*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
December 29, 2023

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

RE: CCN: 245212
Cycle Start Date: December 13, 2023

Dear Administrator:

On December 13, 2023, a 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by March 13, 2024 (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).

In addition, if substantial compliance with the regulations is not verified by June 13, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

**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.**

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

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

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

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

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

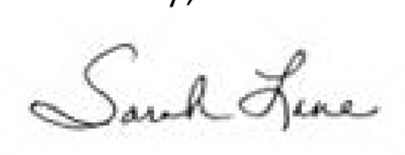
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



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

| 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 _____ | C 12/13/2023 |

| 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 |
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| E 000 | Initial Comments<br><br>On 12/11/23, to 12/13/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On 12/11/23 to 12/13/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>In addition to the recertification survey, the following complaints were reviewed:<br><br>The following complaints were reviewed.<br>H52127623C (MN00094194) with a deficiency issued at 677.<br>H52127624C (MN00093795) with a deficiency issued at 677.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. | F 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 01/08/2024 |

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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| F 000 | Continued From page 1<br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 554 SS=D | Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)<br><br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure residents were assessed for the ability to self administer medications for 2 of 7 residents (R21, R46) reviewed for medication administration.<br><br>Findings include:<br><br>R21<br><br>R21's annual Minimum Data Set (MDS) dated 10/23, identified R21 was independent with cognitive skills for daily decision making and had diagnoses which included: hypertension (high blood pressure), peripheral vascular disease (narrowing of blood vessels other than the heart), thyroid disorder (functioning of the thyroid gland) and depression. Indicated R21 required supervision to partial assistance with dressing and bathing.<br><br>R21's care plan dated 12/12/23, identified R21 was unable to self-administer medications.<br><br>R21's Physician Order Report dated 11/6/23, | F 554 | Education was provided for LPN-A and RN-B on the requirement to stay with residents while receiving/taking oral or respiratory medication unless they have been assessed and care planned to self-administer medications and a provider order for self-administration has been obtained.<br><br>R21 was assessed for ability to self-administer medications and deemed appropriate to take oral medications independently after set up by nursing staff. Plan of care was updated, and an order was obtained for resident to self-administer oral medication.<br><br>R46 passed away from unrelated causes prior to reassessment of ability to self-administer medication.<br><br>All residents in the facility who receive oral or respiratory medications are at risk of being affected by this self-administration of medication practice. | 1/19/24 |

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| F 554 | Continued From page 2<br>included:<br><br>-Tylenol 325 milligram (mg) take two tablets three times a day.<br>-Cetirizine 5 mg daily.<br>-Vitamin D3 125 mcg (5,000 unit) take two tablets daily.<br>-Levothyroxine 137 micrograms (mcg) daily.<br>-Furosemide 40 mg daily.<br>-Zoloft 50 mg daily.<br>-Calcium carbonate-vitamin D3 600 mg-200 unit daily.<br>-Eliquis 5 mg twice a day.<br><br>R21's electronic health record (EHR) revealed a self-administration assessment (SAM) dated 10/25/2018, which identified R21 would not self-administer any medications or treatments.<br><br>R21's EHR lacked a current SAM.<br><br>During an observation on 12/12/23 at 9:38 a.m., licensed practical nurse (LPN)-A provided R21 with the eight medications listed above at the dining table. LPN-A left the medications in a medication cup next to R21, exited the dining room and returned the med cart to the medication room.<br><br>During an interview on 12/12/23 at 1:45 p.m., registered nurse (RN)-A supervisor reviewed R21's EHR and was unable to find a current SAM or a physician order for self-administration of medications. RN-A stated the medications should not have been left with R21 for self administration.<br><br>During an interview on 12/12/23 at 2:38 p.m., LPN-A stated she usually returned to check on | F 554 | The facility Standard Work document Medication Self-Administration was reviewed. A statement was added to indicate that medication will never be left unattended with a resident without appropriate assessment and an order for self-administration. All staff in the facility that administer medication will receive training on this standard work document. Each clinical staff will provide written validation of receipt and competent understanding of the content.<br><br>All residents in the facility will be evaluated for ability to self-administer oral and/or respiratory medication. Any resident that is able and wants to self-administer medications will have a provider order obtained and care plan will be updated to reflect ability to self-administer medication. Reassessment of ability to continue to self-administer medications will occur quarterly and as needed to ensure the resident continues to be able to safely participate in self-administration of medication.<br><br>10 resident medication administration audits will be conducted weekly by nursing leadership for 6 weeks to ensure that medications are not being left unattended for residents that are not care planned and have a provider order for self-administration. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. | |

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| F 554 | Continued From page 3<br>R21 in three to five minutes after leaving the medications for R21 to self-administer. LPN-A reviewed R21's care plan and indicated R21's care plan identified R21 was unable to self administer medications.<br><br>R46<br><br>R46's quarterly MDS dated 10/20/23, identified R46 had severe cognitive impairment and had diagnoses which included; cancer, renal insufficiency (kidney dysfunction), dementia and anxiety.<br><br>R46's care plan dated 12/11/23, indicated R46 had an altered respiratory status and had a history of refusing or removing oxygen and nebulizer treatments.<br><br>R46's Physician Order Report dated 11/6/23, included:<br><br>-Ipratropium-Albuterol solution 2.5 mg/3 ml. Inhalation of 1 vial three times a day.<br><br>R46's EHR revealed a SAM dated 1/10/2022, which identified R46 would not be self-administering any medications or treatments.<br><br>During an observation on 12/13/23 at 7:16 a.m., RN-B placed the vial of medication listed above in a nebulizer, applied the nebulizer with a mask to R46's face, turned nebulizer machine on and exited the room. At 7:52 a.m., R46's door was closed and the nebulizer machine could still be heard running.<br><br>During an interview on 12/13/23 at 8:02 a.m., RN-B stated residents had a SAM in the chart | F 554 | The Director of Nursing will be responsible for ensuring this plan of correction is followed. | |

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| F 554 | Continued From page 4<br>indicating if they could self-administer medications and residents who were cognitively impaired would not be self-administering medications. (RN)-B verified she would check the canister on the nebulizer to see if the medication had been completed to ensure the resident had received the medication. While interviewing at 8:05 a.m., (RN-B) returned to R46's room, opened the door, stated the nebulizer was off and closed the door.<br><br>During a follow up interview on 12/13/23 at 1:04 p.m., RN-B stated she turned the nebulizer on for residents, set a timer for 10 minutes, left them alone during the nebulizer administration and returned to the room in ten minutes after the nebulizer was completed. RN-B stated a nurse did not have to stay with a resident during a nebulizer treatment regardless if they had a SAM identifying they could self- administer or not.<br><br>During an interview on 12/13/23 at 10:52 a.m., consultant pharmacist (CP) stated a resident would require a physician order to self-administer medications and a SAM completed identifying they were able to self-administer medications safely. In addition, CP stated it was expected the facility followed their protocol/procedure to ensure the resident was safe to self-administer medications.<br><br>During an interview on 12/13/23 at 1:15 p.m., the director of nursing (DON) stated residents were able to self administer medications after they had been assessed to safely self administer their medications and a physician's order had been obtained. DON verified the expectation of a nurse would be to stay with a resident who had not been evaluated to self administer medications | F 554 | | |

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| F 554 | Continued From page 5<br>independently to ensure all medications and treatments were taken as ordered.<br><br>The facility policy titled Medication Self-Administration dated 10/2023, indicated the interdisciplinary team (IDT) would assess each resident's cognitive and physical abilities to determine whether self-administering medications was safe and clinically appropriate for the resident including being left alone with oral or respiratory medications. If the IDT determined it was safe and appropriate for the resident to self-administer their medications, it would be documented in the medical record and in the care plan and and order obtained from the physician. | F 554 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide assistance with personal hygiene for 1 of 3 residents( R14) reviewed for activities of daily living (ADL)'s.<br><br>Findings include:<br><br>R14's significant change Minimum Data Set (MDS) dated 11/4/23, identified R14 had moderate cognitive impairment and had diagnosis which included cerebral Palsy, arthritis, and hypertension (elevated blood pressure). Identified R14 required moderate assistance with activities of daily living (ADL's) which included | F 677 | R14 received assistance with facial hair removal on 12/12/23, upon staff notification that these services were needed. R14 was resistant to shaving and required two attempts from staff to complete the task. R14□s plan of care was reviewed and updated to indicate resistance to assistance with some bathing and hygiene tasks. Staff will continue to offer and encourage shaving per the updated plan of care.<br><br>All residents in the facility that require assistance with grooming have the | 1/20/24 |

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| F 677 | Continued From page 6<br>bed mobility, transfers, and personal hygiene.<br><br>R14's current care plan last revised 10/17/23, indicated R14 had deficits with ADL's related to impaired cognition. Indicated staff were to assist R14 with shaving as needed.<br><br>R14's comprehensive Care Area Assessment (CAA) dated 11/4/23, identified R14 required moderate assistance with ADL's.<br><br>During an observation on 12/11/23 at 12:38 p.m.., R14 was lying in bed and had several red one inch long facial hairs present on his cheeks, chin and above his lips.<br><br>During an interview on 12/11/23 at 3:24 p.m.., family member (FM)-A stated R14 always shaved every day. FM-A stated he had been in to visit R14 last week and noted R14's facial hair was long. FM-A indicated R14 would appreciate assistance with shaving.<br><br>During an observation on 12/12/23 at 9:26 a.m., R14 was seated in a stationary chair in his room and continued to have several red one inch long facial hairs present on his cheeks, chin, and above is lips.<br><br>During an observation on 12/12/23 at 10:23 a.m., R14 was seated in a stationary chair in his room and continued to have several red one inch long facial hairs present on his cheeks, chin, and above his lips.<br><br>During an interview on 12/12/23 at 10:25 a.m., R14 stated he did not want to grow a beard and would have liked some assistance with shaving. | F 677 | potential to be affected by the deficient practice. All residents with the potential to be affected have been audited for facial hair and grooming standards have been met per their individual plan of care.<br><br>It is assumed that all residents prefer to have facial hair removed, unless otherwise directed in their plan of care. Standards of care standard work document was reviewed, and no changes were identified. Disposable razors will be available in the spa room and personal razors placed with other personal care items in resident□s room for all residents requiring facial hair removal. All clinical staff will receive education on the standard work. Each clinical staff will provide written validation of receipt and competent understanding of the content.<br><br>All residents that require assistance with grooming will be audited weekly by facility leadership for 6 weeks to ensure that facial hair removal has been provided per the plan of care. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. The Director of Nursing will be responsible for ensuring this plan of correction is followed. | |

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| F 677 | Continued From page 7<br>During an interview on 12/12/23 at 10:38 a.m., nursing assistant (NA)-A stated R14 required staff assistance to shave facial hair. NA-A stated she had assisted R14 with cares that morning however had not offered to assist R14 with shaving and was unsure of the last time R14 had been shaved.<br><br>During an interview on 12/12/23 at 11:10 a.m., registered nurse (RN)-C stated R14 required staff assistance to shave facial hair. RN-A verified R14 had several long facial hairs and was unsure when the last time R14 had been shaved. RN-A stated her expectation was R14 would have been shaved daily or when facial hair was present.<br><br>During an interview on 12/12/23 at 11:19 a.m., director of nursing (DON) indicated R14 required staff assistance with shaving. DON stated her expectation was R14 would have been shaved daily or when facial hair was present.<br><br>Review of a facility policy titled SNF: Activities if Daily Living (ADL's) standards of care undated, indicated residents with facial hair would be shaved daily or when hair was visible. | F 677 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control | F 880 | | 1/19/24 |

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| | 245212 | A. BUILDING _____ B. WING _____ | C 12/13/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| F 880 | Continued From page 8<br>program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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 | F 880 | | |

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| F 880 | Continued From page 9<br>contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to implement hand hygiene for 3 of 7 residents (R46, R48, and R16) observed during medication administration.<br><br>Findings include:<br><br>R46's quarterly Minimum Data Set (MDS) dated 10/20/23, identified R46 had severe cognitive impairment and diagnoses which included: cancer, renal insufficiency, dementia, and anxiety. Identified R46 required substantial/maximal assistance with dressing, personal hygiene and showering/bathing.<br><br>R48's quarterly MDS dated 11/25/23, identified R48 had moderate cognitive impairment and diagnoses which included: hip and knee replacement, hypertension (high blood pressure), Alzheimer's dementia and depression. Identified R48 required substantial/maximal assistance with | F 880 | Education was provided for RN-B on the expectations related to hand hygiene with medication administration.<br><br>All residents in the facility who receive medications are at risk for being affected by this deficient practice.<br><br>Hand hygiene policy and standard work documents were reviewed. All clinical staff that administer medication will receive updated education on hand hygiene with medication administration. Each clinical staff member will provide written validation of receipt and competent understanding of the content.<br><br>10 resident medication administration audits will be conducted weekly by nursing leadership for 6 weeks to ensure that hand hygiene is being appropriately | |

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| F 880 | Continued From page 10<br>dressing, personal hygiene and showering/bathing.<br><br>R16's quarterly MDS dated 11/1/23, indicated R16 was cognitively intact and diagnoses which included: heart failure, diabetes, hypertension. Identified R16 was independent with personal hygiene, substantial/maximal assistance with upper body dressing and showering/bathing.<br><br>During an observation on 12/13/23 at 7:16 a.m., registered nurse (RN)-B entered R46's room and administered medications in pudding with a spoon to R46, placed gloves on, administered eye drops to R46, removed gloves, discarded them, started the nebulizer, placed the nebulizer mask on R46 while touching her hair and face and returned to the medication cart without completing hand hygiene. RN-B opened the medication cart drawer, removed R48's medication cards, placed the pills into a plastic medication cup, locked the medication cart and proceeded to the dining room. RN-B placed the cup of medications on the dining table next to R48, walked to the nearby sink, filled plastic water glass, brought the glass to R48 and proceeded back to the medication cart without completing hand hygiene. At 7:33 a.m., RN-B unlocked the medication cart, pulled out R16's bottles of medications, set them on top of the medication cart, applied a glove to her left hand and placed medications in a plastic medication cup. At 7:49 a.m., RN-B sanitized hands with hand sanitizer on medication cart for the first time during this observation, locked the cart, went to the medication room, unlocked the door and retrieved a container of vital protein collagen powder stock supply. RN-B brought the container to the med cart, removed two scoops out of the container | F 880 | performed during medication passes. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. The Director of Nursing will be responsible for ensuring this plan of correction is followed. | |

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| F 880 | Continued From page 11<br>using a plastic medication cup, placed into a plastic drinking cup, locked the medication cart, took two pill bottles for R16 off of the medication cart along with the cup of powder and the cup of medications. RN-B walked to the end of the hall, took the vital signs machine,went to the dining room, set up the pill bottles, placed the cup of medications and cup of protein powder on the table next to R16. RN-B took R16's blood pressure, pulse, temperature and oxygen saturation level. RN-B sanitized vitals equipment, opened two bottles of medications and placed the medications in a plastic med cup and set the cup in front of R16 to take. RN-B did not sanitize hands after administering R46's, R48's or R16's medications.<br><br>During an interview on 12/13/23 at 1:04 p.m., RN-B confirmed she had not sanitized her hands after completing medication administration, prior to touching items on the medication cart and prior to administering/preparing R48's and R16's medications. RN-B stated the usual practice was to sanitize hands when staff entered and left a resident's room or before after providing medications.<br><br>During an interview on 12/13/23 at 1:15 p.m., director of nursing (DON) confirmed the expectations for staff was to complete hand hygiene before and after gloving and between medication administrations per the CDC (Center for Disease Control) recommendations to prevent the spread of infection.<br><br>Review of the facility policy titled Hand Hygiene dated 3/6/23, identified the facility considered hand hygiene the primary means to prevent the spread of infections. The policy identified when | F 880 | | |

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| F 880 | Continued From page 12<br>hand hygiene was to be performed which included; before and after direct contact with residents, before preparing or handling medications, after removing gloves. | F 880 | | |
| F 883 SS=D | Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the pneumococcal | F 883 | | 1/19/24 |

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| F 883 | Continued From page 13<br>immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 1 of 5 resident (R51, R56) was offered or received pneumococcal vaccinations in accordance with the Center for Disease Control (CDC) recommendations reviewed for immunizations.<br><br>Findings include:<br><br>Review of the current CDC recommendations dated 3/15/2023, revealed older adults who received Pneumococcal conjugate vaccine (PCV13) at any age and Pneumococcal polysaccharide vaccine (PPSV23) before age 65 years, the CDC recommended they receive one dose of PCV20 or PPSV23. | F 883 | R51 was offered and declined the PVC20 vaccine on 12/20/23. Education on risks and benefits were provided at that time. R56 was offered and administered the PVC20 vaccination on 12/28/23 and is now up to date on all recommended pneumonia vaccines.<br><br>All residents in the facility are at risk for being affected by the deficient practice. Vaccination records for all residents in the facility were reviewed and compared to current CDC recommendations. All pneumonia vaccines were offered to each resident based on current recommendations. Documentation of | |

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| F 883 | Continued From page 14<br><br>Review of R51's facesheet identified R51, age 70 was admitted to the facility on 12/7/23. Review of R51's Minnesota Immunization Information Connection (MIIC) undated, identified R51 had received the PPSV23 on 10/24/2006. R51's medical record lacked documentation R51 had been offered or received the PCV20 vaccine or another dose of the PPSV23.<br><br>Review of R56's facesheet identified R56, age 74 was admitted to the facility on 10/17/23. Review of R56's MIIC undated, identified R56 had received the PPSV23 on 7/22/2014, and the PCV13 on 7/27/2016. R56's medical record lacked documentation R56 had been offered or received the PCV20 vaccine or another dose of the PPSV23.<br><br>During an interview on 12/12/23 at 2:54 p.m., infection preventionist (IP) confirmed R51 and R56 had not been offered or received the pneumococcal vaccines as recommended by the CDC. IP stated her expectation was the facility would offer and administer all vaccinations per CDC recommendations.<br><br>During an interview on 12/12/23 at 3:40 p.m., director of nursing (DON) stated she was aware of the CDC recommendations for the pneumococcal vaccinations. DON confirmed R51 and R56 had not been offered or received the pneumococcal vaccinations as recommended by the CDC. DON stated her expectation would have been that all residents would have been offered and received all pneumococcal vaccines per Centers For Disease Control (CDC) recommendations. | F 883 | vaccine administration or refusal is documented in each residents medical record.<br><br>The standard work document “Vaccination of residents – Influenza and pneumococcal” was reviewed and updated with current reference information related to current CDC vaccination recommendations. All residents were reviewed for current vaccination status and updated vaccines were provided as appropriate. All nurses will receive education on this updated standard work document. The infection preventionist will track residents needing future vaccines as well as audit every new admission for vaccination status to ensure that updated vaccines are offered as appropriate. Those that refuse the vaccination will receive education on the current recommendations and will be re-offered the recommended vaccine annually.<br><br>DON will audit all current residents to validate appropriate documentation is in place for updated administration or declination of vaccine. 3 new admits will be audited weekly for the next 6 weeks to ensure vaccinations are offered as appropriate. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. The Director of Nursing will be responsible to ensure this plan of correction is followed. | |

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| F 883 | Continued From page 15<br>Review of a facility policy titled SNF Vaccination of residents-Influenza, pneumococcal, revised 8/22, indicated pneumococcal vaccinations would be offered and administered to all eligible residents as appropriate. | F 883 | | |

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| | 245212 | A. BUILDING **02 - EXISTING BUILDING 02**<br>B. WING _____ | **12/12/2023** |

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| **ESSENTIA HEALTH OAK CROSSING** | **1040 LINCOLN AVENUE**<br>**DETROIT LAKES, MN 56501** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/12/2023. At the time of this survey, Essentia Health Oak Crossing building 02 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>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.<br><br>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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. | K 000 | | |

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

Electronically Signed | 01/08/2024

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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| K 000 | Continued From page 1<br>Healthcare Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St. Paul, MN 55101-5145, OR<br><br>By email to:<br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>Oak Crossing<br><br>1968 02 building 2-story with a basement Type II(000), the 2008 addition is type II (111)<br><br>The building is divided into 8 smoke compartments and is separated from the 1999 addition by a 2 hour fire barrier due to the type V construction.<br><br>The building has a full automatic fire sprinkler | K 000 | | |

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| K 000 | Continued From page 2<br>system and a fire alarm system with smoke detection in the resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification<br><br>The facility has a capacity of 95 beds and had a census of 80 at the time of the survey.<br><br>The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: | K 000 | | |
| K 346 SS=C | Fire Alarm System - Out of Service<br>CFR(s): NFPA 101<br><br>Fire Alarm - Out of Service<br>Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.<br>9.6.1.6<br>This REQUIREMENT is not met as evidenced by:<br>Based on document review and staff interview, the facility did not properly implement a fire watch protocol for when the fire alarm system is out of service for more than 4 hours in a 24-hour period, according to NFPA 101 2012 edition, Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 12/12/2023, 09:30AM and 1:30PM, during documentation review it was revealed that the | K 346 | Changing the wording in our Policy from This shall be their only duty. To this is their sole duty. Noted by the Fire Marshal.<br><br>Reviewed the policy again for other working issues.<br><br>This wording was permanently changed in the policy.<br><br>facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur during policy | 12/12/23 |

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|---|---|
| **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 346 | Continued From page 3<br>facility's fire watch policy did not state that the person performing fire watch is the sole duty of that employee.<br><br>This deficient practice was verified by the Maintenance Director at the time of discovery. | K 346 | review annually. | |
| K 372 SS=D | Subdivision of Building Spaces - Smoke Barrie<br>CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 12/12/2023, 09:30AM and 1:30PM, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors leading to | K 372 | The Maintenance team filled in the penetration at the time of the survey.<br><br>Will inspect all firewalls.<br><br>During our annual Door inspection, we will now be inspecting all fire walls for penetrations.<br><br>A check-off sheet for each area will indicate that the Firewall was inspected on both sides. | 12/12/23 |

| 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 _____ | **12/12/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| K 372 | Continued From page 4<br>elevator alcove TCU.<br><br>This deficient practice was verified by the Maintenance Director at the time of discovery. | K 372 | | |

| 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 _____ | **12/12/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/12/2023. At the time of this survey, Essentia Health Oak Crossing building 03 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code.<br><br>Essentia Health Oak Crossing Building 03 was built in 1999 and is one-story without a basement that was determined to be of Type V(111) construction. It is fully protected throughout by an automatic fire sprinkler system and has a fire alarm that is monitored for automatic fire department notification. It is separated from Building 02 by a two-hour fire-rated wall.<br><br>The facility has a capacity of 95 beds and had a census of 80 at time of the survey.<br><br>The requirements at 42 CFR, Subpart 483.70(a), are MET. | K 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 01/08/2024 |

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.

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered
January 30, 2024

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

RE: CCN: 245212
Cycle Start Date: December 13, 2023

Dear Administrator:

On January 24, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance.  Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us