DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 15, 2021

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

RE: CCN: 245458
Cycle Start Date: January 29, 2021

Dear Administrator:

On February 19, 2021, we notified you a remedy was imposed. On March 10, 2021 the Minnesota Departments of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 5, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 6, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 19, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 6, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 5, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

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

Electronically delivered
February 19, 2021

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

RE: CCN: 245458
Cycle Start Date: January 29, 2021

Dear Administrator:

On January 29, 2021, a survey was completed at your facility by the Minnesota Departmen of Health 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 6, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 6, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 6, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION (Delete this section if SQC tags are cited and this note)

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 6, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Essentia Health Virginia Care Cent will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 6, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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 July 29, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and

1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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 _____	C 01/29/2021

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 On 1/28/21, through 1/29/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H#5458026C. The following complaint was found to be unsubstantiated: H5458027C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		3/5/21

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

Electronically Signed | 03/01/2021

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F 689	Continued From page 1 by: Based on interview, and document review, the facility failed to ensure the care plan was followed to prevent falls with injuries for 1 of 3 residents (R1) reviewed for accidents. This resulted in actual harm for R1 who sustained a scalp laceration and fractured hip. Finding include: R1's Face Sheet printed 1/29/21, included diagnoses included of hemiplegia (paralysis on one side of the body), and hemiparesis (slight paralysis or weakness to one side of the body) following cerebral infarction (stroke), affecting right dominant side. R1's quarterly Minimum Data Set (MDS) dated 1/5/21, indicated R1 had moderately impaired cognition, required extensive assistance from staff for transfers, and had experienced one fall with injury. R1's care plan initiated 4/2/20, indicated R1 required extensive assistance for grooming, toileting, and transfers. R1's care plan further indicated R1 had several falls since admission, with a goal of not to be injured by avoidable falls. R1's updated care plan 11/20/20, directed staff to provide 15-minute checks while R1 was asleep. R1 was to be in direct line of sight of staff when out of bed until 2:00 p.m., and staff was to provide one-on-one supervision from 2:00 p.m. to 8:00 p.m., or until R1 was in bed asleep for the evening. On 12/4/20, an Event Report indicated at 3:02 p.m. R1 was found on the floor face down in her room. The facility's root cause conclusion was	F 689	POC F689 Falls Compliance Date 3/5/2021 Resident was evaluated immediately by RN in facility and sent to ED for further evaluation. Care plan was review and revised and a new RCA was completed anticipating Resident return. However, Resident did not return to the facility and was discharged on 1/26/2021. The Interdisciplinary Team reviewed all resident falls in the preceding 3 months. Root Cause Analysis reviewed to ensure completeness and to determine if appropriate interventions were in place. Care plans were reviewed and updated as necessary. Staff were educated on the care plan and intervention changes. Care Plan Policy and Procedures were reviewed and updated. Specifically, among other things, provisions were included to ensure that each care plan change will be promptly communicated to the front-line staff. All nursing staff were educated on the Policy revisions. Director of Nursing/designee will perform audits of Care Plans to ensure compliance with the updated Care Plan Policy as follows: all care plan changes will be reviewed daily for 7 days; then 25% of resident charts weekly for 3 weeks; then 25% of resident charts monthly for 2 months; then quarterly for 3 quarters. All issues will be brought to the Administrator's attention for immediate	

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F 689	Continued From page 2 R1 attempted to transfer herself from her wheelchair to bed, and may have tripped over the call light which was around R1's right ankle. R1's care plan was updated to place the call light on R1's left side, and not to place the call light between the wheelchair and the bed. On 12/4/20, a progress note indicated R1 was found face down on the floor in her room near her bed. Upon examination, R1 obtained a large hematoma on the right upper part of the eye, and an abrasion to the right knee. The note further indicated R1 tried to self transfer into bed, and fell to the floor. R1 was transferred to the emergency department (ED) for evaluation. On 12/4/20, the ED note indicated R1 was seen in the ED for an evaluation post fall. R1 presented with a contusion (bruise) to her right eye/head. Facial imaging was completed and suggested a contusion on the forehead and around the orbit (eye socket) with no evidence of a fracture. R1's elbow x-ray was negative for a fracture. On 1/25/21, an Event Report indicated at 9:00 a.m. R1 was found in her room on the floor with her left arm on her side rail, and her wheelchair was behind her. R1 had increased pain, was bleeding from the right side of her scalp, and was sent to the emergency room. On 1/25/21, a progress note indicated R1 had an unwitnessed fall in her room. R1 attempted to self-transfer, obtained a laceration to the right region of the scalp, and was sent to the ED. On 1/25/21, another progress note indicated R1 was impulsive related to cerebral infarction, and preferred to lie down after meals. During the time R1 fell, staff were not in R1's room and staff were	F 689	follow up. Administrator will bring to the QAPI committee at least quarterly for additional follow up as directed.	

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F 689	Continued From page 3	F 689		

answering call lights.

On 1/25/21, the ED note indicated R1 was admitted post fall and was treated for a scalp laceration, and closed right intertrochanteric fracture (hip fracture). R1 was hospitalized.

On 1/28/21, at 1:20 p.m. nursing assistant (NA)-A was interviewed and stated R1 was in the hospital following a fall with a fracture which occurred on 1/25/21. NA-A stated when R1 was in her room awake, R1 needed to have someone with her because she would try to transfer herself into bed, usually after meals. NA-A stated if R1 was supposed to be in line of staff's site, and if R1 was in her room, staff could not see her, so R1 was supposed to sit in the hallway or buy the nurse's desk.

On 1/29/21, at 9:59 a.m. registered nurse (RN)-A was interviewed and stated R1 had poor judgement of safety awareness, and would attempt to transfer herself into bed from her wheelchair. RN-A stated according to R1's care plan, R1 was to be in line of site when up until 2:00 p.m., then from 2:00 p.m.- 8:00 p.m., one-on-one with staff. RN-A further stated R1's falls on 12/4/21, and 1/25/21, both occurred in R1's room, and R1 was left unsupervised both times. RN-A stated if R1 was in direct line of sight, or on one-on-one with staff as the care plan directed, R1 would not have self-transferred and fallen.

On 1/29/21, at 10:32 a.m. RN-B stated she worked 1/25/21, the morning R1 fell and obtained a head laceration. RN-B stated she was summoned by NA-A, who found R1 in her room on the floor. RN-B stated R1's care plan

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F 689	Continued From page 4	F 689		

interventions included R1 to be in line of sight with staff during the day, and one-on-one with staff supervision from 2:00 p.m. until R1 went to bed for the night. RN-B stated at the time R1 fell, R1 was alone in her room, while staff were busy with breakfast trays.

On 1/29/21, at 10:58 a.m. NA-D stated she was passing linen on 1/25/21, and noticed R1's door was closed. NA-D stated she opened R1's door, and R1 was on the floor next to her bed. NA-D stated R1 said she was trying to go to bed when she fell. NA-D stated R1's care plan indicated R1 was to be in line of sight, and R1 would normally be in the hallway doing an activity, or by the nurse's desk. NA-D stated staff would rotate and sit with R1 during the one-on-one times, and there was not staff directly assigned to only R1.

On 1/29/21, at 11:49 a.m. NA-E stated she found R1 on the floor in her room on 1/25/21. NA-E stated she had taken R1's breakfast tray our of her room that morning, and about five minutes later NA-E returned to R1's room and found R1 on the floor with blood coming from her head. NA-E stated she was not aware at that time R1's care plan directed R1 to be in line of sight from the time R1 got up in the morning, and from 2:00 p.m. to 8:00 p.m. R1 required one-on-one staff until she went to bed for the night.

On 1/29/21, at 12:14 p.m. an interview was conducted with the administrator in training. The administrator in training stated when residents were to be in line of sight, it would include being able to always visualize the resident, and one-on-one would include one staff to one resident. The administrator in training stated there was not one staff member assigned to R1,

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F 689	Continued From page 5	F 689		

and staff rotated to sit with R1. The administrator in training verified R1 should have been in line of sight from the time R1 got up in the morning until 2:00 p.m., and from 2:00 p.m. to 8:00 p.m. had one-on-one staff supervision until in bed for the night, and checks every 15 minute check during the night. The administrator in training stated R1's care plan was not being followed which contributed to her falls on 12/4/20, and 1/25/21, both resulting in injuries. The administrator in training verified R1 remained hospitalized.

The facility policy Baseline Care Plan Policy reviewed 11/26/20, directed the facility staff or those acting on behalf of the facility would implement the interventions to assist the resident to achieve care plan goals and objectives. The policy further directed direct care staff would be educated about the care plan interventions.

The facility policy Care Conferences/Care Planning reviewed 3/15/20, indicated each resident shall have a plan of care so that he/she will receive the care necessary to enable him/her to achieve and/or maintain the highest practical physical, mental and psychological well-being. The policy further indicated care plan assessment and changes would be made quarterly and as needed. Care plans are reviewed with direct care staff as needed.

Electronically delivered
February 18, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: HF7K11

Dear Administrator:

The above facility was surveyed on January 28, 2021 through January 29, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

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

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
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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 _____	C 01/29/2021

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
2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 1/28/21, through 1/29/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be not in compliance with the MN State Licensure.

The following complaint was found to be substantiated: H5458026C with a licensing order

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2 000	Continued From page 1 issued at 0835. The following complaint was found to be unsubstantiated H5458027C. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure the care plan was followed to prevent falls with injuries for 1 of 3 residents (R1) reviewed for accidents. This resulted in actual harm for R1 who sustained a scalp laceration and fractured hip. Finding include: R1's Face Sheet printed 1/29/21, included diagnoses included of hemiplegia (paralysis on one side of the body), and hemiparesis (slight paralysis or weakness to one side of the body) following cerebral infarction (stroke), affecting right dominant side. R1's quarterly Minimum Data Set (MDS) dated 1/5/21, indicated R1 had moderately impaired cognition, required extensive assistance from staff for transfers, and had experienced one fall	2 835	CORRECTED AS OF 03/05/2021.	3/5/21

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2 835	Continued From page 3 with injury. R1's care plan initiated 4/2/20, indicated R1 required extensive assistance for grooming, toileting, and transfers. R1's care plan further indicated R1 had several falls since admission, with a goal of not to be injured by avoidable falls. R1's updated care plan 11/20/20, directed staff to provide 15-minute checks while R1 was asleep. R1 was to be in direct line of sight of staff when out of bed until 2:00 p.m., and staff was to provide one-on-one supervision from 2:00 p.m. to 8:00 p.m., or until R1 was in bed asleep for the evening. On 12/4/20, an Event Report indicated at 3:02 p.m. R1 was found on the floor face down in her room. The facility's root cause conclusion was R1 attempted to transfer herself from her wheelchair to bed, and may have tripped over the call light which was around R1's right ankle. R1's care plan was updated to place the call light on R1's left side, and not to place the call light between the wheelchair and the bed. On 12/4/20, a progress note indicated R1 was found face down on the floor in her room near her bed. Upon examination, R1 obtained a large hematoma on the right upper part of the eye, and an abrasion to the right knee. The note further indicated R1 tried to self transfer into bed, and fell to the floor. R1 was transferred to the emergency department (ED) for evaluation. On 12/4/20, the ED note indicated R1 was seen in the ED for an evaluation post fall. R1 presented with a contusion (bruise) to her right eye/head. Facial imaging was completed and suggested a contusion on the forehead and around the orbit (eye socket) with no evidence of a fracture. R1's	2 835		

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2 835	Continued From page 4 elbow x-ray was negative for a fracture. On 1/25/21, an Event Report indicated at 9:00 a.m. R1 was found in her room on the floor with her left arm on her side rail, and her wheelchair was behind her. R1 had increased pain, was bleeding from the right side of her scalp, and was sent to the emergency room. On 1/25/21, a progress note indicated R1 had an unwitnessed fall in her room. R1 attempted to self-transfer, obtained a laceration to the right region of the scalp, and was sent to the ED. On 1/25/21, another progress note indicated R1 was impulsive related to cerebral infarction, and preferred to lie down after meals. During the time R1 fell, staff were not in R1's room and staff were answering call lights. On 1/25/21, the ED note indicated R1 was admitted post fall and was treated for a scalp laceration, and closed right intertrochanteric fracture (hip fracture). R1 was hospitalized. On 1/28/21, at 1:20 p.m. nursing assistant (NA)-A was interviewed and stated R1 was in the hospital following a fall with a fracture which occurred on 1/25/21. NA-A stated when R1 was in her room awake, R1 needed to have someone with her because she would try to transfer herself into bed, usually after meals. NA-A stated if R1 was supposed to be in line of staff's site, and if R1 was in her room, staff could not see her, so R1 was supposed to sit in the hallway or buy the nurse's desk. On 1/29/21, at 9:59 a.m. registered nurse (RN)-A was interviewed and stated R1 had poor judgement of safety awareness, and would attempt to transfer herself into bed from her	2 835		

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2 835	Continued From page 5	2 835		

wheelchair. RN-A stated according to R1's care plan, R1 was to be in line of site when up until 2:00 p.m., then from 2:00 p.m.- 8:00 p.m., one-on-one with staff. RN-A further stated R1's falls on 12/4/21, and 1/25/21, both occurred in R1's room, and R1 was left unsupervised both times. RN-A stated if R1 was in direct line of sight, or on one-on-one with staff as the care plan directed, R1 would not have self-transferred and fallen.

On 1/29/21, at 10:32 a.m. RN-B stated she worked 1/25/21, the morning R1 fell and obtained a head laceration. RN-B stated she was summoned by NA-A, who found R1 in her room on the floor. RN-B stated R1's care plan interventions included R1 to be in line of sight with staff during the day, and one-on-one with staff supervision from 2:00 p.m. until R1 went to bed for the night. RN-B stated at the time R1 fell, R1 was alone in her room, while staff were busy with breakfast trays.

On 1/29/21, at 10:58 a.m. NA-D stated she was passing linen on 1/25/21, and noticed R1's door was closed. NA-D stated she opened R1's door, and R1 was on the floor next to her bed. NA-D stated R1 said she was trying to go to bed when she fell. NA-D stated R1's care plan indicated R1 was to be in line of sight, and R1 would normally be in the hallway doing an activity, or by the nurse's desk. NA-D stated staff would rotate and sit with R1 during the one-on-one times, and there was not staff directly assigned to only R1.

On 1/29/21, at 11:49 a.m. NA-E stated she found R1 on the floor in her room on 1/25/21. NA-E stated she had taken R1's breakfast tray our of her room that morning, and about five minutes later NA-E returned to R1's room and found R1

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2 835	Continued From page 6	2 835		

on the floor with blood coming from her head. NA-E stated she was not aware at that time R1's care plan directed R1 to be in line of sight from the time R1 got up in the morning, and from 2:00 p.m. to 8:00 p.m. R1 required one-on-one staff until she went to bed for the night.

On 1/29/21, at 12:14 p.m. an interview was conducted with the administrator in training. The administrator in training stated when residents were to be in line of sight, it would include being able to always visualize the resident, and one-on-one would include one staff to one resident. The administrator in training stated there was not one staff member assigned to R1, and staff rotated to sit with R1. The administrator in training verified R1 should have been in line of sight from the time R1 got up in the morning until 2:00 p.m., and from 2:00 p.m. to 8:00 p.m. had one-on-one staff supervision until in bed for the night, and checks every 15 minute check during the night. The administrator in training stated R1's care plan was not being followed which contributed to her falls on 12/4/20, and 1/25/21, both resulting in injuries. The administrator in training verified R1 remained hospitalized.

The facility policy Baseline Care Plan Policy reviewed 11/26/20, directed the facility staff or those acting on behalf of the facility would implement the interventions to assist the resident to achieve care plan goals and objectives. The policy further directed direct care staff would be educated about the care plan interventions.

The facility policy Care Conferences/Care Planning reviewed 3/15/20, indicated each resident shall have a plan of care so that he/she will receive the care necessary to enable him/her to achieve and/or maintain the highest practical

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2 835	Continued From page 7 physical, mental and psychological well-being. The policy further indicated care plan assessment and changes would be made quarterly and as needed. Care plans are reviewed with direct care staff as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure care plans are being followed and interventions are being implemented to reduce risk for falls. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 835		