



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

March 11, 2025

Administrator

ESSENTIA HEALTH DEER RIVER HOME CARE
115 10TH AVENUE NORTHEAST
DEER RIVER, MN 56636

RE: Event ID: 64AF5-H2

Dear Administrator:

On March 5, 2025, 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.

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

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

February 7, 2025

Administrator

ESSENTIA HEALTH DEER RIVER HOME CARE
115 10TH AVENUE NORTHEAST
DEER RIVER, MN 56636

RE: Event ID: 64AF5H-1

Dear Administrator:

A partial extended survey was completed at your agency on January 28, 2025 for the purpose of assessing compliance with Federal certification regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division noted one or more deficiencies and found that your agency was not in substantial compliance with the participation requirements. The findings from this survey are documented on the electronically delivered form CMS 2567.

At the time of this survey, it was determined that the following Conditions of Participation were found not met:

E 0001 42CFR § 484.102 Emergency Preparedness

G 940 42CFR § 484.105 Organization and Administration of Services

Since these deficiencies limit your capacity to provide adequate care to patients, you must respond within ten calendar (10) days with your plan of correction. The plan must be specific, realistic, include the date certain for correction of each deficiency and be signed and dated by the administrator or other authorized official of the agency.

An acceptable plan of correction must contain the following elements:

- The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- What correction action(s) will be accomplished for those patients found to have been affected by the deficient practice;
- How you will identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements, i.e., what quality assurance program will be put into place;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correction will be completed.

If your agency has failed to achieve compliance by the date certain, sanctions including but not limited to fines of up to \$10,000.00 per day, may be recommended for imposition to the Centers for Medicare and Medicaid Services (CMS) location. Informal dispute resolution (IDR) for the cited deficiencies will not delay imposition of any recommended enforcement actions. A change in the seriousness of the noncompliance at the time of the revisit may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

The plan of correction should be directed to:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

Please make a copy of your plan of correction for your records.

Failure to submit an acceptable written plan of correction of Federal deficiencies within ten calendar days may result in decertification and a loss of Federal reimbursement. Additionally, your continued certification is contingent upon corrective action.

If, upon a revisit within forty five (45) days of the survey exit date, correction is not ascertained, we will have no recourse except to recommend to the Centers for Medicare and Medicaid Services (CMS) Location that your certification be terminated, effective April 28, 2025.

HOME HEALTH AIDE TRAINING AND/OR COMPETENCY EVALUATION PROHIBITION

Federal Law, as specified in 42 CFR **484.80(f)(3)**, prohibits any home health agency from offering and/or conducting a home health aide training and/or competency evaluation program which, within the previous two years, has been found:

- (A) Out of compliance with requirements of 42 CFR **484.80(f)(3)**;
- (B) To permit an individual that does not meet the definition of “home health aide” as specified in §484.4 to furnish home health aide services (with the exception of licensed health professionals and volunteers);
- (C) Has been subject to an extended (or partial extended) survey as a result of having been found to have furnished substandard care (or for other reasons at the discretion of CMS or the State);
- (D) Has been assessed a civil monetary penalty of not less than \$5,000 as an intermediate sanction;
- (E) Has been found to have compliance deficiencies that endanger the health and safety of the HHA’s patients and has had a temporary management appointed to oversee the management of the HHA;
- (F) Has had all or part of its Medicare payments suspended; or
- (G) Under any Federal or State law within the 2-year period beginning on October 1, 1988--
 - (1) Has had its participation in the Medicare program terminated;
 - (2) Has been assessed a penalty of not less than \$5,000 for deficiencies in Federal or State standards for HHAs;
 - (3) Was subject to a suspension of Medicare payments to which it

otherwise would have been entitled;

(4) Had operated under a temporary management that was appointed to oversee the operation of the HHA and to ensure the health and safety of the HHA's patients; or

(5) Was closed or had its residents transferred by the State.

Therefore, your facility is precluded from conducting a home health aide training and/or competency evaluation program for a period of two years beginning January 28, 2025.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.745, you have one opportunity to dispute condition-level survey findings warranting a sanction 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:

Home Health Agency Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Health.HRD.Appeals@state.mn.us

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies.

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

If you have any questions on this matter, please do not hesitate to call.

Sincerely,



Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247223		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2025	
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH DEER RIVER HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST , DEER RIVER, Minnesota, 56636			
(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
E0000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 1/27/2025-1/28/2025 during a recertification survey. The facility is not in compliance with the Appendix Z Emergency Preparedness Requirements			E0000			
E0001	Establishment of the Emergency Program (EP) CFR(s): 484.102 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section,			E0001			

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		TITLE	(X6) DATE
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E0001	Continued from page 1 utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: 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: Emergency Preparedness, 42 CFR § 484.102 at E0001. The agency failed to have an Emergency Preparedness program. This had the potential to affect all patients served by the agency. The cumulative effect of the systemic problem resulted in the provider's inability to ensure the provision of quality health care in a safe environment. See E0004, E0013 and E0036. When interviewed on 1/28/25 at 1:20 p.m., the interim home care manager confirmed there was not an EP program for the Deer River home health care agency. On 1/28/25 at 1:20 p.m., the administrator confirmed the EP program excluded the home care department. Refer to: E0004: Based on interview and document review, the facility failed to ensure compliance with all applicable Federal, State and local emergency preparedness requirements. The facility failed to develop, establish and maintain, a comprehensive emergency preparedness program that meets the requirements of this section. The facility failed to develop an Emergency Plan and failed to review and update the plan as required. This had the possibility to affect all staff and patients that received care from the agency. E0013: Based on interview and document review, the home health agency (HHA) failed to conduct a comprehensive all-hazards community-based risk assessment to determine potential disasters which could impact the HHA and develop corresponding policies and procedures to ensure patient safety and quality care during a disaster. This had the possibility to affect all staff			E0001			

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E0001	Continued from page 2 and patients that received care from the agency. E0036: Based on interview and document review, the home health agency (HHA) failed to conduct a comprehensive all-hazards community-based risk assessment to determine potential disasters which could impact the HHA and develop corresponding policies and procedures to ensure patient safety and quality care during a disaster. This had the possibility to affect all staff and patients that received care from the agency.		E0001				
E0004	Develop EP Plan, Review and Update Annually CFR(s): 484.102(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an		E0004				

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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E0004	Continued from page 3 emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure compliance with all applicable Federal, State and local emergency preparedness requirements. The facility failed to develop, establish and maintain, a comprehensive emergency preparedness program that meets the requirements of this section. The facility failed to develop an Emergency Plan and failed to review and update the plan as required. This had the possibility to affect all staff and patients that received care from the agency. A review of the facility policy Essentia Health Deer River Emergency Operation Plan dated 1/1/25, indicated plans for the following facilities: Deer River Hospital, Deer River Swing Bed, Deer River Clinic. Deer River Pharmacy, Deer River Hospice and Deer River Homestead. The plan did not address home health care patients and staff. The facility failed to ensure the following emergency preparedness program for home health care patients and staff: -§484.102(a)(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. -§484.102(a)(2) Include strategies for addressing emergency events identified by the risk assessment. -§484.102(a)(3) Address patient population, including, but not limited to, the type of services the HHA has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. -§484.102(a)(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the HHA's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. During an interview on 1/28/25 at 1:20p.m., the interim home care manager confirmed there was not an EP plan for the Deer River home health care agency.			E0004			

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E0004 E0013	Development of EP Policies and Procedures CFR(s): 484.102(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in	E0004 E0013			

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E0013	Continued from page 5 paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is NOT MET as evidenced by: Based on interview and document review, the home health agency (HHA) failed to conduct a comprehensive all-hazards community-based risk assessment to determine potential disasters which could impact the HHA and develop corresponding policies and procedures to ensure patient safety and quality care during a disaster. This had the possibility to affect all staff and patients that received care from the agency. A review of the facility policy Essentia Health Deer River Emergency Operation Plan dated 1/1/25, indicated plans for the following facilities: Deer River Hospital, Deer River Swing Bed, Deer River Clinic, Deer River Pharmacy, Deer River Hospice and Deer River Homestead. The plan did not address home health care patients and staff. The facility failed to ensure the following emergency preparedness program for home health care patients and staff: -§484.102(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. -§484.102(b)(1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55. -§484.102(b)(2) The procedures to inform State and local emergency preparedness officials about HHA patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment.			E0013			

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E0013	Continued from page 6 -§484.102(b)(3) The procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The HHA must inform State and local officials of any on-duty staff or patients that they are unable to contact. -§484.102(b)(4) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records. -§484.102(b)(5) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency. During an interview on 1/28/25 at 1:20p.m., the interim home care manager confirmed there was not an EP plan in place for the Deer River home health care agency	E0013		
E0036	EP Training and Testing CFR(s): 484.102(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program	E0036		

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E0036	Continued from page 7 that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is NOT MET as evidenced by: Based on document review and interview, the agency failed to develop and maintain an emergency preparedness training and testing program based on the emergency plan, risk assessment, policies and procedures and an appropriate communication plan. This had the possibility to affect all staff and patients that received care from the agency. A review of the facility policy Essentia Health Deer River Emergency Operation Plan dated 1/1/25, indicated plans for the following facilities: Deer River Hospital, Deer River Swing Bed, Deer River Clinic. Deer River Pharmacy, Deer River Hospice and Deer River Homestead. The plan did not address home health care patients and staff. The facility failed to ensure training and testing policies had been developed and implemented and included the following:	E0036		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E0036	Continued from page 8 -§484.102(d) Training and testing. The HHA must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. -§484.102(d)(1) Training program. The HHA must do all of the following: Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. Provide emergency preparedness training at least annually. Maintain documentation of the training. Demonstrate staff knowledge of emergency procedures. -§484.102(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. Complete a second full-scale that is community-based or individual, facility-based. Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. During an interview on 1/28/25 at 1:20p.m., the interim home care manager confirmed there was no testing or training policies and procedures for the Deer River home health care agency.			E0036			
G0000	INITIAL COMMENTS On 1/27/2025-1/ 28/2025 a recertification survey was conducted. This resulted in a partial extended survey at Essentia Health Deer River Home Care. The agency was found to have not met the requirements at 42 CFR. Part 484 for Home Health			G0000			

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G0000	Continued from page 9 Agencies. Based on the number and/or severity of the deficiencies cited the home health agency failed to meet the Condition of Participation: 42 CFR § 484.105 at G0940. 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: 1 Total home visits conducted: 1 Parent location: 115 10th Avenue NE, Deer River, MN 56636 No branch offices Hours of Operation: 8 a.m. to 4:30 p.m. Total number of records reviewed: 2	G0000		
G0940	Organization and administration of services CFR(s): 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. 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 for Organization and administration of services, 42 CFR § 484.105 at G0940. The agency had skilled nursing services available and lacked at least one additional therapeutic service available for current and future patients the agency may admit. See G982.	G0940		

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G0940	Continued from page 10		G0940				
G0982	Refer to G0982: Based on interview and document review, the agency failed to provide skilled nursing services and at least one other therapeutic at time of survey affecting one of one patient (P1) and any future admissions. Skilled services furnished CFR(s): 484.105(f) Standard: Services furnished. Skilled nursing services and at least one other therapeutic service (physical therapy, speech-language pathology, or occupational therapy; medical social services; or home health aide services) are made available on a visiting basis, in a place of residence used as a patient's home. An HHA must provide at least one of the services described in this subsection directly, but may provide the second service and additional services under arrangement with another agency or organization. This STANDARD is NOT MET as evidenced by: Based on interview and document review, the agency failed to provide skilled nursing services and at least one other therapeutic at time of survey affecting one of one patient (P1) and any future admissions. During entrance interview on 1/28/25, at 9:00 a.m. the administrator indicated the agency had not served any home care clients for the majority of 2024. She stated the agency has had a difficult time filling vacant positions but would like to continue to provide services in the area. She further indicated the agency had no home health aides (HHA), occupational therapists (OT) or physical therapists (PT) employed so was unable to provide these services. When interviewed on 1/28/25 at 9:00 a.m. the interim home care manager indicated if the agency received a referral who required HHA, PT or OT, they would have to decline it. She further indicated the agency could utilize an HHA from the hospice department and provide home care training, which could take one to two weeks. Documents reviewed revealed the agency had one active patient that received skilled nursing services, with a start of care (SOC) of 1/2/25. The previous patient served indicated SOC date of 12/1/23, discharge (DC) date of 1/9/24.		G0982				

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247223		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2025	
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G0982	Continued from page 11 The organization chart provided indicated "PT/OT/SLP/MSW (Currently looking at realigning services) Not available currently." Further, "HHA (home health aide) (Currently looking at realigning services) Not available currently."			G0982			



Protecting, Maintaining and Improving the Health of All Minnesotans

Delivered Via Email

February 7, 2025

Administrator

ESSENTIA HEALTH DEER RIVER HOME CARE
115 10TH AVENUE NORTHEAST
DEER RIVER, MN 56636

Re: Enclosed State Licensing Orders
Event ID:64AF5-H1

Dear Administrator:

A survey of the Home Care Provider named above was completed on January 28, 2025, for the purpose of assessing compliance with State licensing regulations. At the time of survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these regulations that are issued in accordance with Minnesota Statutes, sections 144A.43 to 144A.482.

In accordance with Minnesota Statute section 144A.477, for home care providers that are licensed to provide home care services and are also certified for participation in Medicare as a home health agency under Code of Federal Regulations, title 42, part 484, with survey and enforcement by the Minnesota Department of Health as an agent for the United States Department of Health and Human Services, the requirements under Minnesota Statute section 144A.477 subd. 2 (1) to (16) are considered equivalent to the federal requirements. Because your facility is a certified home health agency, violations of the requirements under Minnesota Statute section 144A.477 subd. 2 (1) to (16) may lead to enforcement actions under Minnesota Statute section 144A.474. If your facility fails to comply with all the federal deficiencies issued as a result of this Department's survey completed on January 28, 2025, the findings supporting the federal violations shall be considered violations of the applicable licensure requirements.

The notice of termination from the Medicare program by the Centers for Medicare and Medicaid Services (CMS) or the failure to attain compliance with the federal regulations within the time periods

approved by CMS may constitute grounds for the revocation, suspension or nonrenewal of the license.

State licensing orders are delineated on the attached Minnesota Department of Health order form. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes for home care providers.

The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN requirement is not met as evidenced by."

We urge you to review these orders carefully. If you have questions, please contact the supervisor listed below. When all orders are corrected, the order form should be signed and returned to this office at:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minnesota Statutes, section 144A.474, subd. 8 (c), by the correction order date, the home care provider must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction orders in future surveys, upon a complaint investigation, and as otherwise needed.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. 144A.474, subd. 12, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine(s) assessed.

The written request for reconsideration and all supporting documents must be received by the Commissioner within 15 calendar days of the correction order receipt date.

The Commissioner shall respond in writing to the request within 60 days of the date the provider requests a reconsideration. Any documentation received after the 15 calendar days will not be considered. You are required to send your written request and all supporting documents to Health.Homecare@state.mn.us; or, if you prefer you can mail it to:

Home Care Correction Order Reconsideration Process

Health Regulation Division
625 Robert St. N
St. Paul, MN 55164-0975
Telephone 651-201-4200
Health.CM-Cert@state.mn.us

Failure to correct state licensing correction orders may result in enforcement actions in accordance with the provisions of Minnesota Statutes, sections 144A.43 to 144A.482.

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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00000	Initial Comments On 1/27/2025-1/28/2025 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, this correction order(s) has 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				
00780	Display of License CFR(s): 144A.479, Subd. 1 The original current license must be displayed in the home care provider's principal business office and copies must be displayed in any branch office. The home care provider must provide a copy of the license to any person who requests it. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation and interview the licensee failed to display the original current home care license at the place of business, which had the potential to affect 1 of 1 client and any new admissions to the home health agency. This practice resulted in a level one violation (a		00780				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota State Department of Health

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00780	Continued from page 1 violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected). Upon observation, the agency failed to have their current home care license posted at the facility. When interviewed on 1/28/25, at 9:00 a.m. the Administrator indicated she had the license in her office in a file and it had not been displayed. She further indicated that there was not a dedicated home health care office located at the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days		00780				
00835	Statement of Home Care Services CFR(s): 144A.4791, Subd. 3 Prior to the date that services are first provided to the client, a home care provider must provide to the client or the client's representative a written statement which identifies if the provider has a basic or comprehensive home care license, the services the provider is authorized to provide, and which services the provider cannot provide under the scope of the provider's license. The home care provider shall obtain written acknowledgment from the clients that the provider has provided the statement or must document why the provider could not obtain the acknowledgment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the licensee failed to ensure a written statement of comprehensive home care services was provided to the client and/or the client's representative for 2 of 2 clients (C1, C2) reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety) and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). C1's start of care (SOC) was 1/2/25. C1's clinical record lacked evidence the client and/or the client's representative was provided with a written statement that identified the licensee as a comprehensive home care provider, and the services provided under their license.		00835				

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00835	Continued from page 2 C2's SOC was 12/1/23. C2's clinical record lacked evidence the client and/or the client's representative was provided with a written statement that identified the licensee as a comprehensive home care provider, and the services provided under their license. Review of the licensee's admission packet, lacked a written statement that identified the licensee as a comprehensive home care provider, and the services provided under their license. On 1/28/25, at 1:15 p.m. the director of home care indicated she added the Statement of Home Care Services to the admission packets at her agency located in Detroit Lakes. She further indicated it was missed at the Deer River location. Agency policy for Statement of Home Care Services was requested, but not received.		00835				
00945	Medication Mgt for Clients Away from Home CFR(s): 144A.4792, Subd. 10(a) (a) A home care provider who is providing medication management services to the client and controls the client's access to the medications must develop and implement policies and procedures for giving accurate and current medications to clients for planned or unplanned times away from home according to the client's individualized medication management plan. The policy and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by a licensed nurse according to appropriate state and federal laws and nursing standards of practice; This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review and interview, the licensee failed to have a policy in place regarding medication management for clients during planned time away. This had the potential to affect all clients that received services from the licensee. 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to		00945				

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00945	Continued from page 3 affect a large portion or all of the clients). When interviewed on 1/28/25, at 1:30 p.m. the interim home care director indicated she could not locate any policies regarding medication management for clients during planned time away. A policy regarding medication management for clients with planned time away was requested but not received. TIME PERIOD FOR CORRECTION: Seven (7) days		00945				
00950	Medication Mgt for Clients - Unplanned CFR(s): 144A.4792, Subd. 10(b) (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall give the client or client's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the client or client's representative must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the client's name and the dates and times that the medications are scheduled; and (5) the client or client's representative must be provided in writing the home care provider's name and information on how to contact the home care provider. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to clients; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the client. The procedures must address: (i) the type of container or containers to be used for		00950				

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00950	Continued from page 4 the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) the written information about the medications to be given to the client or client's representative; (iv) how the unlicensed staff must document in the client's record that medications have been given to the client or the client's representative, including documenting the date the medications were given to the client or the client's representative and who received the medications, the person who gave the medications to the client, the number of medications that were given to the client, and other required information; (v) how the registered nurse shall be notified that medications have been given to the client or client's representative and whether the registered nurse needs to be contacted before the medications are given to the client or the client's representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed staff must document in the client's record any unused medications that are returned to the provider, including the name of each medication and the doses of each returned medication. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review and interview, the licensee failed to have a policy in place regarding medication management for clients with unplanned time away. This had the potential to affect all clients that received services from the licensee. 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). When interviewed on 1/28/25, at 1:30 p.m. the interim home care director indicated she could locate any policies regarding medication management for clients with unplanned time away.		00950				

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00950	Continued from page 5 A policy regarding medication management for clients with unplanned time away was requested but not received. TIME PERIOD FOR CORRECTION: Seven (7) days			00950			