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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: M81Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00604

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245469**

2.STATE VENDOR OR MEDICAID NO.
(L2) **173347801**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER**
(L4) **5211 HIGHWAY 110**
(L5) **AURORA, MN** (L6) **55705**

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 **02/05/2014** (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 **50** (L18)

13.Total Certified Beds **50** (L17)

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(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 :
Rebecca Wong, HFE NE II — 02/05/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 03/07/2014 (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
04/01/1987
(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
01/27/2014
(L33)

DETERMINATION APPROVAL

Page 2
Provider Number:
Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective January 13, 2014, the facility is certified for 50 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245469

February 11, 2014

Ms. Laura Ackman, Administrator
Essentia Health Northern Pines Medical Center
5211 Highway 110
Aurora, Minnesota 55705

Dear Ms. Ackman:

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 January 13, 2014, the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 11, 2014

Ms. Laura Ackman, Administrator
Essentia Health Northern Pines Medical Center
5211 Highway 110
Aurora, Minnesota 55705

RE: Project Number S5469024

Dear Ms. Ackman:

On December 19, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 12, 2013. 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 February 5, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 12, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 13, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 12, 2013, effective January 13, 2014 and therefore remedies outlined in our letter to you dated December 19, 2013, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245469	A. Building B. Wing	2/5/2014

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0333** Reg. # **483.25(m)(2)** LSC	Correction Completed **01/13/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **01/13/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **01/13/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **01/13/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **01/13/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PH/KJ	2/11/2014	30951	2/5/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/12/2013			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00604	A. Building B. Wing	2/5/2014

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **21385** Reg. # **MN Rule 4658.0800 Subp. 3** LSC	Correction Completed **01/13/2014**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **01/13/2014**	ID Prefix **21545** Reg. # **MN Rule 4658.1320 A.B.C** LSC	Correction Completed **01/13/2014**
ID Prefix **21630** Reg. # **MN Rule 4658.1350 Subp. 2 A.I** LSC	Correction Completed **01/13/2014**	ID Prefix **21685** Reg. # **MN Rule 4658.1415 Subp. 2** LSC	Correction Completed **01/13/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PH/KJ	2/11/2014	30951	2/5/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/12/2013			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 11, 2014

Ms. Laura Ackman, Administrator
Essentia Health Northern Pines Medical Center
5211 Highway 110
Aurora, Minnesota 55705

Re: Enclosed Reinspection Results - Project Number S5469024

Dear Ms. Ackman:

On December 12, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 12, 2013, with orders received by you on December 23, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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.

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)

cc: Original - Facility
Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: M81Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00604

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245469**
2.STATE VENDOR OR MEDICAID NO.
(L2) **173347801**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER**
(L4) **5211 HIGHWAY 110**
(L5) **AURORA, MN** **55705** (L6)

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 **12/12/2013** (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 **50** (L18)

13.Total Certified Beds **50** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(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 :
Cheryl Johnson HFE NE II — 01/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 01/23/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN-245469

At the time of the standard survey completed December 12, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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), whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7154

December 19, 2013

Ms. Laura Ackman, Administrator
Essentia Health Northern Pines Medical Center
5211 Highway 110
Aurora, Minnesota 55705

RE: Project Number S5469024

Dear Ms. Ackman:

On December 12, 2013, 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.

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:

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

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

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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:

Pat Halverson, Unit Supervisor
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007

Telephone: (218) 302-6151
Fax: (218) 723-2359

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 January 21, 2014, 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 March 12, 2014 (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 June 12, 2014 (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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

RECEIVED
JAN 03 2014
MN Dept of Health
Duluth

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(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 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 ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. CENSUS: 67	F 000	OK 1-15-14 PLH	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure physician's orders were clarified to prevent transcription/medication errors; and failed to ensure Novolog sliding scale insulin was administered as ordered to prevent significant medication errors for 1 of 5 residents (R32) whose medications were reviewed. Findings include: R32's Novolog sliding scale insulin order was	F 333	Element # 1 Resident # 32 was not negatively affected as a result of this error. The physician's order was immediately corrected to reflect the intent of the order. The nurse who transcribed the order was educated regarding transcribing orders. Element # 2 A baseline audit was performed of all sliding scale orders and found to be accurate. All new admissions orders and changes in orders for current residents requiring new sliding scale coverage will be reviewed for accuracy by a licensed nurse. All transcribed orders are dually verified by a nurse.	1/13/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura J Ackerman — TITLE: Administrator — (X6) DATE: 1/2/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(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 333	Continued From page 1 contradictory regarding dosage parameters for when to give 3 units (U) and 5 U. The order was not clarified and was transcribed incorrectly. In addition, R32 did not consistently receive the sliding scale insulin (an injection used to treat diabetes and lower blood sugar) according to the physician's ordered sliding scale insulin parameters. On the evening of 12/9/13, and throughout the days of 12/10/13, and 12/11/13, R32 was intermittently observed. No signs or symptoms of low blood glucose (BG) or high BG were noted. The Resident Admission Record indicated R32 had multiple diagnoses which included type II diabetes. The quarterly Minimum Data Set (MDS) dated 11/27/13, indicated R32 had moderate decision making impairment; had a diagnosis of diabetes; and received "injections" on seven out of seven days in the assessment period. The MDS did not specifically identify insulin injections. The Current Orders directed R32 should receive Lantus insulin 5 U daily (dated 10/24/12), and BG checks QID (four times a day) with Novolog sliding scale insulin (dated 11/26/13). Current parameters for the administration of the sliding scale insulin starting 11/26/13, were as follows: 150-199 = 2 U 200-300 = 3 U 251-300 = 5 U 301-350 = 7 U 351-400 = 9 U over 400 = 11 U & contact NP/MD (nurse practitioner/physician) - (NP first if available). The orders for the second and third insulin dosages were contradictory and both directed to give 3 U	F 333	Element # 3 Policy has been updated/reviewed to reflect new transcription and verification procedures. Licensed nursing staff has been educated regarding the policy. Element # 4 Audits will be performed by the DON/Designee of all insulin sliding scale orders daily x 7, weekly x 3, monthly x 2 and then quarterly ongoing. Exceptions will be reported to the Administrator and reviewed at QAPI at least quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(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 333	Continued From page 2 and/or 5 U for a BG within the range of 251-300. The facility clarified the sliding scale insulin order on 12/12/13, after being questioned by the surveyor, and reported the second dosage parameter was inaccurate and should have been BG 200-250 = 3 U. The electronic Medication Administration History (MAH) records for R32 from 11/26/13, to 12/11/13, indicated R32 did not receive sliding scale insulin as directed by the physician orders. The MAH indicated as follows: On 11/26/13, at 11:30 a.m. BG 190 - R32 should have received 0 U or 2 U of sliding scale insulin depending on when the new sliding scale order was written - "10" U was documented as administered. On 11/26/13, at 8:00 p.m. the "charted date - time" section of the MAH indicated the sliding scale insulin was administered late at 9:24 p.m.; however, the MAH lacked any documentation of the BG or if any sliding scale insulin dose was administered. On 11/30/13, at 8:00 p.m. BG was 152 - R32 should have received 2 U of sliding scale insulin. "0" was documented. On 12/6/13, at 8:00 p.m. BG was 256 - R32 should have received 5 U sliding scale insulin - "1.5" was documented as administered. On 12/8/13, at 11:30 a.m. BG was 298 - R32 should have received 5 units of sliding scale insulin - "3" U was documented as administered. On 12/9/13, at 8:00 p.m. BG was 169 - R32 should have received 2 U of sliding scale insulin - "0" was documented. On 12/12/13, at 2:01 p.m. the director of nursing (DON) stated the sliding scale insulin order was	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(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 333	Continued From page 3 transcribed into the computer by a registered nurse (RN) and confirmed the order had been transcribed incorrectly. The DON stated when an order was transcribed into the computer by the health unit coordinator (HUC) a second signature from nursing was required; however, no second signature was required if an RN transcribed the order. The DON added, no one noticed the error and it had been reviewed by many people. The DON verified the errors in the MAH for the sliding scale insulin administration. A Resident Progress Note dated 11/29/13, indicated the consultant pharmacist reviewed R32's medications. The note indicated no irregularities were found. The Medication Orders policy dated 8/6/12, indicated the prescriber would be contacted to verify or clarify an order if the directions were confusing. The policy did not address how to enter physician's orders into the electronic medical record (EMR) or what kind of checks to verify accuracy should be completed.	F 333		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	Element # 1 Resident # 32 was not negatively affected as a result of this error. The physician's order was immediately corrected to reflect the intent of the order. The consulting pharmacist was immediately notified and the consultant pharmacist services provider requirements policy was reviewed.	1/13/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(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 428	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the consultant pharmacist (CP)-E failed to identify and report to the facility transcription/medication errors for Novolog sliding scale insulin for 1 of 5 residents (R32) whose medications were reviewed. Findings include: R32's Novolog sliding scale insulin order dated 11/26/13, was contradictory regarding dosage parameters for when to give 3 units (U) and 5 U. The order was not clarified and was transcribed incorrectly. In addition, R32 did not consistently receive the sliding scale insulin (an injection used to treat diabetes and lower blood sugar) according to the physician's ordered sliding scale insulin parameters. CP-E did not identify and report the irregularities to the director of nursing (DON) and attending physician. On the evening of 12/9/13, and throughout the days of 12/10/13, and 12/11/13, R32 was intermittently observed. No signs or symptoms of low blood glucose (BG) or high BG were noted. The Resident Admission Record indicated R32 had multiple diagnoses which included type II diabetes. The Current Orders directed R32 should receive Lantus insulin 5 U daily (dated 10/24/12), and BG checks QID (four times a day) with Novolog sliding scale insulin (dated 11/26/13). Current parameters for the administration of the sliding scale insulin starting 11/26/13, were as follows:	F 428	Element # 2 A baseline audit was performed of all sliding scale orders and found to be accurate by the pharmacist. Element # 3 Policy has been updated/reviewed by consultant pharmacist. A separate line item has been added to the monthly consultant report reflecting the accuracy of sliding scale orders. . Element # 4 Audits will be performed by the DON/Designee of consultant pharmacy reports monthly ongoing. Exceptions will be reported to the Administrator and reviewed at QAPI at least quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(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 428	Continued From page 5 150-199 = 2 U 200-300 = 3 U 251-300 = 5 U 301-350 = 7 U 351-400 = 9 U over 400 = 11 U & contact NP/MD (nurse practitioner/physician) - (NP first if available). The orders for the second and third insulin dosages were contradictory and both directed to give 3 U and/or 5 U for a BG within the range of 251-300. The facility clarified the sliding scale insulin order on 12/12/13, after being questioned by the surveyor, and reported the second dosage parameter was inaccurate and should have been BG 200-250 = 3 U. The electronic Medication Administration History (MAH) records for R32 from 11/26/13, to 11/29/13, indicated R32 did not receive sliding scale insulin as directed by the physician orders. The MAH indicated as follows: On 11/26/13, at 11:30 a.m. BG 190 - R32 should have received 0 U or 2 U of sliding scale insulin depending on when the new sliding scale order was written - "10" U was documented as administered. On 11/26/13, at 8:00 p.m. the "charted date - time" section of the MAH indicated the sliding scale insulin was administered late at 9:24 p.m.; however, the MAH lacked any documentation of the BG or if any sliding scale insulin dose was administered. On 12/12/13, at 2:01 p.m. the director of nursing (DON) stated the sliding scale insulin order was transcribed into the computer by a registered nurse (RN) and confirmed the order had been	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(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 428	Continued From page 6 transcribed incorrectly. The DON stated when an order was transcribed into the computer by the health unit coordinator (HUC) a second signature from nursing was required; however, no second signature was required if an RN transcribed the order. The DON added, no one noticed the error and it had been reviewed by many people. The DON verified the errors in the MAH for the sliding scale insulin administration. A Resident Progress Note dated 11/29/13, indicated CP-E reviewed R32's medications. The note indicated no irregularities were found. CP-E was interviewed on 12/12/13, at 2:12 p.m. and stated he had reviewed R32's medications on 11/29/13. CP-E stated he does review new orders, and verified he did not identify the transcription error or the two sliding scale insulin administration errors. The Consultant Pharmacist Services to Provider Requirements policy dated 8/6/12, indicated the CP would identify, communicate, address, and resolve concerns/issues related to the provision of pharmaceutical services. The policy further indicated the CP would evaluate the process of receiving and interpreting prescriber's orders, and review Medication Administration Records (MAR's) and physician orders to ensure proper documentation of medication orders and administration of medications to residents.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431	Element # 1 There were no negative outcomes as a result of this deficiency. The nurses who were audited by the survey were immediately educated regarding proper disposal of the Fentanyl Patch in accordance with the Federal Drug Enforcement Agency.	1/13/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(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 431	Continued From page 7 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Fentanyl patches were disposed of in accordance with Federal Drug Enforcement Agency (DEA) regulations for 2 of 2 residents (R52, R22) who were prescribed Fentanyl patches.	F 431	Element # 2 A baseline audit of communication flow was assessed. Educational information was on the pharmacy report. Review of 12 months of pharmacy consultant communications displayed no other communication breakdown. Element # 3 Policy has been updated/reviewed to reflect current DEA requirements for destruction of narcotic medications. All licensed nurses have been educated regarding the current guidelines. Fentanyl Patch destruction has been added to the orientation and annual medication pass competency. Pharmacist consultant report will now be transmitted electronically to DON/ADON Element # 4 Audits will be performed by the DON/Designee monthly and all pharmacy reports will be signed off by an RN. Exceptions will be reported to the Administrator and reviewed at QAPI at least quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(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 431	Continued From page 8 Findings include: On 12/11/13, at 9:20 a.m. during the medication storage observation of the medication cart on North Haven unit with the licensed practical nurse (LPN)-B present, two boxes of Fentanyl pain patches (for residents R52 and R22) were observed in the double locked narcotic drawer of the cart. When asked how the used Fentanyl pain patches were disposed of, LPN-B stated the afternoon shift nurse would remove the pain patch, fold it in half, and dispose of it in a large red sharp's container under the sink in the medication storage room. LPN-B opened the cabinet underneath the medication room sink and a large red sharp's disposal container was observed with the lid open. LPN-B stated two nurses would observe and sign off for each pain patch disposal. LPN-B stated when full, a nurse would transport the closed sharp's container to a locked room where maintenance personnel would pick up the full containers and transport them to a disposal facility. On 12/11/13, at 10:10 a.m. the director of nursing (DON) stated the consultant pharmacist (CP)-E and the assistant director of nursing (ADON) were aware of current policy for disposal of Fentanyl patches. On 12/11/13, at 10:20 a.m. CP-E stated the policy and procedure for the disposal of Fentanyl patches had changed from placing them in a sharp's container to flushing the used patches down the toilet. CP-E further stated the information in the policy change had been passed on to the ADON.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(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 431	Continued From page 9 On 12/11/13, at 12:38 p.m. ADON stated she was not aware of the recommended policy change on disposal of the Fentanyl patches and did not provide education on the change to nursing staff. An Internet printed page dated 5/2012, titled Another Fentanyl Patch Warning from FDA was provided as the facility's policy for the disposal of Fentanyl patches. The page indicated the patches should be disposed of in a secure sharps container after folding the patch over on itself with witnessed disposal. ADON had signed the page noting it as the facility's most current practice. A Consultant Pharmacist report dated 10/31/13, indicated the pharmacy had received notification Fentanyl patches were to be flushed down the toilet/sewer and not thrown in the sharps, garbage, or pharmaceutical waste.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	Element # 1 Resident # 26 was not negatively affected as a result of this Practice. LPN-C was educated regarding infection control practices during medication pass including standard precautions and cleansing of the glucometer. Additionally, LPN-C was educated regarding proper eye drop administration. Element # 2 Base line audit was performed of nursing staff regarding infection control practices during medication pass including insulin injections and eye drops.	1/13/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(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 441	Continued From page 10 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper infection control practices related to handwashing, gloving, and disinfection were followed when performing a blood glucose test for 1 of 1 resident (R26) who were observed for blood glucose monitoring. Findings include: During the medication administration observation on 12/11/13, at 8:28 a.m. with licensed practical nurse (LPN)-C gloves were not worn while performing a blood glucose monitoring procedure, hands were not washed between tasks procedures, and the shared blood glucose	F 441	Element # 3 Policies has been updated/reviewed to reflect proper infection control practices during medication pass including insulin injections and eye drops. Licensed nursing staff has been educated regarding these policies. Element # 4 Audits will be performed by the DON/Designee of 10% of nurses during medication pass including insulin injections and eye drops weekly x 4 then monthly x 2 then during orientation and annually with competency checks. Exceptions will be reported to the Administrator and reviewed at QAPI at least quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(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 441	Continued From page 11 monitor was not disinfected properly after the test was completed. On 12/11/13, at 8:28 a.m. LPN-C was observed at the medication cart outside of the assistant director of nursing's (ADON) office. LPN-C was observed to sanitize her hands with hand-sanitizer gel and draw up an insulin dose in a flex pen for R26. - LPN-C placed the insulin-loaded flex pen along with a bottle of eye drops in her uniform top pocket. LPN-C then placed a blood glucose strip into the blood glucose monitor and set it into a blue plastic basket on top of the medication cart. - LPN-C then pushed R26 seated in a wheelchair into the ADON's office. LPN-C brought in the blue plastic basket containing the blood glucose monitor on top of a supply of cotton balls, alcohol wipes, and lancets. LPN-C placed the blood glucose monitor on the ADON's desk and the basket of supplies on another desk top. - LPN-C cleansed R26's right index finger tip with an alcohol wipe and poked the cleansed finger tip with a lancet. LPN-C verbalized how cold R26's hands were and proceeded to squeeze R26's finger tip with her ungloved hands to produce a drop of blood. LPN-C then applied the blood glucose monitor strip to the drop of blood on R26's finger tip and set down the monitor back on the ADON's office desk top. R26's blood glucose reading appeared on the monitor at 94. LPN-C announced R26's blood glucose reading and applied a cotton ball to R26's finger tip with pressure. LPN-C wiped R26's poked finger tip with the cotton ball, and then disposed of the used lancet, cotton ball, and monitor strip into a red sharps container. - LPN-C reached into her uniform top pocket and removed the insulin flex pen. LPN-C informed	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(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 441	Continued From page 12 R26 she was going to give the insulin in R26's left upper arm, and wiped R26's left upper arm skin with a new alcohol wipe. LPN-C injected the insulin, replaced the needle cap, and returned the insulin flex pen to the uniform pocket. - LPN-C removed the bottle of eye drops from the uniform pocket and informed R26 she was going to administer the eye drop to R26's left eye. LPN-C obtained a disposable tissue. With bare and unwashed hands, LPN-C was observed to attempt to administer R26's eye drops to the left eye with no success. LPN-C set down the eye drop bottle on a desk top, left the room, returning with a pair of disposable gloves from the medication cart in the hallway. LPN-C applied the gloves and then administered R26's left eye drop. LPN-C removed the gloves, returned the used blood glucose monitor to the blue plastic basket, placing it on top of the supplies and placed the basket on top of the medication cart. LPN-C then wheeled R26 back to the dining room. - LPN-C returned to the medication cart and used hand sanitizer to cleanse her hands. - At 8:33 a.m. LPN-C removed the blood glucose monitor from the blue plastic basket and wiped the monitor with Sani wipes and then returned the monitor to the basket. When asked at what point gloves should be used, LPN-C stated she should have put on gloves prior to performing the blood glucose monitor procedure and added hands should have been washed in between the tasks. LPN-C confirmed the Sani wipes used to disinfect the blood glucose monitor were alcohol based and did not contain bleach. LPN-C also verified she was not sure what kind of disinfecting wipes should be used on the blood glucose monitor. On 12/11/3, at 12:40 p.m. registered nurse (RN)-B stated gloves should be worn when doing	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(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 441	Continued From page 13 blood glucose monitoring procedures with hands washed afterwards and before beginning another procedure. RN-B confirmed the facility uses Sani wipes to disinfect the shared blood glucose monitor. A Handwashing Policy dated 6/1998, directed hands should be washed before preparing or handling medication, after contact with blood or broken skin, and after handling items potentially contaminated with any blood. A blood glucose testing policy dated 1/14/13, directed standard precautions were to be followed when doing bedside glucose testing.	F 441	Element # 1 Room belonging to R48 has been spackled and painted. Unable to identify the rooms attached to R19, R42, R36 and R5, so they are included in Element #2. Rooms belonging R6, R48 and R27 have had caulk applied to the toilets and stains cleaned. Wall in R32's room has been repaired. Radiator in R14's room has been painted. The woman's bathroom adjacent to the main dining room has had floor replaced. The 500 wing shower room has had the wall repaired. Element # 2 A baseline audit was performed of all resident rooms, resident bathrooms, common areas and common area bathrooms and repairs/replacements are being made to rooms identified as needing repairs to walls, flooring and toilet caulking.	1/13/14
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure walls and floors were maintained to provide a clean, comfortable and homelike environment for 9 of 67 residents living in the facility. Findings include: During the environmental tour of the facility on 12/12/13, at 9:08 a.m. the following was observed: - Resident rooms and bathrooms were noted to have chipped, scratched and marred paint on the	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDICAL CENTER	5211 HIGHWAY 110 AURORA, MN 55705

(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 465	Continued From page 14 walls for (but not limited to) R19, R42, R36, R48 and R5. - The bathroom floors were noted to be stained a brownish color and some missing caulk around the toilets for (but not limited to) R6, R48 and R27. - A patched, but unpainted hole, approximately three inches around was noted in the wall near R32's bed. - The radiator cover in R14's room showed scratched, scraped and marred paint. - The women's bathroom near the large dining room had brown staining on the floor and was missing caulk around the toilet. - The shower room on the 500 wing had a wall covering which was observed to be separating from the wall, as evidenced by large air pockets. On 12/12/13, at 9:30 a.m. the environmental supervisor (ES) stated the air pockets were a result of water damage from the shower. Review of the preventative maintenance schedule provided by the ES established the walls and radiators were touched up every three months and were last done on October 14th and 17th, 2013. - At 9:24 a.m. ES stated the walls and floors were on a preventative maintenance program and are touched up on a quarterly basis. ES acknowledged every three months may not be often enough to maintain a homelike environment.	F 465	Element # 3 Maintenance protocol regarding keeping the facility safe, clean and homelike has been reviewed and revised to ensure that damaged floors and walls are repaired on a routine schedule. Radiator scratches and caulking toilet line items have been added to the preventative maintenance rounds tool. Environmental staff has been educated to report items in rooms and common areas that need caulking, spackling, discolored tiles and/or painting. Element # 4 Audits will be performed by the Environmental Supervisor or Designee during preventative maintenance rounds weekly x 4 weeks, then monthly thereafter. Exceptions will be reported to the Administrator and reviewed at QAPI at least quarterly.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245469	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/10/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDIC	**5211 HIGHWAY 110 AURORA, MN 55705**

(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 Northrn Pines C & NC 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. Essentia Northern Pines C & NC is a 1-story building with no basement. The original building was constructed in 1959, with an addition in 1970. Both buildings are of the same type construction, Tyep II (111). therefore the facility was inspected as one building. The nursing home is properly 2 hour fire seperated from the attached hospital. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 50 beds and had a census of 48 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7154

December 19, 2013

Ms. Laura Ackman, Administrator
Essentia Health Northern Pines Medical Center
5211 Highway 110
Aurora, Minnesota 55705

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5469024

Dear Ms. Ackman:

The above facility was surveyed on December 9, 2013 through December 12, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to:

Pat Halverson, Unit Supervisor
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007

Telephone: (218) 302-6151
Fax: (218) 723-2359

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00604	A. BUILDING: _____ B. WING _____	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH NORTHERN PINES MEDIC.	5211 HIGHWAY 110 AURORA, MN 55705

(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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/9/13, through 12/12/13, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using the federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column	