



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

May 21, 2026

Administrator

114 FRAZEE STREET EAST
DETROIT LAKES, MN 56501

RE: Event ID: 1E3E81-H2

Dear Administrator:

On May 5, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance with federal regulations and state licensing statutes.

Feel free to contact me with any questions related to this letter.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

cc: Licensing and Certification File



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May 21, 2026

Administrator

ESSENTIA HEALTH HOME CARE WEST
114 FRAZEE STREET EAST
DETROIT LAKES, MN 56501

Re: State Licensing Orders
Event ID#: 1E3E81-H2

Dear Administrator:

On May 5, 2026, staff of the Minnesota Department of Health completed a follow-up survey of your agency to determine correction of orders found on the survey completed on March 12, 2026. At this time these correction orders were found corrected.

Signature here

A handwritten signature in black ink that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

An equal opportunity employer.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248052		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/12/2026	
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH HOME CARE WEST				STREET ADDRESS, CITY, STATE, ZIP CODE 114 FRAZEE STREET EAST , DETROIT LAKES, Minnesota, 56501			
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E0000	Initial Comments		E0000				
	A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 3/9/26 through 3/12/26 during an extended recertification survey. The facility is found to be in compliance with the Appendix Z Emergency Preparedness Requirements.						
G0000	INITIAL COMMENTS		G0000				
	On 3/9/26 through 3/12/26, a recertification survey was conducted. This resulted in an extended survey at Essentia Health Home Care. The agency was found to have not met the requirements at 42 CFR. Part 484 for Home Health Agencies.						
	The cumulative effects of these findings resulted in the Home Health Agency's inability to ensure provision of quality of care.						
	The Condition of Participation: Care Planning, Coordination and Quality of Care at 42 CFR 484.60 at G574 was found not met.						
	The cumulative effects of these findings resulted in the Home Health Agency's inability to ensure provision of quality of care.						
	Unduplicated census previous 12 months: 1310						
	Total home visits conducted: 7						
	Parent Location visited: Essentia Health Home Care West						
	114 Frazee Street East						
	Detroit Lakes, Minnesota (MN) 56501						
	Branch locations:						
	Essentia Health Home Care West						
	900 Hilligoss Boulevard SE						
	Fosston, MN 56542						

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ray Tazak</i>	TITLE <i>RN Director</i>	(X6) DATE <i>4/8/26</i>
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G0000	Continued from page 1 Essentia Health Home Care West 3362 35th Avenue South Fargo, North Dakota, 58104 St Mary's Home Health 201 9th Street West Ada, MN, 56510 Branch locations visited: Essentia Home Health Fargo, North Dakota St Mary's Home Health Ada, MN Hours of Operation: 8:00 a.m.- 4:30 p.m. List total number of records reviewed: 17		G0000				
G0372	Encoding and transmitting OASIS CFR(s): 484.45(a) Standard: An HHA must encode and electronically transmit each completed OASIS assessment to the CMS system, regarding each beneficiary with respect to which information is required to be transmitted (as determined by the Secretary), within 30 days of completing the assessment of the beneficiary. This STANDARD is NOT MET as evidenced by: Based on documentation and interview, the facility failed to report all Outcome and Assessment Information Sets (OASIS) data collected in accordance with federal regulations for timely submission. The total number of records submitted beyond the 30 days after completion of M0090 (the date the assessment was completed) was 25 for the period of 1/1/25 through 12/31/25, with 15/25 being submitted late for reasons other than payor change.		G0372				

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G0372	Continued from page 2 Findings include: On the HHA Error Summary by Agency report period of 1/1/25-12/31/25, the agency had an error code of -3330: record submitted late. The description included the submission was more than 30 days after completion on the new record. The total number of records submitted beyond the 30 days within that period was 25. During interview on 3/12/26 at 11:00 a.m., with director of nursing (DON) and clinical supervisor (CS)-B, OASIS oversight, DON stated the OASIS submission was completed daily, Monday through Friday. A review was completed of the identified late submissions as compiled by agency. Upon reviewing the information, it was noted 15/25 late submissions were for reasons outside of change of payor source. DON stated the OASIS guidance indicated the guidance for completion of the discharged patient must be completed by the last clinician, and at times there is miscommunication as to who is the last person providing services was, which had caused delays or errors in completion. CS-B stated all OASIS came to a work queue, and were assigned to staff by supervisors for the staff. A discussion was held at the Interdisciplinary Team (IDT) meetings to determine the last person who had seen the patient to determine who was to complete the OASIS and to review errors identified. IDT meetings were held weekly in some offices, and every two weeks in others. The facility policy, Home Care Certified Programs Comprehensive Assessment, last reviewed 6/15/23, and identified the OASIS data set requires timely completion and must be completed by the fifth day after the start of care. The policy identified the OASIS must be submitted through the iQIES system within 30 days.	G0372	15 of 15 late submission Oasis were reviewed to determine causes and whether the agency could correct the individual oasis. 1 out of 15 could be corrected and recertification OASIS was completed on 3/20/26. On 4/8/26 Agency ran the EMR report "HH recerts needed" to identify any patients with oasis needs who were not included in the 15 patients referenced in the deficiency. Agency Director will ensure all late oasis identified will be completed. Agency policy was updated to reflect that late oasis will be completed as per CMS guidance on late recertification oasis. Education will be provided to all staff (RN, PT, OT, SLP) who complete OASIS on 4/13/26. This education will include: New IDT template- ensure discharge, recertification, and transfers are discussed. Importance of patients understanding the need to see within the 5-day window Allowing other clinicians to see in the absence of primary case manager. Review of common reasons for late OASIS within agencies	5/4/26
G0546	Last 5 days of every 60 days unless: CFR(s): 484.55(d)(1)(i,ii,iii) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a- (i) Beneficiary elected transfer; (ii) Significant change in condition; or (iii) Discharge and return to the same HHA during the 60-day episode. This ELEMENT is NOT MET as evidenced by:	G0546	Review of common reasons for late OASIS within agencies	

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G0546	Continued from page 3 Based on interview and document review, the agency failed to complete a comprehensive reassessment the last 5 days of each 60-day certification period, beginning with the start of care (SOC), for 1 of 1 patient (P4) who received skilled home care services. P4's plan of care (POC) 1/9/26 to 3/9/26, identified a start of care (SOC) date 1/9/26. Orders included for skilled nurse visits (SNV) one time per week for nine weeks for various assessments and medication administration. Diagnoses included peritoneal abscess (a localized collection of pus in the abdominal cavity) with infection, emphysema (a chronic lung condition), history of bariatric surgery and dependence on oxygen. Review of P4's clinical record lacked any reassessments completed since the SOC on 1/9/26. A skilled nurse visit was on P4's visit schedule to complete a SNV for an Outcome and Assessment Information Set (oasis) recertification, however, a visit had not been completed. During interview on 3/11/26, at 12:08 p.m. the director of nursing (DON) stated she was aware P4 did not receive her scheduled nurse visit. P4's primary nurse was on vacation and P4 would not allow another nurse to make the visit. The DON stated normally she would expect a skilled nurse visit (SNV) within the five days required time frame for recertification a patient for continued home care services. A visit would be made when P4's primary nurse returns from her vacation, and the agency would submit a late oasis. It was not the agency's practice to discharge the patient and do a new SOC when a SNV could not be made to recertify the patient for home care services, they just submitted the oasis late. The agency policy Assessment, Reassessment and Coordination of Patient Services Home Care dated 4/26/24, identified patient assessments were completed by all professional staff within the home health care department. A comprehensive assessment was completed on patients every 55 to 60 days when the plan of care was reviewed and updated or on a resumption of care.		G0546	Supervisors will run HH recerts needed, and all recertifications due will be discussed at each IDT meeting and staff will schedule the recertification/discharge at that time to ensure Oasis visits are scheduled. Any changes to scheduled oasis visits will be communicated to the Supervisor to ensure oasis is not completed late. The revision needed workque will be monitored to ensure timely corrections are completed. Supervisors will audit to ensure that all recert oasis due in the next 14 days is on the schedule. Audits will be completed 100% of all Start of care, Resumptions, recertifications, discharges, and transfers from 4/13/2026 to 6/30/26. Results will be reviewed			
G0570	Care planning, coordination, quality of care CFR(s): 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical,		G0570				

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G0570	Continued from page 4 nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. This CONDITION is NOT MET as evidenced by: Based on the number and/or severity of the deficiencies cited the home health agency failed to meet the Condition of Participation: G570 at 42 CFR 484.60, Care Planning, Coordination, Quality of Care. The agency failed to ensure code status was correctly identified on patient's plan of care and/or transfer summary for 4 of 17 patients (P4, P12, P13, P14) whose medical records were reviewed. Findings include: Refer to G574: Based on interview and record review the home health agency (HHA) failed to ensure the plan of care (POC) included all required components accurately for 4 of 17 patients (P4, P12, P17, P13) whose records were reviewed for code status.		G0570	For P4 and P12, on the next home visit, RN reviewed code status with patient and orders were sent to the PCP for a DNR code status. P17 and P13 have been discharged so unable to complete corrective action. EMR report ran for all patients with a "prior" code status. For these patients, the agency has entered their current code status order under the orders tab in EMR. Additionally in the EMR under the patient summary, the patients code status was entered into the specialty comment area. All staff emailed to ensure they check the specialty comment for the current code status if code status says "prior" during the correction period. After review and discussion with our Home Health Medical Director, it was determined that the POLST is not an appropriate form for home health to be used. After reviewing, it was determined that home health will use a uniform code level form to determine if the patient wants to be a full code or a Do Not Resuscitate. Discussion with the patient regarding code status will be held		5/4/26	
G0574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential;		G0574				

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G0574	Continued from page 5 (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based on observation, interview and document review, the agency failed to ensure the plan of care (POC) included all required components for 5 of 17 patients (P4, P12, P17, P13, and P8) whose records were reviewed. Findings include: P4 P4's plan of care (POC) dated 1/9/26 to 3/9/26, identified a start of care (SOC) date 1/9/26. Orders included skilled nurse visit (SNV) one time per week for nine weeks for various assessments and medication administration. Diagnoses included peritoneal abscess (a localized collection of pus in the abdominal cavity) with infection, emphysema (a chronic lung condition), history of bariatric surgery and dependence on oxygen. The POC identified P4's code status (a medical instruction that identified to healthcare providers what emergency interventions a patient would want if their breathing and heart stopped) as prior. A code status history was listed for three previous code status orders. The first, with inactive date 12/27/25,			G0574	The code level form will be completed and then signed by the patient at start of care. If patient is full code, no order will be sent to the provider, and the uniform code level form will be scanned into the EMR. If the patient chooses to be a DNR, an order will be sent to the patient's primary care provider for signature, noting that patient will have a full code until it is signed by the provider and received by the agency. Agency will scan signed form into the EMR and a copy will be given to the patient. Policy on Home Care-Uniform Code Level Directive for CPR will be updated and approved at the QAPI meeting on 4/8/26. EMR will be updated on 4/13/26 with a "Home Health Code Status" This code status will be for home health only and will not switch to "prior" when going into a facility. The code status that would previously change to "prior" any time the patient went into an outpatient setting will be disabled. Education for 100% of agency employees will be conducted regarding the updated policy. Audits will be completed on 100% of start of care and recertification from 4/13/26-6/30/26. Results will be		5/4/26

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G0574	Continued from page 6 as full code (the patient wants all life saving measures, including cardiopulmonary resuscitation). The second, with inactive date 11/24/25, as full code. A third code status was listed DNR (the patient does not want CPR or life saving measures initiated) inactive date 10/9/25. P4's Service Plan dated 1/9/26, identified P4 had not completed a Provider Orders for Life-Sustaining Treatment form (POLST) but wished to be DNR. P4's POLST signed by P4 and dated 1/9/26, identified P4's wished to be DNR with physician signature 1/20/26. During interview on 3/11/26 at 8:56 a.m., the director of nursing (DON) stated P4's code status identified her as a full code and that was not correct. There was a DNR POLST and order in P4's medical record. There would be a potential for the staff to attempt to resuscitate P4 if P4's heart were to stop when they were conducting a SNV. During telephone interview on 3/11/25 at 10:09 a.m., registered nurse (RN)-C stated there was a blank POLST form in the patient admission packet. The admitting nurse assisted the patient to fill out and then the nurse brought the form back to the office to be signed by the patient's provider. If the POLST indicated DNR, it would be returned to the patient after the physician had signed and it had been scanned in the medical record. The POC identified the patient's current code status. If the POC identified, "prior," as code status, that meant in the orders their previous choice would show up and would be the chosen code status. RN-C was not P4's primary nurse but he could potentially see her when he filled in for other nurses. RN-C reviewed P4's POC and medical record. RN-C stated P4 was listed as a full code and had orders that identified a full code. If RN-C were conducting a SNV with P4 and her heart were to stop, he would call 911 and start CPR. During telephone interview on 3/11/26 at 11:15 a.m., P4 stated she had DNR ordered in her medical record. P4 did not have a POLST form in her home or on her refrigerator that directed health care providers she was DNR, but she wanted to be DNR and had signed something which indicated DNR in her health record on file at the agency. P4 stated she would not want CPR done for her at all. P12 P12's POC 2/1/26 to 4/1/26, identified a SOC 8/5/25. Orders included SNV one every two weeks for eight weeks			G0574			

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G0574	Continued from page 7 for various assessments and medication management. Diagnoses included hypertension (high blood pressure), heart disease, depression, chronic obstructive lung disease (COPD) and dependence on oxygen. The POC identified P12's code status as full code. P12's Service Plan dated 8/7/25, identified P12 had a completed POLST form. P12's POLST, signed by P12 and dated 6/10/25, identified P12's wishes were to be DNR with physician signature 6/19/25. During a home visit on 3/10/26 at 12:00 p.m., P12 stated he wished he, "could just die." P12 stated he was tired of living the way he was, unable to do anything he used to do and just wished it would be over. During interview on 3/11/26 at 10:30 a.m., the DON stated therapy had admitted P12 to home care services in June of 2025 and at that time P12 was DNR. When nursing admitted P12 on 8/5/25, he wanted to be full code. The DON could not find documentation in the medical record to indicate code status had been discussed with P12 or that P12 had indicated he wanted to change his code status from DNR to full code. The DON stated a blank POLST form was always in the admission packet and should always be completed with admissions. One had not been completed when the agency nurse had admitted P12 on 8/5/25, and the only advanced directive was the POLST completed on 6/10/25. During telephone interview on 3/11/26 at 11:20 a.m., P12 stated he had a signed POLST on file that indicated he was DNR. P12 did not remember if he had signed a POLST form with the home care agency but he knew he was DNR on his medical records. P12 stated he had been exposed to agent orange during his service and had a lot of health problems. He would never want anything done to resuscitate him. P12 stated he did not have a POLST form in his home or on his fridge which showed he did not want CPR done but he knew it was listed in his medical records. P17 P17's POC 12/19/25 to 2/16/26, identified a SOC date 12/19/25. Orders included SNV one time per week for nine weeks for various assessments and medication management. Physical therapy visits were ordered one time per week for one week, one time every two weeks for two weeks then one time per week for two weeks for treatment with gait, transfers, mobility and balance.			G0574			

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G0574	Continued from page 8 Occupational therapy was ordered one time per week for six weeks to increase P17's independence with activities of daily living (ADLs). Diagnoses included polymyalgia rheumatica (an inflammatory condition that causes pain in joints and muscles), low back pain, hypertension, cellulitis and depression. P17's POC listed code status as DNR. P17's Service Plan dated 12/19/25, identified P17 did have a completed POLST form. P17's POLST, signed by P17 and dated 12/19/25, identified P17's wishes were to be a full code with physician signature 12/23/25. P17's Transfer Summary dated 1/12/26, identified P17 was being transferred to an inpatient facility with code status listed as DNR. During interview on 3/12/26 at 1:15 p.m., the DON stated P17 had a signed POLST dated 12/19/25, on file that identified her wishes were to be a full code. P17's POC dated 12/19/25 identified P17 was a DNR. They were direct opposite of the other. DON was not sure why they were different and felt maybe the nurses were trying to get through their paperwork too quickly and made an error. During telephone interview on 3/12/26 at 1:30 p.m., RN-E stated she completed the admission visit for P17. When she admitted a patient to home care services, she would have the patient sign all the loose papers in the admission packet, which would include the blank POLST form. RN-E would explain what the POLST was and what each choice on the POLST meant. If the patient chose to fill it out, she would review their choices with them, have them sign and she would sign the back of the form. RN-E brought all the signed paperwork back to the office and the POLST would get sent to the physician for signature and scanned in to the patient's electronic health record (EHR). RN-E would get the form back on her desk to return to the patient at her next visit. RN-E reviewed P17's POC and stated the code status identified DNR and that was the direct opposite of the POLST P17 had signed. RN-E could not think of how the DNR code status had been entered on P17's POC and was sure she had not entered DNR as P17's code status. RN-E was unsure why the POC was not matching the POLST and felt it was a serious matter. RN-E then reviewed all her patient charts to check each had a correct code status listed on the POC and stated all her other patient's POC code status were correct. RN-E planned to try to find out how P17's POC identified the incorrect code status.			G0574			

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G0574	Continued from page 9 P13 P13's POC 11/11/25 to 1/9/26, identified a SOC date 11/11/25. Orders included SNV one time per week for nine weeks for various assessments and diabetes management. Physical therapy visits were ordered one time per week for three weeks for treatment with gait, transfers, mobility and balance. Diagnoses included diabetes, Parkinson's disease and dementia. Code status was listed as, "prior." A code status history was listed for three previous code status orders. The first, with inactive date 8/13/25, was for full code. The second, with inactive order date 8/11/25, was for full code and the third, with inactive order date 8/11/25, was for full code. P13's Service Plan dated 11/11/25, identified P13 had not completed a POLST but had the information if needed. P13's Provider Order dated 11/13/25, identified an order for P13 to be a full code with physician signature dated 11/21/25, however P13's POC with code status, "prior," was not updated to reflect her current code status ordered. During Interview on 3/11/26 at 8:56 a.m., the DON stated the computer program EPIC that was used by the agency would wipe out patient code status any time they had an encounter in the emergency room, clinic or hospital. The system automatically input, "prior," as the patient's code status and so the agency nurses would have to go into the patient's chart and enter in the patient's code status each time. The agency nurses were supposed to look for a patient's POLST, write an order to reflect the patient's code status. If the physician had not signed the code status order, the POC would identify code status as, "prior," until it was signed by the physician. The POLST should be returned to the patient after the first visit and put on the patient's refrigerator. Until a POLST was signed, that identified DNR, every patient was considered a full code. The agency nurses were supposed to put the correct code status in the POC as soon as they were able. Several times, patients would have the POLST on their refrigerator. The nurses would bring the POLST back to the office and get it signed again and then an order would be generated and would reflect in the POC. The nurses would go by the POLST in the home, but DON was not able to ensure every patient would have their current POLST on their refrigerator. It was potentially possible, a nurse would do a full code on a patient that had a DNR POLST if the POC identified, "prior,"			G0574			

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G0574	Continued from page 10 for code status. The nurses were able to see a patient's code status during any of their visits by checking the patient's EHR notes in the home. The agency nurses were well aware the code status was not pulling forward correctly. During telephone interview on 3/11/26, at 10:25 a.m. RN-B stated the nurses put patient code status in the orders tab and generally ask each patient to put their POLST on the refrigerator. Patients did not always keep them there. Nurses could quickly look up a patient's code status in the home by looking in the EHR, under the, "orders," tab during visits. The orders would either indicate full code or DNR. The nurses discussed code status with patients yearly. Sometimes a POC would list code status as, "prior." RN-B was not sure why that was but would then just have to do a new order for the code status. If a code status was identified as, "prior," RN-B would look in the medical record for an advanced directive or POLST. Keeping code status updated and accurate was very important. If a POLST or advanced directive could not be found and the POC listed, "prior," as code status, RN-B stated she would likely initiate CPR. The agency policy Uniform Code Level Directive for CPR dated 2/24/25, identified every patient had the right to appropriate medical treatment that would maximize the opportunity of the prolongation of life in a meaningful way. In recognition of this fact that every individual also had the right to death with dignity. All patients of the agency would be presumptively coded as level one (full code) unless a specific order was written by a physician. Code level 2 (DNR) would be ordered on the attached form or on the POC. If a patient was code level 2 (DNR) they would be provided a photocopy of the form and the original copy of the form would be retained on the patient's medical record. Staff were directed to review with the patient and family uniform code level directives and to make sure a copy of the directive form was in sight at all times. P8 P8's plan of care (POC) 3/4/26 to 5/2/26, identified a start of care date 2/27/26. Services included skilled nurse visits (SNV) one time every two weeks for nine weeks for assessment and education. Additionally, the plan of care identified P8 was to receive home health aide (HHA) visits, one time per week for one week and two times per week for eight weeks to aid with personal needs. The diagnoses included trigeminal neuralgia (a chronic pain disorder which causes intense pain attacks to one side of the face), hypertension (high blood		G0574	P17 was admitted to a SNF so unable to update code status to apply the correct code status. P4's code status was reviewed with the patient and orders sent to the PCP for a DNR code status on 3/20/26. P12 code status was updated and will have a new Uniform code level filled out P13 is unable to be updated as patient was transferred to the hospital and later passed away. P8 DME was updated with the next home health visit to include all DME that the patient has in the home. The wheelchair is owned by the apartment building. All patients will have a home health visit during the month of April where DME will be identified and added to the Plan of Care if necessary as well as a Uniform Code Level form signed and code status updated in the EMR.			

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G0574	Continued from page 11 pressure), age-related osteoporosis (bone disease with weak or fragile bones) without current fracture, and bilateral hip replacements. P8's POC listed durable medical equipment (DME- medically necessary devices and equipment designed for long-term use at home to help manage medical conditions) used for P8 as a walker, wheelchair, and grab bars. During observation on 3/10/26, at 2:30 p.m., HHA-B was observed as she assisted P8 to set up and complete her shower. HHA-B stated the plan of care identified P8's personal needs. The plan of care was accessed online with the use of an agency telephone. P8 was noted to have a wheeled walker in place, as well as a wheelchair. During observation of shower, it was noted P8 had grab bars in the shower. P8 was also noted to have a removable raised toilet seat with arm rests in place, as well as a shower chair, and handheld shower in the shower enclosure. During interview on 3/12/26 at 9:00 a.m., the director of nursing (DON) stated the DME information included on the POC was to include all equipment used in the home. DON stated this was important to alert staff what was currently being used, and stated it was also important to have accurate information in the event a transfer was indicated so the appropriate equipment was available for P8. The facility policy, Home Care Clinical Record Closure and Retention, last reviewed 11/25/25, identified "when care was provided to the client (patient), documentation in the clinical record as a whole shall reflect the client's physical condition, psychosocial status, safety measures to protect the client from injury, and medical care provided, as applicable, from admission to discharge."	G0574	After review and discussion with our Home Health Medical Director, it was determined that the POLST is not an appropriate form for home health to be used. After reviewing, it was determined that home health will use a uniform code level form to determine if the patient wants to be a full code or a Do Not Resuscitate. Discussion with the patient regarding code status will be held during admission, recertifications, and resumptions of care and documented in the EMR. The code level form will be completed and then signed by the patient at start of care. If patient is full code, no order will be sent to the provider, and the uniform code level form will be scanned into the EMR. If the patient chooses to be a DNR, an order will be sent to the patient's primary care provider for signature, noting that patient will have a full code until it is signed by the provider and received by the agency. Agency will scan signed form into the EMR and a copy will be given to the patient. Policy on Home Care- Uniform Code Level Directive for CPR will be updated and approved at the QAPI meeting on 4/8/26. EMR was updated to include the home health code status on the Plan of Care.			5/4/26	
G0580	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. This ELEMENT is NOT MET as evidenced by: Based on interview and document review, the agency failed to provide home health aide, occupational and physical therapy services as ordered on referral or notify physician when the services were not needed for 1 of 17 patients (P4) reviewed for referrals. The agency failed to ensure visits were conducted in accordance with physician orders for 1 of 17 patients (P4) and	G0580	No policy changes are needed regarding documentation of DME, however the agency created a job aid to guide all employees in patient homes. The job aide will cover best practice on entering DME and ensuring all DME that the patient has in the home is entered into the EMR.				

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G0580	Continued from page 12 failed to notify the physician when the visits were not conducted according to the plan of care (POC). In addition, the facility failed to assure orders for frequency of skilled nurse visits and wound care orders appropriately reflected what was currently in place for 1 of 1 patients (P7) observed for wound care. Findings include: Referral P4's plan of care (POC) 1/9/26 to 3/9/26, identified a start of care (SOC) date 1/9/26. Orders included skilled nurse visits (SNV) one time per week for nine weeks for various assessments and medication administration. Diagnoses included peritoneal abscess (a localized collection of pus in the abdominal cavity) with infection, emphysema (a chronic lung condition), history of bariatric surgery and dependence on oxygen. P4's Referral for Home Care Services, dated 1/7/26, identified the reasons for the referral included home health nursing, physical therapy, occupational therapy and home health aide. P4's SOC skilled nurse visit (SNV) note dated 1/9/26, identified an assessment visit was made for a SOC with further visits planned. P4's rehabilitation potential was listed as good to remain in her home with the assistance of home health. P4 had functional limitations of endurance, ambulation, shortness of breath with exertion and was oxygen dependent. P4's goals were to regain strength and prevent hospitalizations. The visit note lacked documentation if therapies or the need for home health aide services had been assessed, discussed and/or offered to P4. Review of P4's medical record lacked documentation why therapy or home health aide services had not been discussed or offered to P4 or if the need for the services had been assessed. The record also lacked documentation if the physician had been notified physical therapy, occupational therapy and home health aide services were not initiated for P4 as ordered on the referral. During interview on 3/11/26 at 11:59 a.m., the director of nursing (DON) stated when a patient had a referral for therapies and/or home health aid and the service was not started, the nurse would generate an order to discontinue the service. The agency did consider a referral as initial orders for services. The agency policy Home Health Admission Process dated			G0580	Audits on code status will be completed 100% of start of care and recertification from 4/13/26-6/30/26. Results will be reviewed at the July QAPI to determine if additional audits are needed. Five Co-visits will take place in DL and Fargo and 3 in Ada and Fosston with patients to ensure the correct DME is in the EMR from 4/13/26-6/30/26. Results will be reviewed at the July QAPI meeting to determine if additional audits are needed.		

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G0580	Continued from page 13 7/26/23, identified a referral was communicated to the home health agency for new SOC, resuming care for client on services or changing or increasing services. Patient needs would be reviewed and verification of staff availability. The agency policy Assessment, Reassessment and Coordination of Patient Services Home Care dated 4/26/24, identified the initial assessment was generally for the purpose of determining the patient's need for care and the type of services required. The initial referral for additional services (therapy, speech or social worker) would be received via provider order. A referral order must be confirmed by completing a written or electronic order that would be signed by the provider. Missed Visits P4's plan of care (POC) 1/9/26 to 3/9/26, identified a start of care (SOC) date 1/9/26. Orders included for skilled nurse visits (SNV) one time per week for nine weeks for various assessments and medication administration. Diagnoses included peritoneal abscess (a localized collection of pus in the abdominal cavity) with infection, emphysema (a chronic lung condition), history of bariatric surgery and dependence on oxygen. Review of P4's electronic health record (EHR) indicated SNVs were completed weekly from SOC 1/9/26 to 2/28/26, however no visits had been completed 3/1/26 to 3/12/26. P4 was due for a SNV recertification for home care services that would need to be completed within the last five days of her 60-day certification period 3/5/25 to 3/9/26, however no visit was completed. This had a potential for discharge of the patient from home care services as P4 would not have the required physician orders for services when her certification period ended on 3/9/26. Review of P4's EHR failed to include documentation to P4's physician to notify a SNV for recertification for home care services had been missed. During interview on 3/11/26 at 12:08 p.m., the director of nursing (DON) stated she was aware P4 did not receive her scheduled nurse visit. P4's primary nurse was on vacation and P4 would not allow another nurse to make the visit. DON stated normally she expected a skilled nurse visit (SNV) within the five days required time frame for recertification for continued home care services. A visit was planned when P4's primary nurse returned from vacation. P4's medical record lacked documentation the physician had been notified of the	G0580	P7 orders were corrected to show the most recent wound care. P7's chart was also updated to reflect that SN was seeing 1x week for wound care and PT would see 1x week for wound care. EMR was updated to reflect these changes. P4 chart was reviewed and verified that current services match the service plan and orders from the POC and education was provided to the employees involved in care regarding contacting the provider when we are not providing services that were ordered. All patients will have a home health visit during the month of April where care plans will be updated to ensure correct wound care, visit sets, and provider notified of any disciplines that were ordered and patient refuses. EMR report ran for missed visits and staff notified of need to document missed visit. No policy changes are needed regarding documentation of careplan, visit sets, or notification of refusal of disciplines, however the agency created a job aid to guide all employees in patient homes. The job aid will cover best practice on wound care orders, visit set order accuracy, and orders for disciplines that the patient refuses. Agency policy/SW on missed visits reviewed with no changes needed. Education will be reviewed on 4/13/26 with all skilled staff including policy requirements. Supervisors will run a report called "visit sets without visits" to ensure timely notification of missed visit has been completed.			5/4/26	

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G0580	Continued from page 14 missed visit and there should have been notification to P4's physician the visit had not been completed. The agency policy Missed Visit Documentation dated 9/11/24, identified notification was required to be sent to the ordering provider when visits were not performed per order. Notification of the visit must include the clinical impact of the missed services or treatment. Wound Care P7's plan of care (POC) 3/6/26 to 5/4/26, identified a start of care date 1/5/26. P7's diagnoses included hypertensive heart disease with heart failure (a condition caused to the heart from years of unmanaged or undermanaged high blood pressure), paroxysmal atrial fibrillation (irregular heart rhythm), atherosclerotic heart disease (narrowing or blockage of the arteries), venous insufficiency (decreased blood flow to the extremities), chronic obstructive pulmonary disease (COPD-an ongoing lung condition), and encounter for change or removal of nonsurgical wound dressing. P7 was to receive skilled nurse visits (SNV) one time every two weeks for eight weeks for INR (International Normalized Ratio) (a standardized blood test to measure of how long blood takes to clot) management and assessment. Although not identified in the SNV order, the narrative under Current Status, identified the orders were for "Medication, education, management and assessment of effectiveness, Disease education, management, and assessment, Pain management-instruct on pain relief measures and assess pain levels each visit and Wound management." The POC outlined the following treatments to bilateral lower legs: Ammonium lactate 12% lotion to affected areas two times a week with wrap/dressing changes for venous dermatitis. Eucerin Cream apply to affected area (legs and feet) for skin irritation. The SNV POC identified under the heading of Goal the following entry: SNV to perform dressing change to left and right stasis ulcers twice weekly. The nurse was to remove old dressing, soaking with saline as needed to remove dressing. Nurse was directed to cleanse area with soap and water, and to apply Vaseline and triple layer short stretch compression. This intervention did			G0580	Education for 100% of agency employees will be conducted regarding care plan documentation, visit scheduling, and notification to primary care providers of refusal of disciplines. Audits will be completed 100% of start of care and recertification from 4/13/26-6/30/26 for compliance with wound care orders, visit set accuracy, and documentation when discipline is ordered but a patient refuses. Wound care audits are ongoing for all offices, audits include: presence of wound care order in EMR, changes in wound care treatment, careplan is accurate to wound care provided, and orders sent to the provider if needed. Results will be reviewed at the July QAPI to determine if additional audits are needed. Audits on missed visits will be completed to ensure timely documentation of missed visits, MD notification, and potential clinical impacts. A process improvement plan will be implemented and added to the QAPI meeting monthly to go from 11% of missed visits not documented to less than 5% within 3 months.		

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G0580	Continued from page 15 not list a start date. The duration for this was six weeks. Under the intervention, identified as having started 1/20/26, staff were to cleanse lower legs with soap and water and cleanse off slough (dead tissue). The nurse was then to apply zinc barrier cream to lower legs, apply Mepilex to weeping areas, and wrap with calamine wrap, covered with compression wrap two times weekly. Although the directions for wound care were outlined in two different fashions under both goal and intervention in care plan, the medication listing and listing for durable medical equipment lacked any of this information and lacked clarification as to which was to be completed, or at what frequency as the frequency for nurse visits in the POC effective 3/6/26 to 5/4/26 indicated frequency of SNV to be completed every 2 weeks. A review of the physician orders dated 1/20/26, identified the treatment above in a modified fashion. The order identified the nurse was to cleanse the right and left lower leg with soap and water and cleanse off slough. The order then directed the nurse to apply hydrofera (a type of dressing) to the open area on the right leg. Zinc barrier cream was to be applied to lower legs, followed by compression wraps. The order directed the registered nurse (RN) to change the dressings weekly, and P7 was to go into the clinic for a second weekly change. On 3/9/26 at 1:30 p.m., a home care visit observation was completed with RN-B in P7's home. Upon arrival, P7 was sitting in recliner, with legs unwrapped, and towel laid on the floor. RN-B assembled supplies for wound care. Once set up, RN-B initiated wound care implementing hand hygiene and glove usage appropriately throughout process. Lower legs were cleansed and slough removed. RN-B applied ammonium lactate to bilateral lower legs. Calamine wrap was then applied and subsequently secured with compression wrap. Following visit, RN-B confirmed the current process was different than what was identified on the POC, which was completed on 3/2/26. A review of subsequent orders entered on 3/9/26, at 2:45 p.m. indicated wound care was to be completed each visit, effective 1/20/26, as followed: RN was to cleanse lower legs with soap and water and cleanse off slough. Ammonia lactade [sic] was to be applied to lower legs. Wrap with calamine wrap covered with compression wrap twice weekly by RN or Physical Therapy (PT). A subsequent order was entered on 3/10/26, at 1:16 p.m, which added one SNV every week for 8 weeks from 3/8/26 to 5/2/26.	G0580	4/8/26- received 4/9/26- reviewed and accepted Nicole Harvey Digitally signed by Nicole Harvey Date: 2026.04.09 16:44:59 -05'00'	

Minnesota State Department of Health

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00000	Initial Comments On 3/9/26 through 3/12/26, a recertification survey was conducted. The following licensing orders are being issued as a result of the survey: **ATTENTION** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, these correction order(s) have been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.		00000				
00935	Documentation of Administration of Medication CFR(s): 144A.4792, Subd. 8 Each medication administered by comprehensive home care provider staff must be documented in the client's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the client's needs when medication was not administered as prescribed and in compliance with the client's medication management plan. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication administration was completed as prescribed for 1 of 7		00935	Agency policy on Home Care Medication Management Services was reviewed and no changes needed at this time. Nurse was educated on proper documentation of IM injections on 3/19/26. Due to the nature of this deficiency, the agency is unable to correct prior documentation. Education to be provided to all nursing staff on 4/13/26 in the correct way to document injections. A job aid was created for all nursing staff to review and ensure we are compliant with administering injections. Education to be provided to all nursing staff on 4/13/26 in the correct way to document injections. 100% of IM injections performed from 4/13/26-6/30/26 will be audited for accuracy. Results will be reviewed at July QAPI to determine if additional audits are needed.		5/4/26	

Office of Primary Care and Health Systems Management

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

Kay Foxen

TITLE

RN Director

(X6) DATE

4-3-26

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/12/2026	
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH HOME CARE WEST				STREET ADDRESS, CITY, STATE, ZIP CODE 114 FRAZEE STREET EAST , DETROIT LAKES, Minnesota, 56501			
(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	
00935	Continued from page 1 clients (C4) reviewed for medication management. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). C4's plan of care (POC) 1/9/26 to 3/9/26, identified a start of care (SOC) date 1/9/26. Orders included skilled nurse visits (SNV) one time per week for nine weeks for various assessments and medication administration. Diagnoses included peritoneal abscess (a localized collection of pus in the abdominal cavity) with infection, emphysema (a chronic lung condition), history of bariatric surgery and dependence on oxygen. Numerous prescribed and patient reported medications were listed which included cyanocobalamin (vitamin B12) 1000 micrograms (mcg) per milliliter (ml) inject 1 ml into the muscle (IM) every 14 days, and thiamine (vit B1) 100 mg per ml, inject 1 ml IM one time per month. C4's skilled nurse visit (SNV) note dated 1/21/26, identified an intervention of administration of injection was completed. The description identified an IM injection alternating arms with B-12 and B1 injections within the next eight weeks. The visit note lacked documentation if one or both of the medications had been given, dose administered, and site of injection or injections. During telephone interview on 3/11/26 at 10:09 a.m., registered nurse (RN)-C stated he had not seen C4, but when he administered IM medications he would start under the medication administration section of the note and click on administration now tab. That would bring up the questions to answer such as where the medication was administered, and the dosage administered. RN-C stated he would also include the medication lot number and expiration date under comments. The system would not let the nurse completing the form to save and exit out of the section until all the required questions regarding the administration of the medication were answered. During telephone interview on 3/11/26 at 10:25 a.m., RN-B stated she recorded IM injections under the medication administration tab in the patient's visit note. RN-B would click that tab and put administered now and fill in the route, site of administration, and	00935					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/12/2026	
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00935	Continued from page 2 she would put in a comment that she gave the B12 or whatever medication it was that day. She did not list the lot number or expiration date any longer. During interview on 3/11/26 at 12:08 a.m., the director of nursing (DON) stated the administration of injections in the SNV note dated 1/26/26, were not documented correctly. The DON expected the nurse to have clicked the administration now tab, which would have pulled up all the prompts for documentation for the nurse to answer. The prompts would have included name of medication, dosage administered, site of administration, patient tolerance to the administration of the medication and the lot number of the medication administered. The DON stated the nurse had not utilized the tab and so the medication did not get documented correctly. The agency policy Home Care Medication Management Services dated 4/26/24, identified each medication administered by comprehensive home care provider staff must be documented in the client's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered and the method and route of administration.	00935	4/8/26- received 4/9/26- reviewed and accepted Nicole Harvey Digitally signed by Nicole Harvey Date: 2026.04.09 16:47:15 -05'00'				