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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HC6J

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 **11/10/2016** (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: **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):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 11/21/2016
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/06/2017
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
11/08/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245212

January 6, 2017

Ms. Laura Seleen, Administrator
Essentia Health Oak Crossing
1040 Lincoln Avenue
Detroit Lakes, Minnesota 56501

Dear Ms. Seleen:

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 November 1, 2016 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 21, 2016

Ms. Laura Seleen, Administrator
Essentia Health Oak Crossing
1040 Lincoln Avenue
Detroit Lakes, Minnesota 56501

RE: Project Number S5212025

Dear Ms. Seleen:

On October 3, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 22, 2016. 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 November 10, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 22, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 1, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 22, 2016, effective November 1, 2016 and therefore remedies outlined in our letter to you dated October 3, 2016, 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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245212 Y1	A. Building B. Wing Y2	11/10/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0176	Correction	ID Prefix F0221	Correction	ID Prefix F0241	Correction
Reg. # 483.10(n)	Completed	Reg. # 483.13(a)	Completed	Reg. # 483.15(a)	Completed
LSC	11/01/2016	LSC	11/01/2016	LSC	11/01/2016
ID Prefix F0282	Correction	ID Prefix F0323	Correction	ID Prefix	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(h)	Completed	Reg. #	Completed
LSC	11/01/2016	LSC	11/01/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GA/mm	11/21/2016	28034	11/10/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/22/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HC6J

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: **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 **09/22/2016** (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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE NEII 10/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/07/2016 (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
Posted 11/07/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5212

At the time of the recertification survey the facility was not in substantial compliance with Federal participation requirements. The facility has been given an opportunity to correct before remedies would be imposed. The most serious deficiency is a 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 are required. In addition at the time of the survey an investigation of complaint number H5212009 was conducted and found to be unsubstantiated. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction for health only. Post Certification Revisit to follow.

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 5699

October 3, 2016

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

RE: Project Number S5212025, H5212009

Dear Ms. Brinkman:

On September 22, 2016, 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the September 22, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5212009 that was found to be unsubstantiated.

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;

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

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140 Fax: (218) 332-5196

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 November 1, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

If an acceptable PoC 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 PoC 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 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 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 December 22, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 22, 2017 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

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 _____	09/22/2016

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 000	INITIAL COMMENTS The facility's plan of correction (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 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. "A recertification survey was conducted and complaint investigation was also completed at the time of the standard survey. " An investigation of complaint [H5212009] was completed and found not to be substantiated.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess for self administration of medication for 1 of 1 resident (R138) who was observed during medication administration. Findings include:	F 176	1. Education provided to the nurse involved. Self-administration of medication observation completed on resident. 2. All residents are assessed for ability to self-administer medications safely upon admission and/or as residents request. 3. All residents who have been assessed	11/1/16

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

Electronically Signed | 10/11/2016

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 _____	09/22/2016

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 176	Continued From page 1 R138's quarterly Minimum Data Set (MDS) assessment dated 9/3/16, identified R138 had moderately impaired cognition and a diagnosis of Alzheimer's Disease. On 9/19/16, at 5:48 p.m. licensed practical nurse (LPN)-C dispensed the following medications into a medication cup: celecoxib(prescription nonsteroidal anti-inflammatory) 200 milligram (mg) 1 capsule , duloxetine(anti-depressant medication) 60 mg 1 capsule, potassium chloride(supplement) tablet extended release 10 milliequilivants (mEq) 1 tablet, while standing at the medication cart which was located outside of the dining room. At 5:56 p.m. R138 was seated in an upright position in a stationary chair located at the dining room table. At this time LPN-C brought R138's medications in the medication cup and placed the medication cup on the dining room table in front of R138 and immediately walked away. LPN-C exited the dining room and returned to the medication cart located outside of the dining room. During interview, LPN-C stated R138 self administered her oral medications all the time, and stated staff administer R138's eye drops and insulin, check R138's blood sugar, but all other medications are left with R138. LPN-C stated she has always left R138's oral medications with R138 to self administer, for as long as she has worked at the facility. She stated all staff always leave her medications with her. LPN-C continued passing medications to the next resident and did not go back to observe if R138 took the medications, nor supervise her self administration of the medications. A review of R138's clinical record was conducted	F 176	to self-administer medications have been reviewed and a cue was placed in the eMAR to reflect current self-administration status. 4. Policy was reviewed and updated to reflect the eMAR prompt addition to the current practice. 5. Mandatory Education/re-education for all licensed nurses and TMAs. 6. Policy will be included in the new orientation for licensed nurses and TMAs. 7. DON will monitor compliance with the policy weekly for four weeks, then monthly pending audit review at QAPI. Nurse managers will conduct randomized medication pass observations for licensed nurse and TMAs weekly for four weeks, then monthly pending audit review at QAPI.	

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on 9/19/16, at 5:57 p.m. of R138's medication administration record, with LPN-C present and confirmed the following findings. R138's record lacked assessment for safe self administration, lacked standing orders, physician orders, and care plan interventions for R138 to self administer her medications without any supervision by licensed staff.

R138's current signed physician orders, dated 9/9/16 included: Celebrex (celecoxib)200 mg 1 capsule twice a day, Cymbalta (duloxetine)60 mg 1 capsule twice a day and potassium chloride tablet extended release 10 mEq twice a day. The orders did not indicate R138 self administered medications.

R138's care plan dated 6/10/16, did not indicate R138 had been assessed for self administration of medications nor address interventions for R138 to self administer medications.

During interview on 9/22/16, at 1:20 p.m. licensed practical nurse (LPN)-D reported R138 was not to be left alone while taking her medications. She stated the usual facility practice was to complete a self medication administration observation form, a monthly nurse observation and watch residents take their medications, as well as chart in the progress notes for all the residents that have been assessed to self administer their medications. LPN-D confirmed none of those protocols were in place for R138 as she was not to self administer her own medications. LPN-D stated her usual practice for R138 did not include R138 to self administer any medications.

During interview on 9/22/16 at 2:56 p.m. the director of nursing (DON) confirmed R138 had

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F 176	Continued From page 3 not been assessed for safe self administration of medications. The DON reported she expected staff to have completed an assessment prior to leaving medications unattended with any residents. Review of facility policy titled, Medication Self Administration, dated 5/20/2016, indicated an individual resident may self administer medication if the resident requests and the interdisciplinary team has determined that the resident is safe in this practice. The policy also indicated staff would complete a self administration assessment, obtain a physicians order, and would be documented in a progress note within the EMR.	F 176		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the use of a wheelchair lap tray device was appropriately assessed as a potential restraint for 1 of 3 residents (R1) reviewed for restraints. Findings include: R1's significant change Minimum Data Set (MDS) dated 7/27/16, identified R1 was severely cognitively impaired and had diagnoses which included dementia, epilepsy, anxiety, and	F 221	1. Restraint-type device was removed from resident's wheelchair. Device observation completed for a more appropriate wheelchair. 2. No restraint-type device will be utilized within the facility unless an assessment has been completed and deemed appropriate for the resident. 3. New device assessment policy was created for facility use. 4. RNCCs audited for current positioning devices in use and assured device	11/1/16

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F 221	Continued From page 4 depression. The MDS identified R1 required extensive assistance from staff for activities of daily living (ADL's) with exception of supervision with eating and locomotion on and off the unit with the use of a wheelchair. Review of R1's current care plan revised 9/12/16, revealed R1 had severe cognitive impairment and required total assistance from facility staff for ADL's. The care plan identified R1 was at risk for falls and had numerous interventions in place to prevent falls including a Buddy Belt Cushion (wheelchair lap tray device) when in the wheelchair. The care plan indicated the device had been assessed and determined the device was for position and not a restraint. Review of a occupational therapy notes dated 8/23/16 revealed R1 had received a buddy belt cushion (lap tray device) for pt's (patients) w/c (wheelchair) to help with prevention of falls. Educated staff on use while pt in w/c. R1's clinical record lacked any occupational therapy assessment for restraint or safety for R1" lap tray device. Review of a facility form titled DL Essentia Device Assessment dated 9/16/16, noted the following: Buddy belt/lap buddy for positioning per OT(occupational therapy). Resident able to remove, also able to stand up as she chooses and it releases in center which does not restrict her mobility/movements as she chooses due to cognition she does not follow direction. On 9/20/16, A physician order was obtained to use the wheelchair lap tray device when R1's was seated in the wheelchair.	F 221	assessments were in place. 5. Mandatory education and attestation provided to nursing staff, nursing leadership, and therapy. 6. Weekly audits of devices and device assessments will be completed through next quarterly QAPI meeting for further evaluation.	

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On 9/20/2016, at 12:55 p.m. R1 was observed seated in a wheelchair with the black colored cushion with a black firm tray over the cushion, covering her entire lap and extending thru the sides of both arms of the wheelchair. The tray and cushion were secured together in multiple areas with approximately two inch thick, black velcro straps which were observed to secure the tray to the cushion and secure the two sections of the cushion together. R1's plate of food and drinking glasses were on the table in front of R1. R1 held a stuffed dog wrapped in a small fleece blanket on top of the lap table. Registered nurse (RN)-A assisted R1 to eat and used a fork to scoop food items from the plate on the table and placed it in R1's mouth. At 1:02 p.m. R1 began to eat independently with the fork. R1 reached across the lap tray device secured across her lap and scooped foods from the plate on the table. RN-A remained seated next to R1 and occasionally redirected R1 to continue to use the fork and independently feed herself. R1's lap tray device remained fastened to the wheelchair extending across R1's lap through out the supervised meal service from 12:50 p.m. to 1:13 p.m.

On 9/20/2016, at 5:51 p.m. R1 was observed in the hallway of the facility with the lap table secured over her lap. At 6:20 p.m. R1 remained in the hallway with the device secured on her lap. A hospice nursing assistant sat in a chair next to R1 and assisted R1 to eat pudding, grapes and drink a nutritional supplement from a can with a straw. The lap table was not removed while being assisted to eat nor while visiting with the hospice aid from 6:20 p.m. to 6:43 p.m.

On 9/21/2016, at 9:27 a.m. nursing assistant

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(NA)-E and NA-G entered R1's room and assisted with morning cares and dressing. At 9:42 a.m. R1 was assisted in to the wheelchair and NA-G pushed the ends of the lap tray device under each arm rest so that the device was secured into place under the arms and surrounded 3 sides of the front wheelchair arm support. NA-G then pushed the two pieces of the lap tray device together so that the wide velcro strip on each piece of the cushion attached securely to each other. NA-G lastly placed the top surface of the lap tray device on top of the two connected pieces matching the velcro strips on the bottom surface of the top covering to the top surface of the cushion.

On 9/22/2016, at 1:08 p.m. R1 was observed seated in her wheel chair at a table in the small dining room. R1 was seated at the table with the lap tray device in place on the wheel chair. R1 reached across the lap tray device attached to her wheel chair to the table and independently drink apple juice. R1's meal of buttered bread, turkey, mashed potatoes and green beans sat on the table in front of R1. The lap tray device was not removed from R1's wheel chair.

On 9/22/2016, at 2:28 p.m. R1 propelled the wheel chair independently with her feet as she leaned forward on to the lap tray device secured across her lap holding on to the blanket and stuffed dog.

On 9/22/2016, at 2:23 p.m. NA-H identified R1 had the lap tray device on the wheel chair at all times when she is in the wheel chair. NA-identified R1's behaviors to be refusals of food, toileting, and attempting to go out of exit doors. NA- identified R1 had the lap table a short time,

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but he/she had not seen R1 remove the lap table independently and was not aware R1 was able to remove it.

On 9/22/2016, at 2:29 p.m. NA-I identified staff were to secure the lap tray device on to R1's wheelchair for safety when ever R1 was seated in the wheelchair. NA-I indicated if R1 became angry staff were to remove the lap tray device and to assist R1 to the toilet of to lay down in bed.

On 9/22/2016, at 3:11 p.m. NA-J identified R1 was to have the lap tray device in place on the wheel chair to prevent her from falling out of the chair and it was only to be removed to assist R1 to the toilet or to lay down. NA-J was not aware of R1 removing the lap tray device independently.

On 9/22/2016, at 3:12 p.m. NA-K verified he/she often cared for R1. NA-K indicated the lap tray device was only to be removed from the wheelchair when R1 was assisted to the toilet or to lay down. NA-K identified he/she had never seen R1 attempt to remove the lap table.

On 2/2016, at 3:27 p.m. RN-A verified R1 was not able to remove the lap tray device on command nor was she able to stand on command because of her cognition impairment. RN-A identified the lap tray device was not considered a restraint because R1 could stand if she wanted to. RN-A identified staff were to secure the lap tray device on to the wheelchair and leave it in place until R1 was assisted to the toilet or to bed. RN-A verified the lap tray device was not to be removed for meals and were to only remove it if R1 was showing the device agitated her.

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F 221	Continued From page 8 A request for the manufactures' guidelines for use of the device was requested and the facility was unable to provide the information. On 9/22/2016, at 3:46 p.m. the director of nursing (DON) could not comment on the facility practice of restraint use. The DON stated,"I would have to check the policy." A facility policy titled, Emergency Restraints, reviewed 4/1/16, identified the purpose: To minimize restraint use and to prevent a restraint proper environment.	F 221		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services in a dignified manner for 1 of 3 residents (R70) who utilized a Foley catheter. Finding include: R70's quarterly Minimum Data Set (MDS) dated 8/25/16, identified R70 had diagnoses which included: Alzheimer's, malignant neoplasm of bladder and chronic kidney disease (stage 4). The MDS identified R70 had severe cognitive impairment and required extensive assistance of one staff for bed mobility, transfers, dressing	F 241	1. Staff member involved was provided education on maintaining resident's dignity. 2. Catheter cover bags were ordered and initiated for all residents who utilize a foley catheter bag. 3. Mandatory education and attestation provided to nursing staff. 4. Residents with foley catheters are tracked daily by DON. RNCCs will audit to assure catheter bags are not exposed three times per week for four weeks, then weekly for four weeks, then evaluated at the next quarterly QAPI meeting.	11/1/16

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toileting, personal hygiene and did not identify the use of an indwelling Foley catheter.

R70's current care plan dated 8/24/16, indicated R70 had experiences of bowel incontinence and had a Foley catheter related to history of frequency, negative for urinary tract infection and bladder cancer. The care plan listed various interventions which included R70 had a Foley catheter, and directed staff to empty every shift, and use a leg bag during the day.

On 9/21/16 at 7:29 a.m. nursing assistant (NA)-A entered R70's room to assist R70 with morning cares. R70 was seated on the edge of her bed wearing blue pajama bottoms and a mint green night gown. NA-A positioned R70's wheelchair by the bed side, placed a transfer belt around R70's waist, grabbed the walker and placed it in front of R70. NA-A picked up R70's catheter bag which contained bright yellow urine, out of a pink basin resting on the floor beside the bed. She hooked the urine bag onto R70s walker and proceeded to assist R70 to stand, pivot and transfer from her bed to her wheelchair. NA-A then moved R70's catheter bag containing bright yellow urine, and hooked it on the cross bars under R70's wheelchair.

At 7:41 a.m. NA-A pushed R70 in her wheelchair down the hallway to the main dining room on unit. R70's catheter bag, approximately 1/4 full of yellow urine, was visible under the wheelchair and the bottom edge of the bag dragged on the floor as R70 was wheeled down the hallway. NA-A proceeded to position R70 up to a dining room table at the far end of the dining room, with several other residents seated at the table. R70 remained seated in the dining room, with her

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catheter bag of yellow urine hanging under her wheelchair with the bottom edge resting on the floor, while other resident's/visitors were present or eating the breakfast meal in the dining room. R70 remained in the dining room with her catheter bag with bright yellow urine, visible to other residents and visitors until 9:02 a.m. when a staff member assisted R70 to return to her room.

On 9/21/16 at 8:55 a.m. NA-B confirmed R70's catheter bag was dragging on the floor and visible to the general public. NA-B indicated staff were to cover the catheter bags when the residents were out into the general population or hook the catheters up to a leg bag appliance, which would be covered by the residents pants. NA-B indicated having the catheter bag exposed was not dignified and stated "I would not be happy if it was me."

On 9/21/16 at 9:02 a.m. LPN-A confirmed R70's catheter bag was visible under her wheelchair and exposed to the general public. LPN-A indicated usually the residents utilized a leg bag and the leg bag was covered up by their pants. LPN-A also indicated if the residents utilized a catheter bag, staff were instructed to use a catheter bag cover to cover it up the contents of the bag. LPN-A indicated it was not dignified to have the uncovered catheter bags exposed for the general population to see.

On 9/22/16 at 1:44 p.m. director of nursing (DON) confirmed catheter bags should be covered when residents were out in the general population of the nursing home. The DON also indicated she would expect staff to use the catheter bags to the cover the catheter bags when in the public. DON also indicated the residents usually utilized legs

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F 241	Continued From page 11 bags during the day and stated the catheter bag should be covered to maintain the residents dignity. Review of the facility policy titled, Plan for Provision of Services, revised on 5/20/16, indicated Oak Crossing provides quality nursing services to rehabilitate or maintain residents to their highest level of function while maintaining the individual's dignity.	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to utilize a gait belt during transfers as directed in the plan of care for 1 of 3 residents (R126) reviewed who required staff assistance with transfers. Findings include: The quarterly Minimum Data Set (MDS) dated 7/18/16, identified R126 with diagnoses which included: dementia with behavioral disturbance and chronic obstructive pulmonary disease. The MDS identified R126 had severe cognitive impairment and required extensive assistance of two staff for transfers, walking in room/corridor and utilized a walker. The MDS also identified R126 was only able to stabilize with human	F 282	1. A transfer status assessment was completed for the resident affected to assure that the current plan of care is appropriate. 2. Mandatory education with attestation provided to all nursing staff on gait belt use with transfers. 3. The current safe patient handling policy was updated with the gait belt use process. 4. The updated policy will be included in new employee orientation. 5. Randomized audits to be conducted on residents who are a transfer status of 1-2 assist with a gait belt three times a week for 4 weeks, then weekly for 4 weeks, then evaluated through QAPI.	11/1/16

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assistance when: moving from seated to standing position, walking with assistive device, turning around and facing the opposite direction while walking, moving on and off the toilet and surface to surface transfers.

The plan of care dated 7/20/16, indicated R12 was at risk for falls and had activity of daily living (ADL) and mobility deficits due to recent hemi-arthroplasty of right femoral neck fracture, weakness, advanced dementia and does not always make safe decisions. The plan of care indicated R126 required one staff assist with transfer and use of walker and a gait belt.

During observation on 9/20/16, at 5:49 p.m. R126 was seated in his recliner in his room with the walker in front of him. Nursing assistant (NA)-C was verbally directing R126 to stand up. R126 reached his hands up on the handles of the walker and began to rock his upper body back and forth to get the momentum to stand, while NA-C was pulling on his right arm using her body and both hands forcefully to try and propel R126 from the seated position. NA-C repeatedly continued to pull on his right arm, while R126 rocked back and forth to get enough strength to stand in an upright position. Once R126 was in an upright/standing position he was very unsteady on his feet and had to get his balance while NA-C continued to hold onto his right arm. NA-C did not utilize the use of a gait belt while she was trying to assist R126 to stand and regain his balance as directed in the plan of care.

On 9/20/16, at 5:57 p.m. NA-D walked past the room and noted that NA-C needed additional staff help to steady R126 on his feet after he stood upright. NA-D entered the room, grabbed onto

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R126's left arm, while NA-C continued to hold his right arm and they began to assist R126 to turn and sit in his wheelchair. R126 remained very unsteady with his balance, shaky and hesitant to pivot and sit down in his wheelchair during the transfer. At 5:59 p.m. NA-C wheeled R126 in the wheelchair down to the dining room for the evening meal. NA-C and NA-D did not utilize the use of a gait belt while they were trying to assist R126 to stand and transfer into his wheelchair.

On 9/21/16, at 7:14 a.m. NA-E confirmed R126 was a fall risk, required assistance from staff for all transfers and utilized bed/chair alarms. NA-E stated "we are to use a transfer belt." NA-E indicated R126 has a hard time standing and a transfer belt is utilized due to his unsteadiness during transfers and experiences hip pain. NA-E further indicated "we should use a transfer belt with all transfers because we don't want him to fall."

On 9/22/16, at 1:39 p.m. NA-G confirmed R126 was a fall risk, needed assistance from staff for all transfers and stated "he is not steady when he gets up." NA-G indicated staff unitize bed/chair alarms, hourly checks and use the transfer belt when he transfers and/or walks. NA-G indicated R126 legs get very wobbly, unsteady at times and will drag one of his feet when he walks and stated "uses a belt for safety precautions.

On 9/22/16, at 3:33 p.m. NA-C confirmed R126 was a fall risk, needed assistance from staff for all transfers and stated "we try to use the gait belt." NA-C indicated all staff was suppose to utilize the transfer belt for R126's because he is unsteady on his feet to keep him safe in case he starts to fall. NA-C stated "I did not offer the gait

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	245212	A. BUILDING _____ B. WING _____	09/22/2016

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 282	Continued From page 14 belt yesterday, I should of used his gait belt, but he refuses it." NA-C indicated that R126's hip was bad and you never know when it might go out and stated "yes, I should be following the care plan." When interviewed on 9/22/16, at 2:05 p.m. physical therapist (PT) confirmed R126 was a high fall risk based on his cognition level and has poor safety awareness when transferring. The PT indicated staff should be utilizing a transfer belt if R126 was unsteady and pulling on his arm to transfer him was not the safest way to transfer R126. PT also indicated that if he fell, it could cause injury to his arm by pulling on it, explaining it does not give staff good leverage for a safe transfer. On 9/22/16, at 1:50 p.m. director of nursing (DON) confirmed R126's care plan as written, verified staff should being utilizing the gait belt when transferring R126 and stated "he is very impulsive, staff should follow the care plan as written." The DON also indicated that staff should not be pulling on R126's limb to get him out of the recliner. She added that staff should maintain safety, decrease the risk for additional injuries, stating "no, this is not the proper way to transfer any resident or him." Review of facility policy titled, Care Conferences, Care Planning, revised on 5/20/16, indicated each resident shall have a plan of care so that he/she will receive the care necessary to enable him/her to achieve and/or maintain the highest practical physical, mental and psychological well-being.	F 282		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		11/1/16

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 _____	09/22/2016

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ESSENTIA HEALTH OAK CROSSING	1040 LINCOLN AVENUE DETROIT LAKES, MN 56501

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F 323	Continued From page 15 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure hot water temperature were within a safe temperature range for 8 of 8 resident rooms (Rooms: 114, 115, 204, 211, 214, 215, 217, 223) tested for safe water temperatures. Finding include: During the environmental tour on 9/19/16, at 8:00 p.m. the administrator and plant operations staff (POS) checked the water temperatures with the facility thermometer. The following water temperatures were noted: -Rm 114 was 129.4 degrees Fahrenheit (F) -Rm 115 was 126.2 degrees (F) -Rm 204 was 125.5 degrees (F) -Rm 211 was 126.0 degrees (F) -Rm 214 was 131.2 degrees (F) -Rm 215 was 130.4 degrees (F) -Rm 217 was 128.8 degrees (F) -Rm 223 was 120.2 degrees (F) During the environmental tour on 9/19/16, at 8:00 p.m. the administrator and the POS confirmed the water temperatures were running hot and stated "the check valve was running hot." The POS verified that temperature should normally be	F 323	1. Mixing valve was replaced. 2. Electronic monitoring installed and set to alarm at 118 F alerting the maintenance department for immediate attention. 3. Audits beyond the monthly routine audits will be conducted by maintenance on a weekly basis, then will be evaluated by QAPI in January.	

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	245212	A. BUILDING _____ B. WING _____	09/22/2016

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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F 323	Continued From page 16 running between 115-120 degrees (F) and indicated the temperature may be elevated due to increased usage tonight. The POS also verified the boiler was running too hot and subsequently adjusted the water temp so it would run at 115 degrees (F). When interviewed on 9/22/16, at 12:34 p.m. the plant operations manager (POM) confirmed finding the water temperature was running hot and stated "the hot water mixing valve failed." The POM indicated they would have to replace the valve and confirmed the water temperatures should be running between 105-115 degrees (F). The POM also indicated they would not have been aware of the hot water temps until the following morning and indicated the facility will be putting in a safety sensor system to detect hot water temperatures as a safety net. Review of the facility policy titled, Hot Water Temperature, revised on 5/14, under Oak Crossing, indicated water temperatures should be maintained between 105-115 degrees per MN Department of Health. Water temperature must never exceed 115 degrees.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING **03 - 2008 SOUTH** B. WING _____	**09/21/2016**

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	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Essentia Health Oak Crossing 03 South Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. 03 South Building 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. The facility is completely protected with an	K 000		

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

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 **03 - 2008 SOUTH** B. WING _____	**09/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 automatic fire sprinkler system in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition with 2 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" (1999 edition). The fire alarm system is monitored for automatic fire department notification. Hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 96 beds and had a census of 83 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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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 _____	**09/21/2016**

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 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 substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 02 Main Building 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. The facility has a complete automatic fire	K 000		

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

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.

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

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	245212	A. BUILDING **02 - EXISTING BUILDING 02** B. WING _____	**09/21/2016**

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	Continued From page 1 sprinkler system in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition with 2 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" (1999 edition). The fire alarm system is monitored for automatic fire department notification. Hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 96 beds and had a census of 83 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		