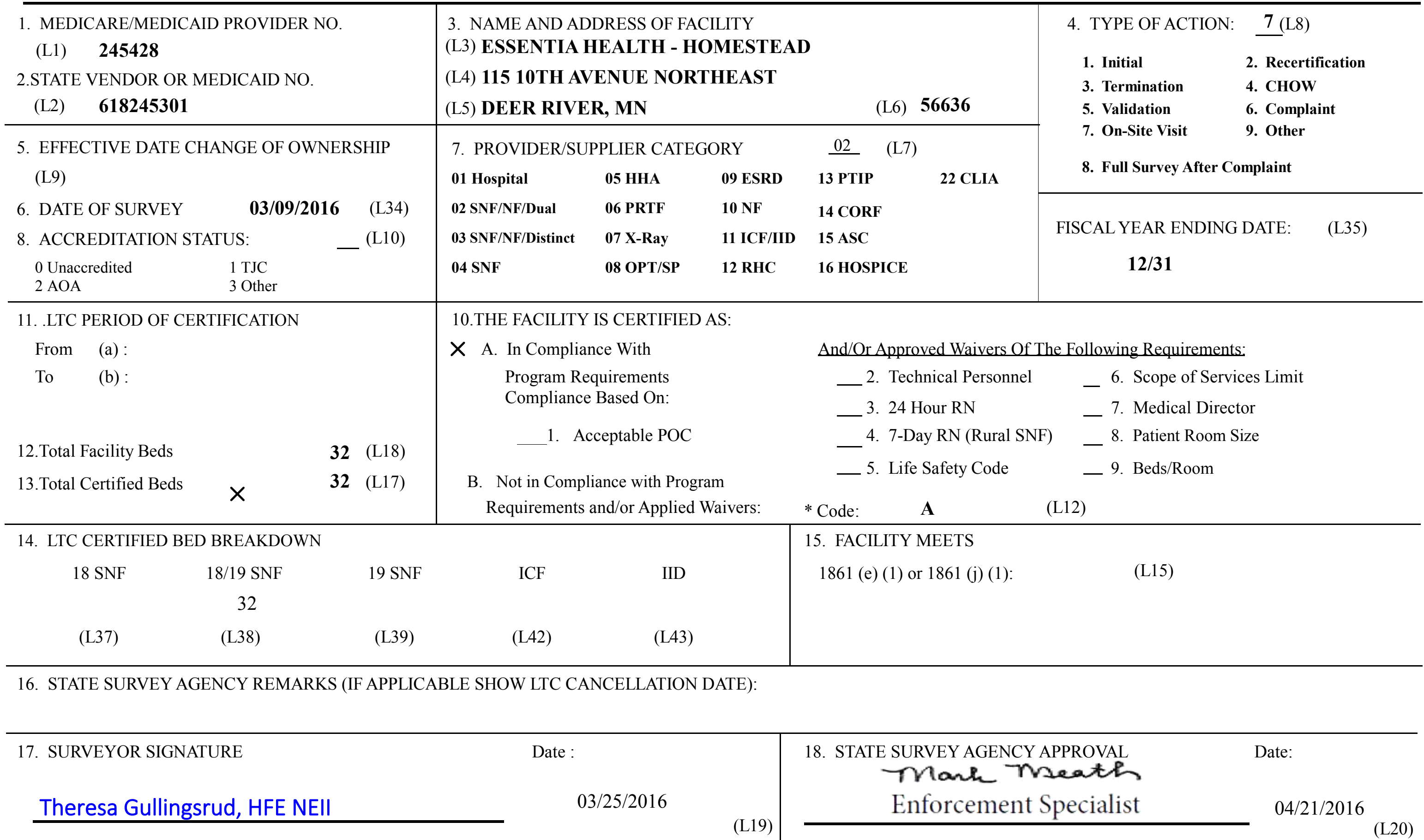
DEPARTMENT OF HEALTH AND HUMAN SERVICES | CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: NBN6
Facility ID: 00296



1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245428**

2.STATE VENDOR OR MEDICAID NO. (L2) **618245301**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH - HOMESTEAD**
(L4) **115 10TH AVENUE NORTHEAST**
(L5) **DEER RIVER, MN** (L6) **56636**

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 **03/09/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds X **32** (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
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE
Theresa Gullingsrud, HFE NEII
Date : 03/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath
Enforcement Specialist
Date: 04/21/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(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
03/16/2016
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245428

April 21, 2016

Ms. Laura Ackman, Administrator
Essentia Health - Homestead
115 10th Avenue Northeast
Deer River, Minnesota 56636

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 March 4, 2016 the above facility is certified for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 skilled nursing facility beds.

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

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

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

Sincerely,

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 25, 2016

Ms. Laura Ackman, Administrator
Essentia Health - Homestead
115 10th Avenue Northeast
Deer River, MN 56636

RE: Project Number S5428025

Dear Ms. Ackman:

On February 10, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 28, 2016 . This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On March 9, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 23, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 4, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 28, 2016, effective March 4, 2016 and therefore remedies outlined in our letter to you dated February 10, 2016, will not be imposed.

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

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

Sincerely,

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

An equal opportunity employer

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245428 (Y1)	A. Building B. Wing (Y2)	3/9/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 03/04/2016	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 03/04/2016	ID Prefix F0318 Reg. # 483.25(e)(2) LSC	Correction Completed 03/04/2016
ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 03/04/2016	ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 03/04/2016	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 (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	TL/mm	03/25/2016	27200	03/09/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
1/28/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245428	A. Building 01 - NURSING HOME B. Wing	3/23/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0011	Correction Completed 03/04/2016	ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 03/04/2016	ID Prefix Reg. # NFPA 101 LSC K0054	Correction Completed 03/04/2016
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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/mm	03/25/2016	33562	03/23/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/26/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: NBN6
Facility ID: 00296

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245428**

2. STATE VENDOR OR MEDICAID NO. (L2) **618245301**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH - HOMESTEAD**
(L4) **115 10TH AVENUE NORTHEAST**
(L5) **DEER RIVER, MN** (L6) **56636**

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 **01/28/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital **05 HHA** **09 ESRD** **13 PTIP** **22 CLIA**
02 SNF/NF/Dual **06 PRTF** **10 NF** **14 CORF**
03 SNF/NF/Distinct **07 X-Ray** **11 ICF/IID** **15 ASC**
04 SNF **08 OPT/SP** **12 RHC** **16 HOSPICE**

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE NEII 02/19/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 03/14/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (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

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
February 10, 2016

Ms. Laura Ackman, Administrator
Essentia Health - Homestead
115 10th Avenue Northeast
Deer River, MN 56636

RE: Project Number S5428025

Dear Ms. Ackman:

On January 28, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**
>
> **Informal Dispute Resolution - your right to request an informal reconsideration to dispute the**

attached deficiencies.

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601
lyla.burkman@state.mn.us
Telephone: (218) 308-2104 Fax: (218) 308-2122

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 March 8, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 8, 2016 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its

effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 28, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 28, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division

P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	**115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the necessary care and services were provided as directed by the care plan related to the removal of facial hair and nail care for 1 of 2 residents (R9) who were reviewed for activity of daily living (ADL). In addition, the facility failed to ensure restorative nursing services were provided as directed by the care plan for 3 of 3 residents (R9, R21, R1) reviewed for range of motion. Findings include:	F 282	F282 Resident (R9) had her facial hair removed and nail care provided and her care plan was reviewed and updated to assure that facial hair removal and nail care, along with refusals were addressed. Residents (R1, R9 and R 21) had care plans reviewed regarding restorative nursing care. Their care plans were reviewed and updated to assure they accurately addressed restorative nursing care. A baseline audit was performed on all	3/4/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 02/19/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 282

Continued From page 1

R9's ADL Assistance care plan dated 11/13/15, indicated R9 had a self care deficit in dressing, grooming and bathing related to a stroke with left sided weakness and paralysis. The care plan's goal included R9 would be clean and odor free and present a groomed appearance to staff and family. The care plan directed R9 needed the assistance of one staff with grooming, brushing dentures and combing her hair. The care plan further directed to cut R9's fingernails and toenails as needed.

The Restorative Care care plan dated 8/1/15, indicated R9 was at risk for a decline in ROM or contractures due to choosing to remain in bed most of the time and a history of CVA with left sided hemiplegia. The care plan directed the following:

Floor restorative nursing program of one staff to offer resting splint to the left upper extremity each day. If R9 refused, offer the splint again at a later time.
Specialized restorative nursing program of one staff person to offer PROM to the left side five times a week. If R9 refused, offer the PROM again at a later time.

On 1/26/16, at 9:51 a.m.; 1/27/16, at 7:20 a.m.; 1/27/16, at 11:10 a.m.; and 1/28/16, at 11:01 a.m. R9 was observed long facial hair on her chin. On the left side there were two long hairs that were approximately two inches long and on the right side were several hairs approximately a half an inch long. All fingers on both hands had a black/brown substance under the nails.

Review of R9's Restorative Nursing Flowsheet's revealed the left hand splint had been offered and

F 282

residents regarding appropriate facial hair removal and nail care. Care plans were updated as appropriate. A baseline audit was performed on all residents regarding restorative nursing care. Care plans were updated as appropriate. The care plans have been implemented and communicated by education, restorative nursing aide, assignment sheets, and restorative book.
Policy regarding facial hair and nail care has been created, educated to nursing staff and implemented. Policy regarding restorative nursing care was reviewed, revised, re-educated to nursing staff and implemented.
Regarding facial hair removal, nail care and restorative nursing care, twenty percent (20%) of residents will be audited by the DON/designee daily for 7 days, then weekly for 4 weeks , then monthly for one month and quarterly ongoing.
Variances will be reported immediately to the Administrator for follow up and at least quarterly at QAPI.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ________ B. WING ________	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	**115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 2 refused 40 times between 11/2/15 and 1/25/16. Of the 98 opportunities to offer the left hand splint, only 40 opportunities were documented. There was no evidence the left hand splint was accepted and applied during this period or that any alternatives were offered to R9. The flowsheet's were also reviewed for the implementation of the PROM program. From 11/2/15 and 1/25/16, of 196 opportunities for PROM services to be offered, R9 received PROM 24 times. There was no evidence of what occurred with the other 172 opportunities for PROM. On 1/27/16, at 2:00 p.m. NA-E stated if the squares on the Restorative Nursing Flowsheet's were blank it meant the PROM was not done and the R meant R9 refused the PROM or the hand splint. The NA verified the Restorative Nursing Flow sheets had several blanks. The NA stated she was to do R9's PROM three times a week. The NA stated she was not aware R9 was to receive the PROM five times a week. The NA stated the floor NAs were to apply the splint. On 1/27/16, at 2:15 p.m. NA-C and NA-D stated NA-E applied R9's hand splint but R9 refused the splint. On 1/28/16, at 8:50 a.m. the director of nursing (DON) stated she would expect staff to apply the hand splint and perform PROM as directed in the care plan. On 1/28/16, at 11:01 a.m. NA-E stated R9 had not worn the splint as she refused. NA-E was unable to find the splint in R9's room. On 1/28/16, at 11:01 a.m. NA-E verified under R9's fingernails were dirty. The NA stated residents' fingernails should be cleaned during	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 3 cares. The NA also verified the presence of the long facial hair on R9's chin. On 1/28/16, at 1:45 p.m. registered nurse (RN-B) stated R9's facial hair should have been removed on her bath day and fingernails should be cleaned when they were dirty. The facility's Restorative Nursing policy and procedure reviewed and revised on 4/5/15, indicated it was the policy of the facility that residents were to be given the appropriate services and treatment to maintain or improve their abilities as directed by the resident's care plan. Restorative Nursing was a nursing intervention utilized to achieve the resident's goal. R21's Care Plan dated 10/29/15, identified a category of restorative care/nursing, with a problem of muscle weakness related to multiple medical problems including cerebral infarction (stroke), and polyneuropathy (damage to the nerves outside the brain or spinal cord featuring weakness, numbness, pins-and-needles, and burning pain). The care plan directed staff to provide lower extremity exercises 3 times a week and red Theraband (latex exercise resistance band) exercises 3 times a week as on pictures/recommendations provided by OT. On 1/26/15, at 1:19 p.m. the fingers of R21's left hand appeared contracted. R21 was able to straighten the fingers out slightly upon request but could not fully extend his fingers. R21 stated the staff exercised his fingers. Review of R21's Restorative Nursing Flowsheet's revealed the following: --Week of 11/16/15, had the opportunity for three nursing rehabilitation sessions and received two --Week of 11/23/15, had the opportunity for three	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	**115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 4	F 282		

nursing rehabilitation sessions and received zero (R21 refused one session)
--Week of 12/21/15, had the opportunity for three nursing rehabilitation sessions and received two
--Week of 1/11/16, had the opportunity for two nursing rehabilitation sessions and received zero

On 01/28/2016, at 1:45 p.m. R21 stated he received ROM services that included exercises on his upper and lower extremities but the staff missed days so sometimes he didn't receive the services.

On 01/28/2016, at 1:54 p.m. nursing assistant (NA)-E stated she was the person primarily responsible to provide restorative nursing services for the facility. NA-E confirmed R21 was to have received restorative nursing services 3 times per week and confirmed there were weeks when he had not received services as ordered.

On 01/28/2016, at 2:56 p.m. director of nursing (DON) confirmed R21 should have received restorative nursing 3 times per week as directed by the care plan.
R1's Restorative Care/Nursing Care Plan, dated 12/24/15, identified R1 had stiffness and joint contracture with a goal to reduce the extent of the contracture and reduce pain. The Care Plan directed staff to provide passive range of motion (PROM) 2-3 times a week-or more if resident tolerated-and to document refusals and attempts. This was to be performed once a day on Monday, Wednesday and Friday between 8:00 a.m. and 16:30 p.m.

R1's Restorative Care/Nursing Care Plan also directed floor restorative nursing to provide PROM for both lower extremities to decrease

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	**115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 5	F 282		

stiffness and joint contracture. The care plan directed staff to provide PROM 2-3 times per week or more frequently if resident tolerated and to document refusals and attempts.

R1's ADL Assistance Care Plan, dated 6/23/13, identified an alteration in mobility related to R1's need for assistance with mobility secondary to a traumatic brain injury (TBI) with the goal that R1 would have no further contractures. The Care Plan directed R1 to attend restorative nursing for PROM exercises to upper extremities to decrease stiffness and prevent contractures of joints. If R1 was resistive to attempt at a later time. Staff were directed to document refusals and attempts. The Care Plan stated R1 was to have PROM 2-3 times/week, may have more frequently if tolerated.

Registered nurse (RN)-B stated on 1/26/16 at 10:41 a.m., registered nurse (RN)-B stated that R1 had a contracture.

In a review of the facility's restorative nursing flowsheet for R1's lower extremity ROM as provided by the Restorative Aide:
-For the week of 12/18/15, had five opportunities for lower extremity PROM and received one (1).
-For the week of 1/4/16, had five opportunities for lower extremity PROM and received two (2).
-For the week of 1/11/16, had five opportunities for lower extremity PROM and received one (1).
-For the week of 1/18/16, had five opportunities for lower extremity PROM and received none (0).

From 12/17/15 until 1/27/16, R1 received only 5 sessions of PROM to her lower extremity when there was the opportunity for 20 sessions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	**115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 6	F 312		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the removal of facial hair and nail care for 1 of 2 residents (R9) reviewed for activities of daily living (ADL) and grooming assistance. Findings include: R9's Resident Admission Record dated 1/28/16, identified diagnoses including type two diabetes with diabetic neuropathy, dementia with behavioral disturbance, hemiplegia (complete paralysis of the entire left or right side of the body) and hemiparesis (weakness on the entire left or right side of the body) following a cerebrovascular accident (CVA/stroke). A quarterly Occupational Therapy (OT) Evaluation dated 10/27/15, indicated R9 required the assistance of one staff with all grooming, dressing, and bathing ADL's. The Care Area Assessment (CAA) dated 10/28/15, indicated R9 had a significant history of CVA with left hemiplegia. R9 was non-weight bearing and required the assistance of a mechanical lift with two staff to transfer. R9	F 312	F312 Resident (R9) had her facial hair removed and nail care provided and her care plan was reviewed to assure that facial hair removal and nail care were addressed along with refusals of care. Residents (R1, R9 and R 21) had care plans reviewed regarding ADL assistance. A baseline audit was performed on all residents regarding appropriate ADL assistance, including facial hair removal and nail care. Care plans were updated as appropriate. The care plans have been implemented and communicated via education, POC (Point of Care) kiosks located throughout the facility and assignment sheets. Procedure regarding ADL assistance (including facial hair and nail care) has been reviewed and policy created, educated to nursing staff and implemented. Twenty percent (20%) of residents needing ADL assistance will be audited by the DON/designee daily for 7 days, then weekly for 4 weeks, then monthly for one month and quarterly ongoing. Variances	3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 7 needed the maximum assistance of staff to dress and groom. The annual Minimum Data Set (MDS) dated 11/10/15, indicated R9 had moderately impaired cognition and had no rejection of cares. R9 needed the extensive assist of two staff with dressing and personal hygiene and the extensive assistance of one staff with bathing. R9 had a functional limitation in range of motion (ROM) which impacted the upper and lower extremities on one side. The ADL Assistance care plan dated 11/13/15, indicated R9 had a self care deficit in dressing, grooming and bathing related to a post CVA. The care plan's goal included R9 would be clean and odor free and present a groomed appearance to staff and family. The care plan directed R9 needed the assistance of one staff with grooming. The care plan further directed to cut R9's fingernails and toenails as needed. The bath schedule updated on 1/25/16, indicated R9 was scheduled to receive a bed bath twice a week on Tuesday and Saturday. On 1/26/16, at 9:51 a.m. R9 was observed with long facial hair on her chin. On the left side there were two long hairs that were approximately two inches long and on the right side were several hairs approximately a half an inch long. All fingers on both hands had a black/brown substance under the fingernails. On 1/27/16, at 7:20 a.m. R9 was observed to continue with facial hair and dirty fingernails. On 1/27/16, at 11:10 a.m. morning cares were	F 312	will be reported immediately to the Administrator for follow up and at least quarterly at QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	**115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 8 observed to be provided by nursing assistant (NA)-C and NA-D. The NAs did not remove or offer to remove the facial hair or clean under R9's fingernails. On 1/28/16, at 11:01 a.m. range of motion (ROM) was observed provided by NA-E. NA-E did not address the facial hair or R9's dirty fingernails. On 1/28/16, at 11:01 a.m. NA-E verified R9's fingernails were dirty. NA-E stated residents' fingernails should be cleaned during cares. R9 would often ask the nurse to do her nails and R9 also had her nails done by activity staff. NA-E verified the presence of the long facial hair on R9's chin and stated female residents' facial hair should be removed on their bath day. NA-E stated she thought R9 received a bath two times a week. On 1/28/16, at 11:01 a.m. R9 stated she did not know there was dirt under her fingernails. R9 stated, "I kept my nails clean and painted at home. I'd do them myself." R9 stated she did not know she had long facial hair, "I plucked them when I was at home. I don't like them." On 1/28/16, at 1:45 p.m. registered nurse (RN-B) stated R9's facial hair should have been removed on her bath day and fingernails should be cleaned when they were dirty. The RN verified R9 received a bath twice a week. On 1/28/16, at 1:45 p.m. NA-D stated facial hair should be removed every other day. A policy was requested and not received.	F 312		
F 318	483.25(e)(2) INCREASE/PREVENT DECREASE	F 318		3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318 SS=D	Continued From page 9 IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure restorative services were consistently provided for 3 of 3 residents (R9, R21, R1) reviewed for range of motion. Findings include: R9's Resident Admission Record dated 1/28/16, indicated R9's diagnoses included diabetic neuropathy, dementia with behavioral disturbance, hemiplegia (complete paralysis of the entire side of the body) and hemiparesis (weakness on the entire side of the body) following a cerebrovascular accident (CVA/stroke). A quarterly occupational therapy (OT) screening performed on 10/27/15, indicated R9 participated in a restorative program for left sided passive range of motion (PROM). The screening indicated that although R9 may have benefited from a left hand splinting program, she had a consistent history of refusals. The restorative PROM remained "crucial for further contracture prevention."	F 318	F318 Residents (R1, R9 and R 21) restorative programs were reviewed by therapy, restorative nurse aide and RN to assure accuracy and appropriateness. Their care plans were reviewed and updated to assure they accurately addressed restorative nursing care. A baseline audit was performed on all residents regarding restorative nursing care. Care plans were updated as appropriate. The care plans have been implemented and communicated by education, restorative nursing aide, assignment sheets, and restorative book. Policy regarding restorative nursing care was reviewed, revised, re-educated to nursing staff and implemented. A registered nurse will review the programs monthly to assure completion and appropriateness. Restorative nursing care audits will be conducted on 50 percent (50%) of residents by the DON/designee daily for 7 days, then weekly for 4 weeks, then monthly for one month and quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	**115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 10 The ADLs (activities of daily living) Functional Status/Rehabilitation Potential Care Area Assessment (CAA) dated 10/28/15, indicated R9 had significant history of CVA with left hemiplegia. R9 was non-weight bearing and required the assistance of a mechanical lift and two staff to transfer. The annual Minimum Data Set (MDS) dated 11/10/15, indicated R9 had moderately impaired cognition and had no rejection of cares. R9 had a functional limitation in range of motion (ROM) which impacted the upper and lower extremities on one side. The Restorative Care care plan dated 8/1/15, indicated R9 was at risk for a decline in ROM or contractures due to choosing to remain in bed most of the time and a history of CVA with left sided hemiplegia. The care plan directed a resting splint to the left upper extremity each day. It further directed a specialized restorative nursing program of PROM to the left side five times a week. In the event of refusals of the hand splint or PROM services, R9 was to be re-approached with an opportunity for services. The undated nursing assistant (NA) Work Assignment Sheet directed staff to encourage the resting splint to R9's left hand daily for four to six hours. On 1/26/16, at 9:52 a.m. R9 was observed in bed. Her left arm was lying parallel to her left side. The left hand was outwardly turned with the hand closed in a fist. On 1/27/16, at 7:20 a.m. R9 was observed in bed. The left arm was lying parallel to the left side with	F 318	ongoing. Variances will be reported immediately to the Administrator for follow up and at least quarterly at QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	**115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 11 the left hand curled in a fist. R9 stated the left arm (affected side) hurt. R9 lifted the left arm with her right hand and placed it on her stomach. R9 was able to open the left hand with her right hand placing it nearly flat on her stomach. On 1/27/16, at 11:10 a.m. morning cares were observed provided by nursing assistant (NA)-C and NA-D. The NAs did not apply or offer to apply the left hand splint. Review of R9's Restorative Nursing Flowsheets revealed the left hand splint had been offered and refused 40 times between 11/2/15 and 1/25/16. Of the 98 opportunities to offer the left hand splint, only 40 opportunities were documented. There was no evidence the left hand splint was accepted and applied during this period or that any alternatives were offered to R9. The flowsheets were also reviewed for the implementation of the PROM program. From 11/2/15 and 1/25/16, of 196 opportunities for PROM services to be offered, R9 received PROM 24 times. There was no evidence of what occurred with the other 172 opportunities for PROM. On 1/28/16, at 11:01 a.m. PROM was observed with NA-E. The NA completed the PROM to the left upper extremity as directed. NA-E then performed the PROM to the left hip, knee and ankle. During PROM to the left foot, R9 complained of foot and leg pain. NA-E stopped the PROM and stated the PROM was as tolerated. On 1/27/16, at 2:00 p.m. NA-E stated if the squares on the Restorative Nursing Flowsheets were blank it meant the PROM was not done and the R meant R9 refused the PROM or the hand	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 12	F 318		

splint. NA-E stated if she was not working or got pulled from restorative nursing to do cares on the unit she was not replaced and the specialized restorative nursing did not get done. NA-E verified the Restorative Nursing Flow sheets had several blanks, and she was to do R9's PROM three times a week. NA-E stated she was not aware R9 was to receive the PROM five times a week, and added the floor NAs were to apply the splint.

On 1/27/16, at 2:15 p.m. NA-C and NA-D stated NA-E was supposed to apply R9's hand splint but R9 refused the splint.

On 1/28/16, at 8:40 a.m. NA-E provided a hand written notebook and stated when she started the restorative position the previous restorative aide updated the notebook. The notebook gave the direction to do R9's PROM three times a week.

On 1/28/16, at 8:50 a.m. the director of nursing (DON) verified the care plan directed the floor restorative nursing program to offer R9 the resting splint to the left upper extremity each day. The DON indicated if R9 refused, the splint was to be offered again at a later time. The DON also stated R9 was to be offered PROM to the left side five times a week. If R9 refused, staff was to offer the PROM again at a later time. The DON stated ROM was reviewed quarterly and R9 had not had a decline in ROM. R9's goal was to maintain her current level of function. The DON stated staff was to offer R9 the hand splint during repositioning and let the nurse know if there was any discomfort. The DON stated the R on the Restorative Nursing Flowsheets meant R9 refused. The DON stated, "I cant speak to what the blanks mean, it could be staff forgot to chart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 13 it, I do not know." The DON stated if the splint was applied she would expect the staff to initial the square. The DON stated staff try to do PROM five times a week but the facility has had staffing issues. The PROM was put at five times a week but the DON would expect three times a week as the goal was to maintain the current level of ROM. The DON stated the restorative aide was scheduled Monday through Friday. If the restorative aide was pulled to do resident cares the DON would expect the floor NAs to do the PROM. NA-E would or could let the other NAs know who needed restorative services. The DON would expect staff to apply the hand splint and perform PROM as directed in the care plan. On 1/28/16, at 11:01 a.m. NA-E stated R9 had not had any loss in ROM since she started in 6/14. The NA stated R9 had not worn the splint as she refused. NA-E was unable to find the splint in R9's room and stated the floor NAs were to apply the splint. R9 then stated she had not used the splint in a long time, "I don't like it." The facility's Restorative Nursing policy and procedure reviewed and revised on 4/5/15, indicated it was the policy of the facility that residents were to be given the appropriate services and treatment to maintain or improve their abilities as directed by the resident's care plan. Restorative Nursing was a nursing intervention utilized to achieve the resident's goal. R21's admission MDS dated 10/20/15, indicated R21 had diagnoses that included heart failure. The MDS also indicated R21 had moderate cognitive impairment and required extensive assistance of two plus staff for bed mobility, transfer, dressing and toilet use and was not ambulatory. R21's annual MDS dated 10/20/15,	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 14	F 318		

indicated R21 had no functional limitations in upper extremity (shoulder, elbow, wrist, hand) or lower extremity (hip, knee, ankle, foot) ROM. However, R21 had an extensive history of a stroke with hemiparesis effecting the left side of the body. On 1/28/2016, at 3:48 p.m. the director of nursing (DON) confirmed R21 had upper and lower extremity impairment on both sides and the MDS was coded inaccurately.

R21's ADL Functional Status/Rehabilitation Potential CAA dated 10/20/15, indicated R21 required assistance with ADLs due to weakness. A stand lift was used for transfers with staff of 1 assist. The CAA indicated R21 was working with therapy on strengthening and endurance.

R21's Occupational Therapy (OT) and Physical Therapy (PT) Evaluation and Treatment Plans both dated 1/14/16, identified the severity of R21's functional limitation at discharge to be at least 60% but less than 80% impaired, limited or restricted. The PT Plan indicated R21 was to be discharged from PT and resume his prior restorative nursing program. The OT Plan indicated no further skilled OT intervention was needed and R21's previously established upper extremity restorative program remained appropriate.

R21's care plan dated 10/29/15, identified a category of restorative care/nursing, with a problem of muscle weakness. The care plan directed staff to provide lower extremity exercises 3 times a week as directed by PT and red Theraband (latex exercise resistance band) exercises 3 times a week as provided by OT.

On 1/26/15, at 1:19 p.m. the fingers of R21's left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 15	F 318		

hand were observed to be contracted. R21 was partially able to straighten the fingers upon request but could not fully extend his fingers. R21 stated the staff exercised his fingers.

Review of R21's Restorative Nursing Flowsheets revealed the following:
--Week of 11/16/15, had the opportunity for three nursing rehabilitation sessions and received two
--Week of 11/23/15, had the opportunity for three nursing rehabilitation sessions and received zero (R21 refused one session)
--Week of 12/21/15, had the opportunity for three nursing rehabilitation sessions and received two
--Week of 1/11/16, had the opportunity for two nursing rehabilitation sessions and received zero

On 1/28/16, at 1:45 p.m. R21 stated he received ROM services that included exercises on his upper and lower extremities but the staff missed days so sometimes he didn't receive the services.

On 1/28/16, at 1:54 p.m. NA-E stated she was the person primarily responsible to provide restorative nursing services for the facility. NA-E confirmed R21 was to have received restorative nursing services 3 times per week and confirmed there were weeks when he had not received services as ordered. NA-E indicated the aides on the floor were supposed to provide restorative nursing services when she was gone, however, this sometimes was not done. NA-E also indicated she was frequently pulled from her restorative duties to perform other duties and restorative nursing services were not provided.

On 1/28/16, at 2:56 p.m. DON confirmed R21 should have received restorative nursing 3 times per week as directed by the care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 16 R1's Admission Record dated 11/14/94, identified diagnoses that included post-concussional syndrome (traumatic brain injury [TBI] from car accident), and chronic pain. R1's quarterly MDS dated 11/18/15, indicated severely impaired cognition and total dependence on staff for her ADLs. The MDS also indicated physical behaviors to others on 1-3 days of the seven day assessment period. The quarterly MDS dated 8/27/15, indicated R1 had no functional limitations in upper extremity (shoulder, elbow, wrist, hand) or lower extremity (hip, knee, ankle, foot) ROM. In an interview with registered nurse (RN)-B on 1/26/16 at 10:41 a.m., registered nurse (RN)-B stated that R1 had a contracture. In an interview on 1/28/16, at 3:36 p.m., the DON stated she would have marked the MDS as R1 having an impairment. R1's Restorative Care/Nursing Care Plan dated 12/24/15, identified R1 had stiffness and joint contracture with a goal to reduce the extent of the contracture and reduce pain. The care plan directed staff to provide PROM 2-3 times a week-or more if resident tolerated and to document refusals and attempts. This was to be performed once a day on Monday, Wednesday and Friday between 8:00 a.m. and 4:30 p.m. R1's ADL Assistance Care Plan dated 6/23/13, identified an alteration in mobility related to R1's need for assistance secondary to a TBI with the goal that R1 would have no further contractures. The care plan directed R1 to attend restorative nursing for PROM exercises to upper extremities to decrease stiffness and prevent contractures of joints. If R1 was resistive to attempt at a later	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 17	F 318		

time. Staff was directed to document refusals and attempts. The care plan stated R1 was to have PROM 2-3 times/week, may have more frequently if tolerated.

On 1/26/16, at 10:41 a.m. registered nurse (RN)-B stated R1 had a contracture.

On 1/28/16, at 11:26 a.m. NA-E stated physical therapy worked with R1 up until approximately a month ago. NA-E stated she has been responsible for restorative nursing in the facility since 6/15. NA-E stated she did the best she could with R1's leg ROM, even if she got pulled to the floor to work. NA-E indicated R1 hadn't had a decline in ROM.

On 1/28/16, at 2:01 p.m. NA-E stated physical therapy had handed her written sheets with exercise instructional pictures, but had not shown her how to perform the exercises for R1. NA-E stated they told her to do these exercises 2 to 3 times a week. NA-E stated she was not confident about what she had to do for R1. NA-E confirmed the recording sheets were an accurate reflection of how often she had worked with residents. NA-E stated she has only had 5 successful sessions with R1 since she started working with her about a month ago. NA-E stated there were times R1 refused and she didn't write that down, but perhaps she should.

The facility's East Hall Work Assignment Sheet directed staff to provide PROM of R1's upper extremities 2-3 times each week on the PM shift. Review of the floor restorative nursing flowsheet indicated this had been accomplished.

Facility restorative nursing flowsheet's for R1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	**115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 18 lower extremity PROM revealed from 12/17/15 until 1/27/16, R1 received only 5 sessions of PROM to her lower extremity when there were twenty opportunities.	F 318		
F 441 SS=E	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. (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	F 441		3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	**115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 19 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 appropriate hand hygiene was performed during and after resident cares for 4 of 4 residents (R16, R9, R21, R1) who were observed during the provision of services. Findings include: R16 was observed on 1/27/16, at 7:58 a.m. while nursing assistant (NA)-C and NA-D were assisting R16 with morning cares. Both NAs donned gloves. Hand washing or sanitizing was not observed prior to donning the gloves. NA-D applied R16's pants and slippers. NA-D then assisted NA-C with turning R16. NA-C washed R16's face, peri area and buttocks. R16 had been incontinent of urine and stool. NA-C removed the soiled incontinent product and applied a clean incontinent product. NA-C then removed the gloves but did not wash or sanitize her hands. Both NAs applied the mechanical lift sling under R16, connected the sling to the lift, and transferred R16 from the bed to the wheelchair. NA-C removed the sling from behind R16. NA-D removed R16's shirt and applied a clean shirt. NA-D removed her gloves and exited the room with the mechanical lift. NA-D did not wash or sanitize her hands prior to exiting the room. NA-C donned a glove on the right hand, picked up the soiled incontinent product and placed it in the	F 441	F441 NA-C and NA-D were immediately re-educated regarding how to perform proper hand hygiene while performing resident cares. Resident (R1, R9, R16 and R21) were not harmed as a result of the NAs failure to perform proper hand hygiene during cares. All nursing staff has completed the hand hygiene education in the SABA system. All nursing staff has been audited regarding when to perform proper hand hygiene during caring for residents Policy regarding hand hygiene has been reviewed and all nursing staff have been re-educated regarding proper hand hygiene during resident care. The hand hygiene of fifty percent (50%) of nursing staff will be audited by the DON/designee daily for 7 days, then weekly for 4 weeks, then monthly for one month and quarterly ongoing. Variances will be reported immediately to the Administrator for follow up and at least quarterly at QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	**115 10TH AVENUE NORTHEAST** **DEER RIVER, MN 56636**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 20 garbage, emptied the wash basin in the bathroom sink, put the supplies away and removed the glove. NA-C then tied the trash bag, retrieved the soiled linen bag from the bathroom and exited the room. NA-C did not wash or sanitize her hands prior to exiting the room. NA-C then entered the soiled utility room by entering a code and turning the door knob. NA-C disposed of the trash and linen, exited the soiled utility room and then used the hand sanitizer in the hall to sanitize her hands. On 1/27/16, at 11:55 a.m. NA-C and NA-D were observed getting R16 up from the bed and transferring him to the wheelchair. NA-C did not wash or sanitize her hands or don gloves. NA-D was not observed to wash or sanitize her hands but donned gloves. R16 was incontinent of stool. NA-D cleansed R16's buttocks, removed the incontinent brief and then removed the gloves. NA-D did not wash or sanitize her hands. NA-D applied a new incontinent product, pulled up R16's pants, applied the mechanical lift sling and both NAs transferred R16 to the wheelchair. NA-C exited the room with the mechanical lift. NA-C did not wash or sanitize her hands prior to exiting the room. NA-D tied and gathered the trash and exited the room. NA-D did not wash or sanitize her hands prior to exiting the room. NA-D then entered the soiled utility room by entering a code and turning the door knob. NA-D did not wash or sanitize her hands prior to exiting the soiled utility room. NA-D then answered a call light in another resident's room. NA-D made that resident's bed, retrieved an item from the closet, and exited the room with soiled linen. NA-D then entered the soiled utility room by entering a code and turning the door knob. NA-D then washed her hands at the nursing station.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 21 R9 was observed on 1/27/16, at 11:10 a.m. while NA-C and NA-D were assisting R9 with cares. NA-D sanitized her hands and donned gloves. NA-C washed her hands and donned gloves. NA-D gathered R9's clothes, lowered the bedding and removed R9's gown. NA-C retrieved a basin of water and the supplies. NA-C washed R9's face, under the arms, breasts, peri area and buttocks. NA-C removed a wet incontinent product. NA-D assisted with turning R9. NA-C placed a clean incontinent product under R9. NA-C gathered the soiled linen and removed her gloves. Both NAs used the lift sheet to pull R9 up in bed. NA-C emptied R9's basin in the bathroom and exited the room. NA-C did not wash or sanitize her hands after removing the gloves or prior to exiting the room. NA-C then entered the clean linen closet down the hall. After returning, NA-C washed R9's glasses, gathered the trash and exited the room. NA-C then entered the soiled utility room by entering a code and turning the door knob. NA-C washed her hands at the nursing station. NA-D applied R9's dress, removed the gloves, entered the linen room down the hall and came back with the clean linens. NA-D returned to R9's room and checked R9's incontinent brief per R9's request. The brief was dry but R9 complained it felt wet. NA-D changed the dry brief with bare hands, raised the head of the bed with the bed controls and exited the room. NA-D did not wash or sanitize her hands prior to exiting the room. NA-D was observed to reach into her shirt pocket and pull out a piece of paper and a pen. The NA returned the items to her pocket and walked into the main ding room with her hands in her pockets. NA-D then entered another resident's room and closed the door.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 22 On 1/27/16, at 2:15 p.m. NA-C and NA-D stated handwashing should be done when leaving a resident's room, after cleaning up a bowel movement, anytime peri cares were done and between glove changes. The NAs stated it was quicker to use sanitizer, "But, you can only use sanitizer so many times then you need to wash." Both NAs verified they did not wash or sanitize their hands after removing gloves and before leaving R16 and R9's rooms. On 1/28/16, at 2:00 p.m. the director of nursing (DON) stated handwashing should be done before and after gloving and anytime gloves were soiled. Also when going from dirty to clean and prior to leaving the resident's room. The facility's Hand Hygiene policy effective 1/1/15, indicated all employees would utilize appropriate hand hygiene techniques to prevent the transmission of infection. The policy directed staff to perform hand hygiene before and after direct contact with residents. After removing gloves. After contact with body fluid or excretions. The policy further indicated gloves should be used in adjunct to and not substituted for hand hygiene. Gloves should be removed and hands washed when care activity was completed and between residents. R21 was observed on 01/27/2016, at 9:01 a.m. while NA-C and NA-D assisted R21 to the toilet. NA-C and NA-D entered R21's room with a mechanical lift and applied the lift sling under R21 while he sat in his wheelchair. NA-C and NA-D then attached the sling to the lift, raised R21 out of his wheelchair and wheeled R21 to the bathroom. They then positioned R21 over the toilet and NA-D lowered R21's pants and brief	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 23 with her bare hands. NA-C lowered the lift while NA-D guided R21 onto the toilet and gave R21 the call light. NA-C and NA-D left the room without performing hand hygiene. NA-D stated R21's incontinent brief was slightly wet. On 1/27/2016, at 2:15 p.m. NA-C indicated it was the facility policy for hand washing to be performed between each resident and with peri cares and confirmed she had not washed her hands prior to exiting R21's room. NA-D confirmed she did not perform hand hygiene before exiting the room and should have done so. On 01/28/2016, at 3:03 p.m. the DON confirmed staff should perform hand hygiene between residents and gloves should be worn when exposure to blood/body fluids is possible. R1 was observed on 1/27/16, at 8:09 a.m. while NA)-A and registered nurse (RN)-A were providing perineal cares. RN-A stated R1 was "full of BM [bowel movement]." RN-A donned gloves and used disposable wet wipes to clean BM off of R1. Without removing her gloves, using hand sanitizer or washing her hands, RN-A assisted in repositioning R1 by touching and arranging pillows under R1's head and body. NA-A, who assisted with positioning, but did not perform perineal cares, did not wash her hands or use hand sanitizer upon leaving R1's room. On 1/27/16, at 12:07 p.m. NA-A stated she could not recall if she washed her hands or used hand sanitizer after providing cares to R1 that morning. Upon reflection, NA-A stated that she will often hold the bag of soiled items in one hand and use the other hand to punch in the code to the soiled utility room and wash her hands in there, or at the	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	**115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 24 nurse's station after disposing of the garbage or soiled linens. NA-A stated she often did hand washing this way, not immediately when leaving a resident's room. On 1/28/16, the DON stated that when a staff person took off their gloves, they also needed to wash their hands. The DON stated that she informed NA-A that if she had already tied the soiled bag, a clean hand could be used to open the soiled utility room door.	F 441		
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 well-maintained resident rooms for nine resident rooms (101, 103, 104, 105, 106, 108, 130, 131, 132). Findings include: During the environmental tour on 1/28/16, at 11:52 a.m. with maintenance (M)-B and M-A, M-B verified the following findings: -Scraped, splintery open wood on the bedside stand and over bed table in room 130. -Bathroom vents with a build up of thick dust in rooms: 131, 132, 104, 106, and 108	F 465	F465 Room numbers 103, 104, 105 and 106 have had the walls and door frames painted. The bathroom vents in resident bathrooms 131, 132, 104, 106 and 108 have been cleaned. The wall gouges in room 101 and the bathroom of 106 have been spackled and painted. The stained ceiling in room 131 was replaced. The bedside stand and over bed table in room 130 have been replaced. The sink in the laundry room is being replaced. A baseline audit was performed on all resident rooms and bathrooms and repairs are being made to rooms that are identified as needing repairs. A baseline	3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 25 -Walls and doorframes with scraped paint in resident bathrooms: 103, 104, 105, 106 -Walls with gouges in the sheetrock, at the level and location of a rocking chair in room 101, and in the bathroom in room 106 -Stained ceiling tile in room 131 During the environmental tour, M-B stated they don't clean inside bathroom vents on an ongoing basis. If someone is painting a bathroom and notices, they would wipe the vents at that time. M-A stated that damage to painted door frames and walls in resident bathrooms happens frequently. He stated he could paint and in a week it would be scuffed. M-A also stated housekeeping is responsible for dusting the outside of vents and maintenance for dusting inside the bathroom vents. M-B stated that there is a preventive maintenance log that included a weekly room inspection that required the inspection of the general condition of all rooms including beds, heaters, and restrooms to ensure resident safety. These logs were reviewed along with a log of room repair projects from Fall of 2015. Wall repairs were completed on several of the rooms that were again noted in the environmental tour (103, 104, 105, and 106). In addition, there was a note stating many door frames needed paint and the painting was finished 7/14/15. M-B stated he was not aware of a preventive maintenance policy. In a review of the facility housekeepers daily cleaning list, dusting the vents was not listed. In an interview on 1/28/16, at 1:49 p.m. housekeeper (H)-B stated she did not dust the bathroom vents on a regular basis, but did dust	F 465	audit was performed on all resident furniture and repairs/replacements are being made. Maintenance protocol regarding keeping the facility safe, clean and homelike has been reviewed and revised to ensure that walls and doors are repaired on a routine basis, that ceiling tiles are checked and replaced when soiled, that vents are cleaned on a regular basis and that furniture in resident rooms is checked. In addition, Staff has been educated to report items in rooms that need attention such as scrapes, nicks, gouges on walls/doors, soiled ceiling tiles and scrapes, etc. on furniture. Audits will be performed by the Maintenance Supervisor/designee during rounds weekly for 4 weeks, then monthly thereafter. Variances will be reported immediately to the Administrator for follow up and at least quarterly at QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	**115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 26 them "once in a while" with a swiffer. During the tour of the facility laundry on 1/28/16, at 8:32 a.m. the laundry room hand wash sink was observed to be dirty with the left hand basin black and appearing corroded. During the tour, laundry aide (LA)-C stated the left hand sink basin in the laundry room was black due to something that maintenance disposed of in that basin. LA-C stated no one is responsible for cleaning the sink and she didn't know if or when it was last cleaned. During an interview on 1/28/16, at 1:40 p.m. the director of housekeeping (H)-A confirmed the sink was black and corroded. H-A stated she did not know what it was from, and indicated she did not know how often the sink was cleaned.	F 465		

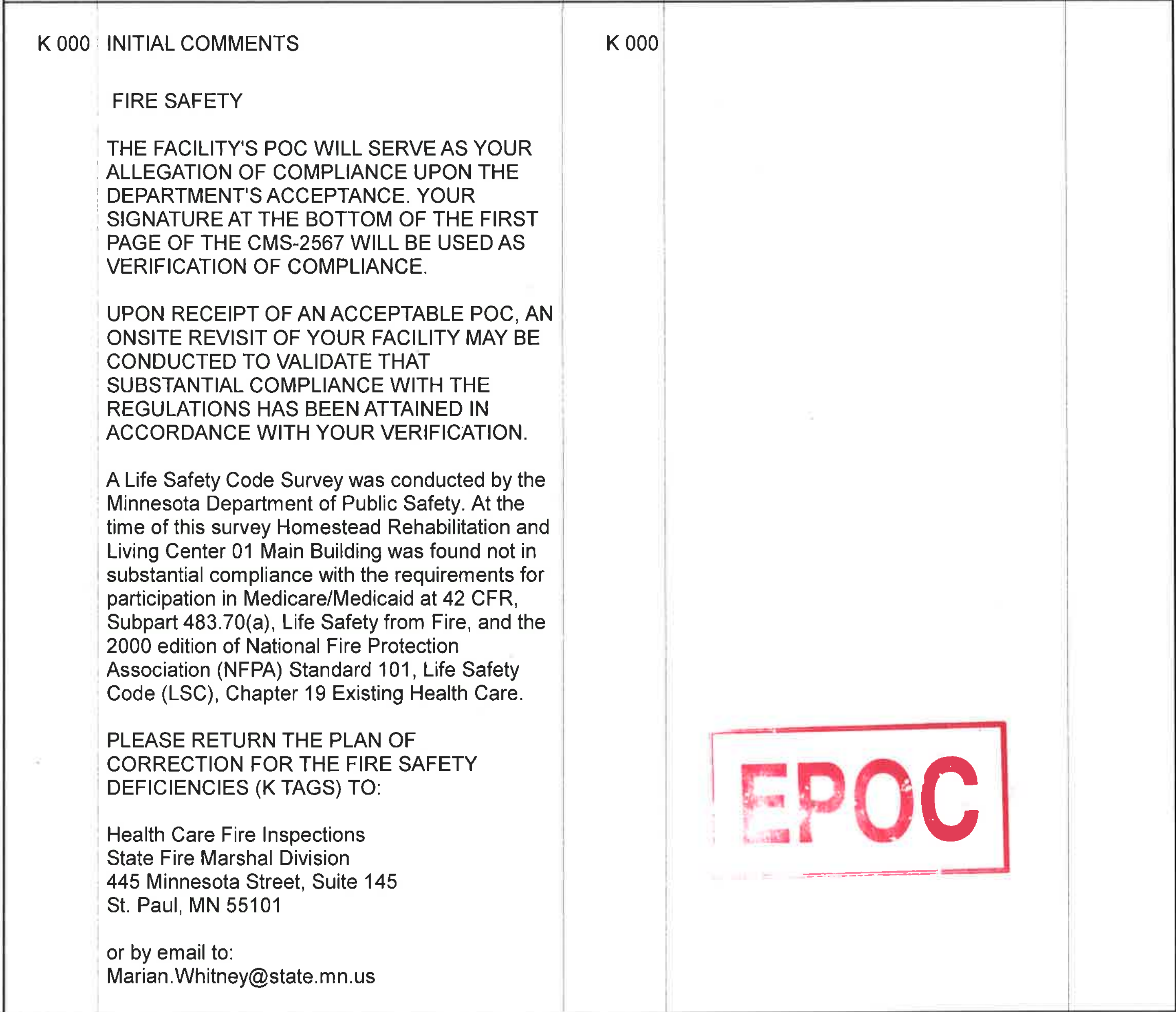
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5428024

PRINTED: 02/19/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING **01 - NURSING HOME** B. WING ______________	**01/26/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	**115 10TH AVENUE NORTHEAST** **DEER RIVER, MN 56636**



(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Homestead Rehabilitation and Living Center 01 Main Building was found not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 or by email to: Marian.Whitney@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/19/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING 01 - NURSING HOME B. WING	01/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Homestead Rehabilitation and Living Center is a 1-story building without a basement that is attached to a hospital. The building was constructed in 2 major stages. The original building was constructed in 1973, was determined to be of Type II(111) construction. In 1990 an addition to the north of the building was constructed and was determined to be of a Type II(111) construction. The hospital is separated from the nursing home building with two hour fire barriers and was not inspected at this time. The building is divided into 2 smoke zones. The building is completely sprinkler protected with an automatic fire sprinkler system that is installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition) with quick response heads, except as noted in K56. The facility has a fire alarm system with smoke detection throughout the corridor system, in spaces open to the corridors and in all sleeping rooms that is monitored for automatic fire department notification installed in accordance	K 000		

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
	245428	A. BUILDING **01 - NURSING HOME** B. WING ______	**01/26/2016**

NAME OF PROVIDER OR SUPPLIER: **ESSENTIA HEALTH - HOMESTEAD**

STREET ADDRESS, CITY, STATE, ZIP CODE: **115 10TH AVENUE NORTHEAST, DEER RIVER, MN 56636**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 with NFPA 72 "The National Fire Alarm Code" (1999 edition). Other hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition) The facility has a capacity of 32 beds and had a census of 28 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 2 fire separations was found not in compliance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.1 and 19.1.1.4.2,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect the 28 of 28 residents, visitors, and staff members of the facility. Findings include: On facility tour between 10:00 AM to 1:00 PM on 01/26/2016, observations revealed that the	K 011	K011 1.Correction: a.The penetration around the pass through tray in the 2 hour fire barrier above the doors separating the nursing home from the hospital located by the boiler room and staff room 45 have been sealed by an appropriate fire barrier seal product. b.A new door has been ordered and will be installed in the 2-hour fire separation T100ACOR. c.The 6 inch by 10 inch penetration in the T100ACOR 2 hour fire barrier above	3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING **01 - NURSING HOME** B. WING ______	**01/26/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	**115 10TH AVENUE NORTHEAST** **DEER RIVER, MN 56636**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 011	Continued From page 3 following deficient conditions were found affecting the fire separations located within the facility: 1. there was a penetration around the pass through tray in the 2 hour fire barrier above the doors separating the nursing home from the hospital located by the boiler room and staff room 45. 2. the door in the 2 hour fire separation T100ACOR has a 30 minute door. 3. there was a 6 inch by 10 inch penetration in the T100ACOR 2 hour fire barrier above the doors separating the nursing home from the hospital. 4. the doors in the 2 hour fire separation in the east hall have a 1/4 inch gap between the doors. This deficient condition was verified by a Maintenance Supervisor.	K 011	the doors separating the nursing home from the hospital has been sealed by an appropriate fire barrier seal product. d.The doors in the 2 hour fire separation in the east hall have had the gap between the doors closed and appropriately spaced. 2.Completion Date: a.Completed by March 4, 2016 b.Ordered by February 19, 2016 and installed by March 4, 2016 or as soon as practicable upon arrival if later than March 4, 2016 c.Completed by March 4, 2016 d.Completed by March 4, 2016 3.Person Responsible: Mark Cook, Manager, will be responsible for the correction and monitoring to ensure that the 2 hour fire barrier is maintained.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING **01 - NURSING HOME** B. WING ______	**01/26/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	**115 10TH AVENUE NORTHEAST** **DEER RIVER, MN 56636**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 4	K 018		
	This STANDARD is not met as evidenced by: Based on observation and interview, the facility had 1 of several corridor doors that did not meet the requirements of NFPA 101 LSC (00) section 19.3.6.3.2. This deficient practice could affect 11 of 28 residents, staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 10:00 AM to 1:00 PM on 01/26/2016, it was observed that resident room H101 door to the corridor was warped and had a 3/4 gap between the top of the door and the frame. This deficient condition was verified by the Maintenance Supervisor.		K018 1.Correction: A new door has been ordered and will be installed at H101. 2.Completion Date: Ordered by February 19, 2016 and installed by March 4, 2016 or as soon as practicable upon arrival if later than March 4, 2016 3.Person Responsible: Mark Cook, Manager, will be responsible for the correction and monitoring to ensure resident room doors are not warped and there are no gaps.	
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3	K 054		3/4/16
	This STANDARD is not met as evidenced by: Based on observations it was determined that one of the automatic smoke detectors, that are on the fire alarm system, is not in accordance with		K054 1. Corrections: a. The smoke detector located in the PT	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING **01 - NURSING HOME** B. WING ____________	**01/26/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	**115 10TH AVENUE NORTHEAST** **DEER RIVER, MN 56636**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 054	Continued From page 5 NFPA 72 " The National Fire Alarm Code" 1999 Edition section 2-3.5.1 nor the Minnesota State Fire Code (2007). Lack of maintenance of the smoke detectors may allow them to fail or delay alarming in a fire emergency causing a delay in the response to the fire emergency, which would negatively impact 11 of 28 residents, visitors and staff in the facility. Findings include: On facility tour between 10:00 AM to 1:00 PM on 01/26/2016, observations revealed the following deficient conditions were affecting the fire alarm system. 1. the smoke detector located in the PT gym was within 36 inches of the heating, ventilation, and air conditioning diffuser. 2. the pull station located at the exit door by resident room 131 was mounted 65 inches above the level of the floor. This deficient condition was verified by the Maintenance Supervisor.	K 054	gym will be moved to be more than 36 inches of the heating, ventilation, and air conditioning diffuser. b. The pull station located at the exit door by resident room 131 will be removed or lowered to the appropriate level 2. Completion Date: a. Completed by March 4, 2016 b. Completed by March 4, 2016 3.Person Responsible: Mark Cook, Manager, will be responsible for the correction and monitoring to ensure that smoke detectors are properly placed and that pull stations are appropriately located.	