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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6ITF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00907

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245212**

2.STATE VENDOR OR MEDICAID NO.
(L2) **623840800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH OAK CROSSING**
(L4) **1040 LINCOLN AVENUE**
(L5) **DETROIT LAKES, MN** (L6) **56501**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/17/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **96** (L18)
13.Total Certified Beds **96** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathleen Lucas, Unit Supervisor 09/18/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 09/18/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1976
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/28/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 18, 2018
CMS Certification Number (CCN): 245212

Administrator
Essentia Health Oak Crossing
1040 Lincoln Avenue
Detroit Lakes, MN 56501

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 4, 2018 the above facility is certified for:

96 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 96 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 18, 2018

Administrator
Essentia Health Oak Crossing
1040 Lincoln Avenue
Detroit Lakes, MN 56501

RE: Project Number S5212027

Dear Administrator:

On August 6, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey completed on July 26, 2018. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 17, 2018, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 4, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 26, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 4, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 26, 2018, effective September 4, 2018 and therefore remedies outlined in our letter to you dated August 6, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6ITF

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Facility ID: 00907

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(L3) **ESSENTIA HEALTH OAK CROSSING**
(L4) **1040 LINCOLN AVENUE**
(L5) **DETROIT LAKES, MN** (L6) **56501**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/26/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **96** (L18)
13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date:
Christine Bodick-Nord, HFE NE II — 08/16/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 08/27/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1976
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
August 6, 2018

Ms. Christy Brinkman, Administrator
Essentia Health Oak Crossing
1040 Lincoln Avenue
Detroit Lakes, MN 56501

RE: Project Number S5212027

Dear Ms. Brinkman:

On July 26, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

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

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

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fischer@state.mn.us
Phone: (320) 223-7338
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 4, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by October 26, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 26, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

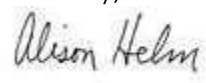
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH OAK CROSSING	1040 LINCOLN AVENUE DETROIT LAKES, MN 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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 7/23/18 to 7/26/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 7/23/18 to 7/26/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,	F 609		9/4/18

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

Electronically Signed | 08/14/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH OAK CROSSING	1040 LINCOLN AVENUE DETROIT LAKES, MN 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
F 609	Continued From page 1 are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure allegations of physical abuse were immediately reported to the administrator within two hours for 1 of 3 residents (R67) reviewed for abuse. Findings include: R67's annual Minimum Data Set (MDS) dated 12/22/17, indicated R67 was cognitively intact. The MDS indicated R67 was an extensive assist with dressing and toileting. Review of an untitled document that did not include a date or time, indicated R67 reported to homemaker (HM)-I during the breakfast meal on 6/27/18, that nursing assistant (NA)-C was "rough	F 609	1. Re-education was provided to homemaker utilizing Essentia Health's Just Culture root cause investigation related to immediate reporting criteria to the RN Charge nurse when administrative leaders are unavailable. 2. All other residents interacting with this homemaker had the potential to be affected by this same deficient practice. 3. The facility Vulnerable Adult policy was reviewed and updated to reflect instructions for who to contact in the event administrative leaders are unavailable. Mandatory education will be completed for all staff (homemakers, neighborhood supports, CNAs, nurses) on the policy change. A competency learning question	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH OAK CROSSING	1040 LINCOLN AVENUE DETROIT LAKES, MN 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
F 609	Continued From page 2 and pulled the sheets out underneath me, leaving a bruise on her hip". During an interview on 7/25/18, at 12:17 p.m. the licensed social worker (LSW) indicated R67 reported the allegation to HM-I during the breakfast period. LSW stated HM-I reported the allegation to LSW in the afternoon about 2:30 to 3:00 p.m. The LSW stated HM-I should have reported immediately to the supervisor. A review of the document the facility provided related to reporting to the State Agency (SA) indicated the licensed social worker (LSW) made a report to the SA on 6/27/18, at 5:23 p.m. regarding R67's allegation. During an interview on 7/26/18, at 11:56 a.m. the administrator stated any staff member who receives a concern from a resident should report to the charge nurse, director of nursing (DON), or social worker, then I am notified of the concern. The administrator stated this concern was reported late and should have been a two hour report to me or the DON. The administrator stated the staff are trained on reporting abuse immediately. The administrator stated they should have been made aware of the allegation sooner. During an interview on 7/26/18, at 12:07 with DON stated a home maker should be expected to report as soon as possible to the administrator, DON, social worker, or charge nurse. The DON stated we like to know concerns to follow up with immediately. The facility policy Resident Protection Plan/Vulnerable Adult dated 8/7/17, indicated	F 609	is included in the mandatory training vulnerable adult post quiz regarding the process of notification in the event leadership is unavailable to immediately report an allegation to. The revised vulnerable adult policy will be replaced in the new employee orientation paperwork. The competency based learning question has been added to the new employee orientation vulnerable adult post quiz regarding the process of notification in the event leadership is unavailable to immediately report an allegation to. This is collected with each new employee hired. The annual training vulnerable adult session has also been updated containing the revised policy and updated vulnerable adult competency posttest. 4. Quality assurance audits to be completed with staff to ensure understanding of immediate reporting criteria for staff. Audit schedule is as follows: 3x/week x4 weeks and then weekly x4 weeks. Results will be reviewed at the monthly QAPI meetings. The QAPI team will determine the auditing scheduled based on audit results. 5. Compliance will be obtained by September 4th, 2018.	

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F 609	Continued From page 3 immediate reporting of events of possible abuse, neglect, misappropriation of resident property, or mistreatment, including injuries of unknown source, should occur in order to protect the residents. The reporter will immediately report the incident to the administrator or immediately report incident to the DON/ ADON (associated director of nursing)/ social worker who in turns reports immediately to the administrator. After hours, the reporter will immediately report to the administrator or the transitional care unit (TCU) registered nurse (RN) in charge who will immediately notify the administrator. If the administrator cannot be reached in person or via cell phone, external reporting should be made and a voice mail left for the administrator on the cell phone.	F 609		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services.	F 655		9/4/18

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F 655	Continued From page 4 (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide a written summary of the care plan to 1 of 1 resident (R128) reviewed as a new admission. Findings include: R128's resident face sheet indicated R128 was admitted to the facility on 7/10/18. During an interview on 7/26/18, at 12:26 p.m. R128 was asked if R128 received a written summary of the base line care plan. R128 stated	F 655	1. Re-education provided to the transitional care unit care team related to providing a copy of the written baseline care plan written summary. The patient was given a copy of her written summary care plan on 7/30/18. 2. Other residents admitted to the transitional care unit could be impacted by this same deficient practice. 3. Mandatory education/ competency training to be completed with the interdisciplinary team members related to the process of providing a copy of the	

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F 655	Continued From page 5 I do not remember if they offered me a copy of the written summary of my plan of care. R128 stated I usually take a copy of paperwork when offered to me. During an interview on 7/26/18, at 12:30 p.m. registered nurse (RN)-B stated at the care conference we go over the base line care plan and have the resident sign it. RN-B stated we do not give a copy of the base line care plan to the resident. R128's progress notes were reviewed and there was no documentation R128 had been given a copy of the base line care plan. The facility policy Care conferences/Care Planning dated 3/22/18, indicated the interdisciplinary team meets with the transitional care unit (TCU) residents within 48 hours of admission to TCU to establish the base line care plan. The policy revealed a member of the resident's care team will assist the resident to obtain their care plan at the resident or resident's representative's request.	F 655	baseline care plan to the patients. The interdisciplinary team will now be including documentation to support that the residents are provided a copy of the written summary, including the long term care neighborhoods. 4. Quality assurance monitoring will be conducted after each care conference to ensure compliance is met with providing residents a copy of their written care plan summary, and documented in the medical record as doing so. Audit schedule is as follows: 3x/week x4 weeks and then weekly x4 weeks. Results will be reviewed at the monthly QAPI meetings. The QAPI team to determine auditing after scheduled audits are complete and compliance is met. 5. Compliance will be obtained by September 4th, 2018.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow standards of practice related to medication administration for 1	F 658	1. Re-education was provided to the nurse utilizing Essentia Health's Just Culture root cause investigation related to	9/4/18

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F 658	Continued From page 6 of 1 residents (R29) observed to receive medication during the evening meal. Findings include: R29's record identified one Self-Administration of Medication (SAM) assessment. The 5/24/17 SAM assessment indicated R29 was appropriate to self administer "icy hot [topical pain analgesic] & cough drops". The assessment identified R29 was cognitively intact with a diagnosis of dementia and was forgetful. R29's quarterly Minimum Data Set (MDS), dated 5/21/18, identified R29 was moderately cognitively impaired. Diagnoses included; dementia, diabetes mellitus, hypertension, and heart failure. R29 was on a scheduled pain medication regimen. R29's Care Plan, dated 5/16/18, indicated R29 self-administers topical (to skin) analgesic medication and cough drops. R29's physician orders included the following: -A 1/8/18 order for bumetanide 1 milligram (mg) orally twice daily for chronic systolic congestive heart failure. -A 2/19/18 order for Tylenol 650 mg orally three times daily and one time daily as needed for unspecified joint pain. -A 6/29/18 order for coumadin (blood thinner) 5 mg orally once daily on Monday, Wednesday, and Fridays for chronic atrial fibrillation. R29's orders included self administration orders for the two assessed self-administration medications of Icy hot and cough drops. R29's orders lacked directions for self-administration of the bumetanide, Tylenol, and coumadin.	F 658	leaving medications unattended/ self-administration of medication policy. 2. All other residents in contact with this nurse had the potential to be affected by this same deficient practice. 3. Mandatory education will be completed for all nurses and TMAs on the policy related to the facility's self-administration of medication policy. A competency based learning question is included in the mandatory training related to the facility's self-administration of medication policy, and how to determine if it's a safe practice to leave medications unattended. The self-administration of medication policy is included in new employee orientation. The self-administration of medication practice and policy is also embedded in the medication administration nurse/TMA competency training completed upon hire, and at the annual skills fair. The policy is included in new employee paperwork. A competency based learning question has been added to the new employee orientation related to not leaving medications unattended unless the resident is otherwise assessed through the facility's self-administration of medication policy and procedure as safe to do so. 4. Quality assurance audits to be completed by all nurses and/or TMAs to ensure understanding of the self-administration of medication program and not leaving medications unattended. Audit schedule is as follows: 3x/week x4 weeks and then weekly x4 weeks. Results will be reviewed at the monthly QAPI meetings. The QAPI team to	

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F 658	Continued From page 7 During observations on 7/23/18, at 5:45 p.m., R29 was sitting at a table in the dining room awaiting dinner. On the table in front of R29 was a medication cup containing 4 tablets. No staff were present at the table. At 5:55 p.m. registered nurse RN-(C) was observed in the Work Room, behind a closed door, and out of view of the dining room. During an interview on 7/23/18, at 5:55 p.m. RN-C stated she had left the medication with R29 in the dining room. RN-C stated "to be honest with you I should not have left them." RN-C stated she left the medication because R29 was alert and oriented. RN-C stated the medication in the cup contained 1 tablet of bumetanide 1 mg, 2 tablets of Tylenol 325 mg, and 1 tablet of coumadin 5 mg. RN-C then walked to the dining room. The 4 tablets remained in the medication cup in front of R29. RN-C stated " [R29] do you want me to bring those back to you?" R29 stated he wished to finish eating his ice cream first. RN-A left the medication at the table. RN-A informed trained medication assistant (TMA)-A that R29 had his medication and asked TMA-A to watch R29. RN-A left the dining room. TMA-A remained in the dining room; however, walked away from R29's table and began assisting other residents in the dining room. R29 was observed to take all 4 tablets in the medication cup at 6:07 p.m. During an interview on 7/26/18, at 1:55 p.m. the director of nursing (DON) stated a nurse first completes a self-administration assessment, to ensure a resident is safe to self administer. If deemed safe, the nurse obtains a physicians	F 658	determine auditing after scheduled audits are complete and compliance is met. 5. Compliance will be obtained by September 4th, 2018.	

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F 658	Continued From page 8 order for the medication the nurse assessed the resident was safe to self-administer. The nurse then updates the care plan. The facility's policy Medication Self Administration, dated 3/22/18, directed if a resident chooses to self administer medication, the nurse will conduct an observation to asses if the resident is clinically appropriate to complete their medication administration. If successful, an order to self administer medication will be obtained from the attending physician. If a resident's status or cognition changes, the resident will be reevaluated to determine their ability to continue with the program. A prompt will be added to the eMAR to reflect that a resident is clinically appropriate to self administer medication.	F 658		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a	F 688		9/4/18

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F 688	Continued From page 9 reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow care planned intervention to maintain and prevent further contractures, skin breakdown, increased pain, and debility for 1 of 2 residents (R59) reviewed for range of motion and mobility. Findings include: R59's Face Sheet undated, indicated diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of the entire side of the body) following unspecified cerebrovascular disease affecting unspecified side, and cerebral infarction (stroke). R59's annual Minimum Data Set (MDS) dated 3/22/18, indicated R59 required extensive assistance for bed mobility, transfers, dressing, and personal hygiene. R59's care area assessment (CAA) dated 3/22/2018, indicated a BIMS score (brief interview for metal status) is less than 13, which indicates little to no cognitive impairment. R59's Physician Order Report dated 7/25/18, revealed an order for rolled wash cloth to left hand due to 3rd finger pain/contractures every shift; days, evenings, nights. R59's care plan revised 6/25/18 identified a goal to have intact skin, free of redness, blisters or discoloration. The intervention directed staff to	F 688	1. A root cause analysis was completed with direct care staff following the deficient practice concern to determine reasoning for why the washcloth was not in place. The root cause analysis revealed that the direct care staff had witnessed the washcloth fall out of her hand, and that she had sometimes refused the intervention to be in place, however the staff failed to communicate this to nurses, causing lack of documentation or exploration of alternative interventions to occur. The washcloth intervention was re-evaluation, and a proper fitting splint was ordered, which has been more acceptable intervention for resident. The resident voices comfort with this splint in place. 2. Other residents with like interventions (i.e. washcloths, splints, etc.) have the potential to be affected by the same deficient practice. 3. Mandatory education will be completed for CNAs, TMAs, and nurses related to following the care plan. A competency based learning question is included in the mandatory training post quiz regarding care plan interventions, implementation of the interventions, and documentation. Care plan competency training has been added to new employee orientation. This will be collected with each new employee hired. 4. Quality assurance audits to be completed to ensure understanding of the special device interventions are in use	

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F 688	Continued From page 10 place a rolled up wash cloth in left hand. 3rd finger contractures. The rolled washcloth is to be utilized as allowed until further assessment by therapy. R59's cares sheet (nursing assistant instructions) indicated rolled wash cloth in left hand at all times. During observation on 7/25/18, at 9:43 a.m. R59 was seated in her wheelchair in the dining room asleep at the table, R59 had a visibly contracted left hand (shortening and hardening of muscle) with the fingers turned inward, towards palm, causing left hand to appear like a fist. There was no rolled wash cloth in R59's left hand. During observation on 7/25/18, at 1:32 p.m. R59 was asleep in her bed, no rolled wash cloth in left hand. During interview and observation on 7/25/18, at 1:35 p.m. registered nurse (RN)-A stated, sometimes R59 takes the wash cloth out. A formed soft splint was observed sitting on a chair in R59's room. RN-A stated there was no order for the splint that I can locate. RN-A went on to say she had been gone for five days, and did not know if R59 has been wearing it. RN-A then place a rolled wash cloth in R59's left hand. RN-A indicated the rolled wash cloth to R59's left hand was an order and was to be signed off on the treatment sheet by licensed nurse every shift. When interviewed on 7/25/18, at 1:50 p.m. certified occupational therapy assistant (COTA)-C stated the occupational therapist (OT) is the one that fit the soft splint yesterday for R59's left hand. COTA-C went on to say the splint in R-59's	F 688	according to the resident's plan of care. Audit schedule is as follows: 3x/week x4 weeks and then weekly x4 weeks. Results will be reviewed at the monthly QAPI meetings. The QAPI team to determine auditing after scheduled audits are complete and compliance is met. 5. Compliance will be obtained by September 4th, 2018.	

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F 688	Continued From page 11	F 688		

room is just a trial and once the splint is a good fit for R59, it will be part of her daily routine, then staff would be instructed on donning and doffing of soft splint.

Therapy progress note dated 7/25/18, indicated the soft splint was removed from R59's room and COTA-C educated four nursing assistants (NA) on evening shift along with the nursing staff on med cart to use towel roll as tolerated for positioning of 3rd digit of left hand until smaller, soft splint has arrived to prevent pressure points/break down of skin on palm.

During observation on 7/26/18, at 10:01 a.m. R59 asleep in her bed left hand is clasped, no rolled wash cloth in left hand or near R59's bed.

When interviewed on 7/26/18, at 10:12 a.m. nursing assistant (NA)-B stated, you need to take it slow when doing cares, need assistance with all activities of daily living (ADL). NA-B also indicated R59 transfers with staff assist and a standing frame. I don't know anything about a rolled wash cloth for R59's left hand that must be something new. NA-B went on to say I know R59's hand is clasped and it was getting kind of red. When shown the cares sheet NA-B stated, she must have missed the rolled wash cloth on the cares sheet.

When interviewed on 7/26/18, at 10:46 a.m. COTA-C stated, I saw R59 yesterday afternoon, after passive range of motion (PROM) R59 was able to stretch left hand and extend fingers. COTA-C went on to say the contractures is not getting any worse at this time and there was no skin breakdown noted. The soft splint was removed from R59's room. COTA-C stated the

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F 688	Continued From page 12 splint was too large and need to order a smaller one. COTA-A stated, "a rolled wash cloth should be used until new splint arrives." COTA-C confirmed that only OT and COTA's are performing PROM on R59 at this time and will develop a PROM program for staff to follow. When interviewed on 7/26/18, at 10:55 a.m. DON stated, "That makes me sad that was not happening." In addition, the DON indicated the use of a rolled wash cloth to left hand was on the cares/treatment sheet. A policy was requested, but not received.	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the oxygen delivery system of a nasal cannula and oxygen tubing were changed in a timely manner for 1 of 1 residents (R39) reviewed for respiratory care. Findings include: R39's Face Sheet identified an admission date of 5/19/18. Diagnoses included chronic obstructive	F 695	1. The oxygen tubing system was immediately replaced out at the time the concern was noted during the health inspection. An EMAR general order was also immediately placed in the medical record to trigger weekly replacement of oxygen tubing. 2. All other residents who utilize oxygen had the potential to be affected by this same deficient practice. The facility also	9/4/18

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F 695	Continued From page 13 pulmonary disease, heart failure, and dependence on supplemental oxygen. R39's admission Minimum Data Set (MDS), dated 5/25/18, indicated R39 required supervision with personal hygiene and dressing. R39 was cognitively intact and receives oxygen. R39's physician orders included an order dated 5/19/18, for oxygen 2 liters per nasal cannula at bedtime. Additionally, for respiratory distress, and chest pain thought to be angina or cardiac in nature, or whenever nursing judgement determines necessary to administer oxygen at 2-3 liters per minute (lpm) via nasal cannula. R39's care plan, dated 6/29/18, directed R39 to receive oxygen at 2 liters per nasal cannula at night and as needed. The Care plan lacked direction for changing the nasal cannula and oxygen tubing. During observations on 7/23/18, at 5:24 p.m. R39 was observed sitting in his room. The oxygen concentrator was on and set at 2 lpm. R39 was receiving oxygen via a nasal cannula. The nasal cannula and oxygen tubing was not dated. During observations on 7/25/18, at 8:21 a.m., R39 was observed sitting in the recliner in his room. R39 was receiving oxygen at 2 lpm via nasal cannula. The nasal cannula and oxygen tubing was not dated. R39's June 2018 and July 2018, Medication Administration Record (MAR) and Treatment Administration Record (TAR) lacked direction for nasal cannula and oxygen tubing changes.	F 695	audited all other residents following the survey, and all other residents were identified as having the EMAR general order in place and tubing changed according to the facility policy. 3. Mandatory education will be completed for all nurses, CNAs, and TMAs on the facility's oxygen supply and weekly replacement of oxygen tubing. The policy has also been included in new employee orientation and an oxygen administration/tubing replacement competency will be completed upon hire. The competency will also be incorporated into the annual skills fair. 4. Quality assurance audits to be completed by all nurses, CNA, and TMAs to ensure understanding of the weekly oxygen tubing replacement process. Audit schedule is as follows: every week x8 weeks. Results will be reviewed at the monthly QAPI meetings. The QAPI team to determine auditing after scheduled audits are complete and compliance is met. 5. Compliance will be obtained by September 4th, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH OAK CROSSING	1040 LINCOLN AVENUE DETROIT LAKES, MN 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
F 695	Continued From page 14	F 695		

R39's medical record lacked documentation of nasal cannula and oxygen tubing changes

During an interview on 7/25/18, at 8:59 a.m. licensed practical nurse (LPN)-B stated when a resident has an order for oxygen, the nurse transcribes the oxygen order onto the MAR or TAR. LPN-B stated at the same time, the nurse initiates an order on the MAR/TAR to change the nasal cannula and oxygen tubing weekly. LPN-B stated the tubing is dated by the nurse when changed. LPN-B observed R39's tubing and stated the tubing was not dated. LPN-B reviewed R39's July 2018 MAR/TAR and stated there was no documentation of tubing changes.

During an interview on 7/26/18, at 1:55 p.m. the director of nursing (DON) stated we shoot for weekly oxygen tubing changes.

The facility's policy Oxygen Supplies & Equipment-Cleaning & Replacement, dated 4/11/18, indicated oxygen supplies and equipment will be cleaned and replaced on a regular schedule to prevent the transmission of organisms. Oxygen extension tubing and nasal cannula will be replaced weekly and labeled with the replacement date.

The manufacturers instructions for use, dated Oct 2017, did not direct when to replace the nasal cannula and oxygen tubing.

A document provided by the DON from Northwest Respiratory, undated, recommended replacing the nasal cannula weekly and the oxygen tubing monthly.

Additional information provided by the facility on

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F 695	Continued From page 15 7/27/18 included a security camera photograph dated 7/22/18, at 1:15 p.m. of staff entering a room. The facility document indicated the staff entering the room was a nursing assistant and identified the room as R39's. On the photograph, the nursing assistant is holding a white package, which the facility identified as oxygen tubing. A photograph dated 7/27/18, at 1:16 p.m. identified the nursing assistant leaving the room without the tubing. The document indicated the nursing assistant (unidentified) had changed the oxygen tubing on 7/22/18 as directed by a nurse. No additional information was provided of nasal cannula and oxygen tubing changes between the dates of 5/26/18 to 7/15/18.	F 695		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		9/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 16 by: Based on observation, interview and documentation review, the facility failed to ensure a safe temperature of less than 41 degrees Fahrenheit (F) was maintained in a food storage refrigerator. This practice could promote bacterial growth and food borne illness and had the potential to affect all 21 residents who resided on that unit. Findings include: During observation on 7/26/18, at 9:01 a.m. of Cedar Ridge kitchen refrigerator, that serves 21 residents, the stand alone thermometer read 60 degrees. The homemaker (HM)-D assigned in Cedar Ridge kitchen stated she thought the thermometer was broken and stated she turned up the temperature of the refrigerator but wasn't sure if she put it on the right setting. HM-D stated she told the clinical dietitian (CD) of the broken thermometer the day before as the refrigerator read 60 degrees then as well. During interview on 7/26/18, at 9:22 a.m. the CD stated a refrigerator temperature of 60 degrees was not reported to her and this is the first she has heard of it. CD stated she would like to go check the temperature of the food in the refrigerator herself, stating it is possible that someone put in a maintenance request and she may not have seen that. CD stated the homemakers have several training days and the process is to take temperature of the food if a thermometer is out of normal range and if not in normal range, they are not use the food and fill out maintenance slip or report to maintenance or herself. The CD stated it is very concerning that food is being served to residents from a	F 812	1. Re-education was provided to the homemaker utilizing Essentia Health's Just Culture root cause investigation related to proper temperature log temping. 2. All other residents who reside in the Cedar Ridge neighborhood had the potential to be affected by this same deficient practice. 3. A competency was developed and will be a training point for all current employees identified to be homemakers or usual homemaker workers as well new employees upon orientation. 4. Temperature log audits to be performed weekly for 3 months and reported on at monthly QAPI meetings. If temperature logs are not completed to 95% weekly the monitoring will continue until completion goal is consistently met for a 3-month period of time. 5. Competencies to be completed by September 4th.	

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F 812	Continued From page 17	F 812		

refrigerator with a reading of 60 degrees.

During interview with CD present on 7/26/18, at 09:33 a.m. HM-D stated she has not taken the temperature of the food in the refrigerator for the last two days and has been serving the food in the refrigerator to the residents in Cedar Ridge dining room.

During observation and interview with CD and HM-D on 7/26/18, at 9:35 a.m. CD was taking the temperature of the food in the refrigerator, tomato juice and lemonade 48 degrees and needed to be thrown out. The fresh food brought up from main kitchen was holding it temperature, however all other food was to be thrown out per CD request of HM-D. Some items to be thrown out included older lettuce, tomatoes, milk, desert, cranberries, three cartons liquid eggs, cottage cheese, fruit, cheddar cheese, etc.

During observation of refrigerator and interview with HM-D and CD on 7/26/18, at 11:00 a.m. it was noted that all food from the refrigerator was not thrown out per earlier request. the refrigerator temp was now reading 64 degrees and the reading was with a new thermometer. The CD took temperature of liquid eggs that remained in refrigerator, reading was 50 degrees. The CD repeated her request from earlier to throw out all food.

During observation and interview on 7/26/18, at 11:06 a.m. the CD found ice in the lower back of the refrigerator and stated there is definitely a problem with the refrigerator and stated there was a problem with this refrigerator a couple weeks ago with it icing up.

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F 812	Continued From page 18 During interview on 7/26/18, at 12:11 p.m. the nutrition service manager (NSM) stated the homemakers should be following the directions from the documentation of their findings on the temperature log for refrigerators. They should try a new thermometer if needed, or a request for maintenance should be filled out if temperature is out of range and the food in the refrigerator should be checked for temperature as well. The NSM stated the homemakers have food safety classes, on the job training, infection control and completing documents with the corrective actions. The NSM went on to state she would expect the homemakers to take the temperature of the food and would expect that once the food is found to be out of normal range, to immediately discard the food. A review of the Temperature Log for Refrigerator Outside the kitchen revealed that the temperature of the refrigerator was not recorded on 7/24, 7/25, or 7/26/18. The last temperature recorded on 7/23/18, was 37 degrees. the document clearly states if temperature greater than 41 degrees to alert maintenance immediately and to follow directions at the bottom of the page. 1. Take temperature of perishable food items, if greater then 41 degrees discard the food. 2. Move any non-perishable and temperature safe (still less than 41 degrees but perishable) foods to another refrigerator. 3. Make sure that maintenance and dietitian have both been called to report the issue. A review of the facility policy titled Sanitary procedures and techniques are applied in the preparation and handling of all foods revised 7/2010 indicates all foods stored in refrigerators and freezers are covered, labeled, and dated to	F 812		

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F 812	Continued From page 19 protect them from contamination by foreign agents. Refrigerator temperatures should be in range between 33 degrees and 40 degrees.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		9/4/18

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F 880	Continued From page 20 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure infection control standards for discarding a lancet device for 1 of 1 residents (R50) observed during a blood glucose check.	F 880	1. The nurse self-reported this error, and immediately identified this to the surveyor. Re-education was provided to the nurse utilizing Essentia Health's Just Culture root cause investigation related to proper disposal of sharps products.	

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F 880	Continued From page 21 Findings include: R50's annual Minimum Data Set (MDS) dated 6/7/18, indicated R50 had a diagnoses of Diabetes Mellitus and received insulin. During observations on 7/25/18, at 7:13 a.m. licensed practical nurse (LPN)-B cleansed hands with alcohol based sanitizer and donned (put on) gloves. LPN-B cleaned R50's right thumb with an alcohol wipe. LPN-B placed a self retracting lancet (device used to puncture the skin to get a blood sample to test glucose) onto R50's right thumb and activated the lancet. R50 wiped away the first drop of blood and placed a drop of blood onto the test strip, located in the Nova Statstrip blood glucose monitor. Upon reading the results, R50 doffed (removed) her gloves. When doffing the gloves, R50 held onto the used lancet, leaving the lancet inside the glove. R50 disposed of the glove containing the lancet into the trash can in R50's room. R50 again used alcohol based sanitizer to cleanse hands, donned new gloves, and administered R50's scheduled 60 units of Novolog insulin. LPN-B doffed her gloves, alcohol rubbed her hands, and exited R50's room with the Nova Statstrip monitor. Once at the medication cart, LPN-B cleaned the glucose monitor with a super sani-wipe, wrapped the monitor into the wipe and placed the monitor on top of the medication cart. When asked how she disposed of the lancet used to perform R50's glucose test, LPN-B stated "It's in my glove." LPN-B stated she turned the used lancet into her glove and disposed of it in the trash in R50's room. LPN-B stated normally she brings the used lancet back to the medication cart and puts the lancet "in here" pointing to a sharps container.	F 880	2. All other residents in contact with this nurse had the potential to be affected by this same deficient practice. 3. Mandatory education will be completed for all nurses and TMAs on Essentia's policy related proper disposal of sharps products. The medication administration and glucometer check competency has been updated to specifically address proper disposal of sharps products into the sharps containers. The policy has been included in new employee orientation. The medication administration and glucometer check competency has been incorporated into new employee orientation that is collected with each new hire. 4.Quality assurance audits to be completed by all nurses and/or TMAs to ensure understanding proper lancet disposal into sharps containers. Audit schedule is as follows: 3x/week x4 weeks and then weekly x4 weeks. Results will be reviewed at the monthly QAPI meetings. The QAPI team to determine auditing after scheduled audits are complete and compliance is met. 5. Compliance will be obtained by September 4th, 2018.	

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	245212	A. BUILDING _____ B. WING _____	07/26/2018

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F 880	Continued From page 22 During an interview on 7/26/18, at 1:55 p.m. the director of nursing (DON) stated staff are directed to dispose of used lancets in the sharps container. Manufacturer's instructions, undated, provided by the facility for the Pressure Activated Safety Lancets direct to: 1. Twist the cap a full 360 degrees to remove. 2. Push gently against test site. 3. Dispose in sharps container. The facility's policy related to the the disposal of used lancets was requested and not provided.	F 880		

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	245212	A. BUILDING **01 - ADMINISTRATION 01** B. WING _____	**07/24/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH OAK CROSSING	**1040 LINCOLN AVENUE** **DETROIT LAKES, MN 56501**

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K 000	INITIAL COMMENTS FIRE SAFETY Bldg 1 Admin Bldg, type V A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Essentia Health Oak Crossing 02 Main Building was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. The facility was surveyed as two buildings Essentia Health Oak Crossing is a 2-story building with a basement. The building was constructed at 3 different times. The original building (02) was constructed in 1968, is 2-story building with a small basement and was determined to be of Type II(000) construction due to the on going remodeling of this building. In 1999 an Administration / Entrance addition was constructed south of the original building and an addition to the hospital north of the original building. The entrance addition is Type V (111) construction, 2-stories without a basement and the hospital addition is Type II (111) construction, 1-story without a basement. In 2008 a 2-story building, without a basement, separated with two 2-hour fire barriers south of the entrance addition and was determined to be Type II (111) construction. The buildings are divided into 12 smoke zones (6 per floor) by 2- hour and 30 minute fire barriers.	K 000	EFOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/14/2018

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

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	245212	A. BUILDING **01 - ADMINISTRATION 01** B. WING _____	**07/24/2018**

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K 000	Continued From page 1 The survey consisted of two bldgs. one type II and one type V. The facility is completely protected with an automatic fire sprinkler system in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a fire alarm system with manual pull station near each exit door, smoke detection in the corridor system properly spaced and all common areas in accordance with NFPA 72 "The National Fire Alarm Code." The facility has a capacity of 96 beds and had a census of 86 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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	245212	A. BUILDING **02 - EXISTING BUILDING 02** B. WING _____	**07/24/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY Bldg 2 Main bldg & 2008 addition, type II THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State fire Marshal Division. At the time of this survey Essentia Health Oak Crossing bldg 03 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/14/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING **02 - EXISTING BUILDING 02** B. WING _____	**07/24/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH OAK CROSSING	**1040 LINCOLN AVENUE** **DETROIT LAKES, MN 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
K 000	Continued From page 1 DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was surveyed as two buildings: Essentia Health Oak Crossing is a 2-story building with a basement. The building was constructed at 3 different times. The original building (02) was constructed in 1968, is 2-story building with a small basement and was determined to be of Type II(000) construction due to the on going remodeling of this building. In 1999 an Administration / Entrance addition was constructed south of the original building and an addition to the hospital north of the original building. The entrance addition is Type V (111)	K 000		

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	245212	A. BUILDING **02 - EXISTING BUILDING 02** B. WING _____	**07/24/2018**

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K 000	Continued From page 2 construction, 2-stories without a basement and the hospital addition is Type II (111) construction, 1-story without a basement. In 2008 a 2-story building, without a basement, separated with two 2-hour fire barriers south of the entrance addition and was determined to be Type II (111) construction. The buildings are divided into 12 smoke zones (6 per floor) by 2- hour and 30 minute fire barriers. The facility is completely protected with an automatic fire sprinkler system in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a fire alarm system with manual pull station near each exit door, smoke detection in the corridor system properly spaced and all common areas in accordance with NFPA 72 "The National Fire Alarm Code." The facility has a capacity of 96 beds and had a census of 96 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K 211		9/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING **02 - EXISTING BUILDING 02** B. WING _____	**07/24/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH OAK CROSSING	**1040 LINCOLN AVENUE** **DETROIT LAKES, MN 56501**

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K 211	Continued From page 3 Based on observations, record review and staff interview, the facility failed to provide unobstructed access to the means of egress as required by the Life Safety Code (NFPA 101) 2012 edition section 19.2.1 & 7.1.6. This deficient practice could affect the exiting ability of 36 of the 90 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 07/24/2018 observations revealed personal decorations on the floor in the corridors in front of resident rooms 122 and 257. This deficient condition was confirmed by the Engineering Manager	K 211	1. The residents and their representative have been notified that they cannot have personal items stored in the egress corridor. 2. All other residents residing in Oak Crossing have the potential to be impacted by this same deficient practice. 3. Resident representative and residents have been re-educated on the facility policy that personal items cannot be stored in the egress corridor—this was published in the facility newsletter that was mailed August 2018. We will be adding this to our monthly fire alarm sheet so when we conduct our fire alarm drill we will do a facility wide walk through to make sure no personal items are stored in the egress corridor. 4.The life safety code says that we must conduct fire drill every month. We have a fire drill log that is filled out to make sure that we are complying. This is audited by the maintenance manager every month. 5. Compliance will be obtained by September 4th, 2018	