminophen at 12:52 a.m., 5:23 a.m., 9:47 a.m., 4:11 p.m. and 8:16 p.m. for a total of 5000 mg or 5 gm within a 24 hour period. On 8/30/17, at 11:06 a.m. registered nurse (RN)-B verified R61 received 5 gm of acetaminophen within 24 hours on 7/13/17, and confirmed it was not the practice of the facility to administer that much acetaminophen in a 24 hour period. RN-B stated their protocol was to not exceed 4000 mg or 4 gm in a 24 hour period. On 8/30/17, at 11:32 a.m. R61 was observed seated at a table, by herself, outside the south dining room. R61 stated she was on a lot of medications and indicated she managed them all herself when she was at home. R61 indicated	F 329	dosing from 2017 Mosby's Nursing drug Reference, side effects, black box warning, & copies of our current revised standing orders for facility. G. Licensed staff (RNs, LPNs, TMAs) not attending are provided written education on acetaminophen not to exceed 4000mg in 24 hours per discretion of physician & will document by signature that they received the information. Acetaminophen 3000mg in standing orders per standing orders of facility. Staff provided with education that will include recommended dosing from the 2017 Mosby's Nursing drug Reference, side effects, black box warning, & copies of our current revised standing orders - prior to their next scheduled shift and with all new employee orientation. H. Compliance of Acetaminophen dosing reported to our QA program by DON and reported to QAPI meetings quarterly and to Pharmacy and Therapeutic meetings quarterly. I. Completion date 10-10-17	

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she planned to discharge as soon as possible to an apartment in town. R61 stated her pain had been controlled with the use of Tylenol while at the facility. R61 also indicated she had been satisfied with her medication regimen and was very involved with her medication management. R61 further indicated the facility included her in decisions about her medications.

On 8/30/17, at 12:58 p.m. the director of nursing (DON) confirmed it was not the facility policy to administer more than 4 gm of acetaminophen in 24 hours and indicated she believed it was addressed in the facility standing orders.

On 8/30/17, at 1:41 p.m. consultant pharmacist (CP)-A stated the typical maximum dose for acetaminophen was 4 gm in 24 hours unless there had been some assessment to use otherwise. CP-A indicated he had not reviewed R61's record on 8/28/17, and stated he would not necessarily have made an individual recommendation regarding excessive acetaminophen dose for R61. However, CP-A indicated he would have wanted to discuss acetaminophen dosing parameters at a global level with nursing and discuss the issue at the facility QAPI (quality assessment and performance improvement) meeting.

The Tylenol dosing guidelines published by Johnson & Johnson Consumer Inc, McNeil Consumer Healthcare Division dated 2017, indicated the total labeled daily dose of Tylenol Extra Strength (500 mg per tablet) was 3000 mg. Professional discretionary dosing indicated if pain

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F 329	Continued From page 9 or fever persists at the total labeled daily dose, healthcare professionals may exercise their discretion and recommend up to 4000 mg/day.	F 329		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F 428		9/22/17

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F 428	Continued From page 10 (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility consultant pharmacist failed to identify resident drug regimens were free from excessive doses of acetaminophen for 1 of 5 residents (R61) whose drug regimens were reviewed. Findings include: R61's admission Minimum Data Set (MDS) dated 7/12/17, indicated R61 was cognitively intact and had diagnoses which included collapsed lumbar vertebra with subsequent encounter for fracture, gout, and arthritis. The MDS also indicated R61 received as needed pain (PRN) medication for occasional pain rated 4 on a 0-10 scale. R61's undated Care Plan indicated R61 had a	F 428	First Care Living Center ensures that each resident's drug regimen is reviewed at least once a month by licensed pharmacist to identify any irregularities of unnecessary medications such as excessive dose, excessive duration, adverse consequences, or without adequate monitoring/indications for use. A. First Care Living Center policy for Consultant Pharmacy medication regimen reviewed. At least monthly review of medication regimen or a more frequent review if deemed necessary by prescriber, DON or other licensed nurse. Consultant Pharmacist report irregularities to the attending physician, medical director and facility DON on the Consultant Pharmacist Medication Review form. The attending physician addresses the recommendation at their next scheduled visit. Medical Director and Director of Nursing reviews	

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F 428	Continued From page 11 potential for pain related to lumbar fracture, congestive heart failure, edema and generalized deconditioning. The Care Plan directed staff to administer medications as ordered, attempt non-pharmacological interventions prior to using medications for pain management, and attempt pain rating scale prior to intervention use and to use log roll technique for supine (lying face upward) to sit and getting out of bed, do not twist back. The Care Plan also directed staff standing orders were in place and to update MD [physician] and family as needed with changes in comfort level. R61's Physician Order Report dated 7/23/17 - 8/23/17, included the following orders: --acetaminophen 1000 milligrams (mg) every 4 hours as needed for fracture of third lumbar vertebra. The order start date was identified as 7/5/17. --May use standing orders. The order start date was identified as 7/5/17. The Standing Orders of First Care Medical Services Nursing Home dated 5/20/13, directed Tylenol (acetaminophen) administration was not to exceed 3 grams (gm) daily. This included Tylenol in combination drugs. On 8/30/17, at 7:35 a.m. R61 was observed up and dressed, walking independently with a walker toward the dining room. Her gait was steady. She greeted staff members in the hall and the interactions were friendly and cordial. No mood or pain symptoms were observed.	F 428	and signs form when addressed. B. Consultant Pharmacy reviews monthly all resident's medication orders to ensure they are free from unnecessary drugs. Consultant Pharmacy provides documentation of audits for acetaminophen to orders allow only maximum dose. For example: if the acetaminophen order says 1000mg q 4 hours prn, will have physician change the order to QID prn so only can give 4000gm. Also, if acetaminophen is scheduled 650mg TID, will only allow 650mg prn order to say TID prn (at most) to avoid unintentional overdose. C. DON or her designee audits all new orders for acetaminophen or any other medication that contains acetaminophen weekly x 4 weeks, then random monthly audit thereafter and will document results. D. DON or her designee audits all consultant pharmacy mediation review end of visit summary forms monthly x 4 months, then random monthly audit thereafter and documents results. E. At Licensed staff meeting on October 4, 2017 all Licensed staff (RNs, LPNs, TMAs) education verbally on compliance for acetaminophen not to exceed 4000mg in 24 hours with discretion from physician. Acetaminophen 3000mg in 24 hours per standing orders of facility. Written education provided will include recommended dosing from 2017 Mosby's Nursing drug Reference, side effects, black box warning, & copies of our current revised standing orders for facility. Documentation of signature staff received and understand information.	

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F 428	Continued From page 12 Review of R61's Medication Administration History dated 7/1/17 - 7/31/17, revealed on 7/13/17, R61 received 1000 mg of acetaminophen at 12:52 a.m., 5:23 a.m., 9:47 a.m., 4:11 p.m. and 8:16 p.m. for a total of 5000 mg or 5 gm within a 24 hour period. The Pharmacist's Drug Regimen Review dated 8/28/17, indicated "Considering increased PRN (as needed) analgesic use and diagnosis of rheumatoid arthritis, appears ongoing use/current dose of prednisone is appropriate. PRN Tylenol appears to be effective and well tolerated. Will continue to monitor. Worsened symptoms of anxiety/depression. Celexa increased due to increased anxiety/depression. Gradual dose reductions of psychotropic drugs not appropriate at this time. Advised nursing on documentation of PRN meds." The Review did not address the excessive dose of acetaminophen administered on 7/13/17, or recommend parameters for acetaminophen dosage. On 8/30/17, at 11:06 a.m. registered nurse (RN)-B verified R61 received 5 gm of acetaminophen within 24 hours on 7/13/17, and confirmed it was not the practice of the facility to administer that much acetaminophen in a 24 hour period. RN-B stated their protocol was to not exceed 4000 mg or 4 gm in a 24 hour period. On 8/30/17, at 11:32 a.m. R61 was observed seated at a table, by herself, outside the south dining room. R61 stated she was on a lot of	F 428	F. Licensed staff (RNs, LPNs, TMAs) not attending are provided written education on acetaminophen not to exceed 4000mg in 24 hours per discretion of physician. Acetaminophen 3000mg in standing orders per standing orders of facility. Education includes recommended dosing from the 2017 Mosby's Nursing drug Reference, side effects, black box warning, & copies of our current revised standing orders – the will document by signature they have read and understood information prior to their next scheduled shift and with all new employee orientation. G. Compliance of Acetaminophen dosing of Consultant Pharmacy audits and DON audits reported to our QA program by DON and reported to Pharmacy and Therapeutic meeting quarterly & QAPI meetings quarterly. H. Completion date 10-10-17	

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F 428	Continued From page 13	F 428		

medications and indicated she managed them all herself when she was at home. R61 indicated she planned to discharge as soon as possible to an apartment in town. R61 stated her pain had been controlled with the use of Tylenol while at the facility. R61 also indicated she had been satisfied with her medication regimen and was very involved with her medication management. R61 further indicated the facility included her in decisions about her medications.

On 8/30/17, at 12:58 p.m. the director of nursing (DON) confirmed it was not the facility policy to administer more than 4 gm of acetaminophen in 24 hours and indicated she believed it was addressed in the facility standing orders. DON indicated she would have expected the pharmacist to catch that R61 exceeded that limit on their monthly drug review.

On 8/30/17, at 1:41 p.m. consultant pharmacist (CP)-A stated the typical maximum dose for acetaminophen was 4 gm in 24 hours unless there had been some assessment to use otherwise. CP-A indicated he had not reviewed R61's record on 8/28/17, and stated he would not necessarily have made an individual recommendation regarding excessive acetaminophen dose for R61. However, CP-A indicated he would have wanted to discuss acetaminophen dosing parameters at a global level with nursing and discuss the issue at the facility QAPI (quality assessment and performance improvement) meeting.

On 8/30/17, at 2:32 p.m. CP-B indicated he had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH FOSSTON	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

(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 428	Continued From page 14 not identified R61 had received 5 gm of acetaminophen on 7/13/17, and confirmed he had not made any recommendations to the facility regarding acetaminophen dosage. The Tylenol dosing guidelines published by Johnson & Johnson Consumer Inc, McNeil Consumer Healthcare Division dated 2017, indicated the total labeled daily dose of Tylenol Extra Strength (500 mg per tablet) was 3000 mg. Professional discretionary dosing indicated if pain or fever persists at the total labeled daily dose, healthcare professionals may exercise their discretion and recommend up to 4000 mg/day. A policy regarding consultant pharmacist drug regimen reviews was requested but not provided.	F 428		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);	F 441		9/22/17

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F 441	Continued From page 15 (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 441		

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F 441	Continued From page 16 (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to appropriately clean nebulizer equipment in between use for 1 of 1 resident (R30) observed to receive a nebulizer treatment without proper cleaning of the equipment following its use. Findings include: On 8/29/17, at 11:20 a.m. registered nurse (RN)-A was observed to complete a scheduled nebulizer treatment (aerosol medication) on R30. RN-A removed nebulizer tubing and face mask out of a plastic bag which was hanging on the wall next to R30's bed. RN-A hooked the tubing onto the nebulizer machine, inserted the medication, placed the facial mask on R30 and started the treatment. RN-A stated R30's tubing and mask was changed weekly and had just been changed yesterday. -At 11:35 a.m. the nebulizer treatment was completed. RN-A shut the nebulizer machine off, took the tubing and medication canister off the machine, and the removed the facemask from R30. RN-A proceeded to walk into the bathroom, ran tap water over the canister and mask and	F 441	First Care Living Center strives to provide a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, etc. A. First Care Living Center's Policy for Administering Medications through a small volume (handheld) Nebulizer and Policy for Cleaning and Disinfecting Nebulizer Equipment have been reviewed & updated by DON & Respiratory Therapy according to CDC guidelines on 9/22/17. B. At October 4, 2017 licensed staff meeting, (RNs, LPNs, and TMA) nursing staff educated verbally and provided written copies of updated policies and procedures for Administering medications through a Small Volume (handheld) Nebulizer and Policy for Cleaning and Disinfecting Nebulizer Equipment. Documentation by signature that they have received and understand information. C. Licensed staff (RNs, LPNs, TMAs) not attending are provided written copies of updated policies and procedures for Administering Medications through a Small Volume Nebulizer and Cleaning and	

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F 441	Continued From page 17 placed the items back into the plastic bag which was hanging on the wall next to R30's bed. On 8/30/17, 9:05 a.m. the director or nursing (DON) stated the nebulizer equipment was to be cleaned with sterile water. The DON verified the RN did not follow the facility procedure for cleaning the nebulizer equipment. The facility policy, Infection Control-Legionnaires disease new regulations, dated 6/12/17, indicated all nebulizer cups and masks were to be rinsed with new sterile water vials and directed staff to use breathable plastic bags to store nebulizer tubing and oxygen tubing when not in use. The facility policy, Respiratory Infection Control, dated 6/12/17, indicated the Respiratory Therapy and Nursing departments would follow the facilities infection control policies and specific policies that pertain to respiratory equipment. All equipment would be cleaned with approved Essential Health product. Aerosol oxygen setups would be rinsed with 5 ml (millimeter) unit dose sterile water after each use and allowed to air dry, changed weekly and as needed. The facility's undated, Cleaning your nebulizer policy indicated after each use staff were to rinse each piece with warm water and to let air-dry on a clean paper or cloth towel. - Once a day while in use (cleaning) soak the nebulizer pieces in warm soapy water for 20-30 minutes. Rinse each piece with warm water. Let	F 441	updated policies and procedures for Cleaning and Disinfecting of Nebulizer Equipment. Document by signature the understanding of this information prior to their next scheduled shift and protocol included with all new employee orientation. D. DON or her designee audits for compliance that staff are following policy for administering medications through a small volume nebulizer and cleaning and disinfecting of nebulizer equipment, by observation of each nursing staff completing the skill prior to 10/10/17. E. Compliance of nebulizer cleaning education and audits reported by DON to our QA program and reported to QAPI meetings quarterly and Essentia Infection Control meetings quarterly. F. Completion date 10-10-17	

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	245512	A. BUILDING _____ B. WING _____	08/30/2017

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F 441	Continued From page 18 air-dry on a clean paper or cloth towel. -Twice a week disassemble nebulizer. Mix 1/2 cup white vinegar and 1 1/2 cup water. Soak the nebulizer pieces in the mixture for 30 minutes. Rinse each piece with warm water. Let air-dry on a clean paper or cloth towel. Store nebulizer in a clean/dry plastic bag. -Replace nebulizer equipment every two weeks.	F 441		

Electronically delivered
September 14, 2017

Mr. Kevin Gish, Administrator
Essentia Health Fosston
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

Re: Project Number S5512027

Dear Mr. Gish:

The above facility was surveyed on August 28, 2017 through August 30, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman at (218) 308-2104 or email: lyla.burkman@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.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00461	A. BUILDING: _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH FOSSTON	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

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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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING **01 - NURSING HOME** B. WING _____	**08/29/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Essentia Health NH 01 Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/22/2017

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.

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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Essentia Health NH is a 1-story building without a basement. The building was constructed at 2 different times. The original building was constructed in 1972 and was determined to be of Type II(111) construction. In 1997, additions to the sleeping rooms and an activates room to the north east corner were constructed. Theses additions are Type II(111) construction. The building is divided into 4 smoke zones with a 30 minute and two 2-hour fire barriers. The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 The Standard for the Installation of Automatic Sprinkler Systems . The facility has a fire alarm system with smoke detection in the corridor system, in all sleeping rooms and in common areas, installed in accordance with NFPA 72 "The National Fire	K 000		

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K 000	Continued From page 2 Alarm Code" . The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system. The facility has a capacity of 50 beds and had a census of 41 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 131 SS=E	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: * They are not intended to serve four or more inpatients. * They are separated from areas of health care occupancies by construction having a minimum 2-hour fire resistance rating in accordance with Chapter 8. * The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the proper 2 hour fire resistive ratings for occupancies as described in the Life Safety Code (NFPA 101) 2012 edition section 19.1.3.3. This deficient practice could	K 131	Maintenance worker used a fire stop foam product to fill the gap between the roof/ceiling and wall. The facility manager will monitor this to prevent reoccurrence.	9/4/17

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K 131	Continued From page 3 allow for the transfer of smoke or fire from another occupancy and affect 16 of the 41 residents and an undetermined amount of staff and visitors. Findings include: At 10:50 am on 08/29/2017 observations revealed the top of the 2 hour fire barrier wall at the North Wing was not properly fire stopped. This deficient condition was confirmed by the facility Maintenance Engineer.	K 131		
K 321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops	K 321		9/8/17

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K 321	Continued From page 4 d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one hazardous room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor and other adjacent spaces making them untenable and affect the quick and efficient exiting for 16 of 41 residents and an undetermined amount of staff and visitors . Findings include: At 11:31 am on 08/29/2017 observations revealed mechanical room #206 had a hole in the ceiling approximately 12 inches x 18 inches. This deficient conditions was confirmed by the facility Maintenance Engineer.	K 321	The ceiling was patched by the maintenance department. The facility manager will monitor the room to insure compliance.	
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.	K 353		9/8/17

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH FOSSTON	**900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 5 a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all of the 41 residents and an undetermined amount of staff and visitors. Findings include: At 9:40 am on 08/29/2017 record review revealed documentation of the last internal sprinkler inspection was not available. This deficient condition was confirmed by the facility Maintenance Engineer	K 353	We have had a company complete an obstruction test on all of our sprinkler systems. This was completed on 9/8/2017. I have scheduled this test to be completed every 5 years per code. The facility manager will monitor this to ensure compliance.	