DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 22, 2021

Administrator
Essentia Health - Homestead
115 10th Avenue Northeast
Deer River, MN 56636

RE: CCN: 245428
Cycle Start Date: August 31, 2021

Dear Administrator:

On September 21, 2021, we notified you a remedy was imposed. On October 7, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 5, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 6, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 21, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 6, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 5, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically Submitted
September 21, 2021

Administrator
Essentia Health - Homestead
115 10th Avenue Northeast
Deer River, MN 56636

RE: CCN: 245428
Cycle Start Date: August 31, 2021

Dear Administrator:

On August 31, 2021, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On August 30, 2021, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of F.

Also on August 30, 2021, the situation of immediate jeopardy to potential health and safety cited at F886 was removed. However, continued non-compliance remains at the lower scope and severity of F.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 6, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 6, 2021, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 6, 2021, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 6, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 1, 2022 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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 _____	C 08/31/2021

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
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 8/26/21 through 8/31/21, using CMS Appendix Z Emergency Preparedness Requirements. The facility was in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 8/26/21 through 8/31/21, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. In addition, a standard abbreviated survey was conducted at your facility. Your facility was found to not be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The complaint H5428017C (MN76189) was found to be substantiated; however, no deficiencies were cited due to actions taken by the facility prior to survey. The survey resulted in two Immediate Jeopardy (IJ) situations to resident safety at F880 and F886. F880 -The IJ began on 8/6/21, when the facility failed to quarantine and initiate transmission based precautions (TBP) when R17 reported COVID-19 signs and symptoms of aching all over along with a headache; and the facility continued the practice of not quarantining and initiating TBP when R5, R1, R2, R4, R6, R9 and R10 began displaying signs and symptoms of COVID-19. In addition, the facility failed to ensure staff; licensed practical nurse (LPN)- B, nursing assistant (NA)-A	F 000		

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

Electronically Signed | 09/29/2021

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F 000	Continued From page 1 and registered nurse (RN)-A reported all signs of symptoms of COVID-19 prior to starting their shifts and did not work with signs and symptoms of COVID-19 until a COVID-19 diagnosis could be ruled out. The facility administrator and director of nursing (DON) were notified of the IJ on 8/30/21, at 7:32 p.m. The IJ was removed on 8/31/21, at 5:15 p.m. when an acceptable removal plan could be verified. F886- The IJ began on 8/27/21, when staff were observed to complete COVID-19 tests in a manner not consistant with manufacturers recommendations. In addition, the facility failed to ensure staff responsible for testing were trained and competency tested per manufacturers recommendation to ensure accurate testing. The administrator, director of nursing (DON) and registered nurse (RN)-B were notified of the IJ on 8/27/21, at 4:35 p.m. The IJ was removed on 8/30/21, at 10:15 a.m. when an acceptable removal plan could be verified. 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 880 SS=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		10/5/21

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F 880	Continued From page 2 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 3 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents displaying signs and symptoms of COVID-19 were quarantined to their rooms; transmission based precautions initiated and tested per The Centers for Disease Control and Prevention's (CDC) guidance to prevent the spread of COVID-19 for 8 of 21 residents (R17, R5, R1, R2, R4, R6, R9, R10). In addition, the facility failed to ensure staff who displayed signs and symptoms of COVID-19 were removed from the schedule per the the CDC's guidance. This deficient	F 880	F880 R2, R3, R5, R15, and R17 are no longer residing in the facility. The following corrective actions regarding the facility□s isolation/ quarantine practices were taken: " R1, R4, R6, R7, R8, R9, R10, R11, R12, R14, and R16 were all placed in isolation upon testing positive for COVID-19. " Facility implemented isolation/quarantining in room for all	

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F 880	Continued From page 4 practice resulted in an immediate jeopardy (IJ) situation which had the high likelihood to cause serious illness and/or death to all residents residing in the facility during the COVID-19 Focused Infection Control Survey; including 17 residents (R17, R5, R1, R2, R3, R4, R6, R15, R9, R10, R7, R11, R12, R14, R8, R16) who contracted COVID-19. This resulted in actual harm to R2, R3 and R5 who expired with COVID-19 and R4 and R15 who were hospitalized with COVID-19. The IJ began on 8/6/21, when the facility failed to quarantine and initiate transmission based precautions (TBP) when R17 reported COVID-19 signs and symptoms of aching all over along with a headache; and the facility continued the practice of not quarantining and initiating TBP when R5, R1, R2, R4, R6, R9 and R10 began displaying signs and symptoms of COVID-19. In addition, the facility failed to ensure staff; licensed practical nurse (LPN)- B, nursing assistant (NA)-A and registered nurse (RN)-A reported all signs of symptoms of COVID-19 prior to starting their shifts and did not work with signs and symptoms of COVID-19 until a COVID-19 diagnosis could be ruled out. The facility administrator and director of nursing (DON) were notified of the IJ on 8/30/21, at 7:32 p.m. The IJ was removed on 8/31/21, at 5:15 p.m. following an acceptable removal plan; however non-compliance remained at the lower scope and severity of F, widespread with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: The CDC guidance People with Certain Medical Conditions dated 5/13/21, identified older adults	F 880	residents during the outbreak period and initiated transmission-based precautions for all residents displaying signs/symptoms consistent with Covid. " Residents testing positive for COVID-19 were moved to the North wing for isolation/quarantine, which was the facility□s dedicated Cohort during outbreak for COVID positive residents. In addition to correcting its isolation/ quarantine practices, the below TBP were implemented: " Dedicated medical equipment (i.e., mechanical Lift, vital sign equipment) was provided for the Cohort wing. " For facility residents in isolation/ quarantine, the following was placed on the door to their room: proper signage indicating resident□s isolation/ quarantine status and appropriate PPE to be donned by staff upon entry. " PPE carts were placed outside of rooms for donning by staff prior to room entry. " Waste baskets and linen hampers were placed inside room for doffing of PPE by staff prior to room departure. " Resident monitoring of symptoms consistent with Covid is being completed daily on all shifts. " Staff displaying any signs or symptoms of COVID have been removed from the schedule and instructed to contact the Essentia Facilities Workability Department to arrange for further evaluation.	

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F 880	Continued From page 5 were more likely to get seriously ill from COVID-19. More than 80 percent of COVID-19 deaths have occurred in people over the age of 65, and more than 95 percent of COVID-19 deaths have occurred in people older than 45. Further, among adults, the risk for severe illness from COVID-19 increases with age, with older adults at highest risk. Severe illness means that the person with COVID-19 may require hospitalization, intensive care, or a ventilator to help them breathe, or they may even die. During entrance conference on 8/26/21, at 10:15 a.m. the director of nursing (DON) stated there were nine residents in the facility with COVID-19, three residents had expired with COVID-19 and three residents were in the hospital with COVID-19. Further, 98 percent of residents were vaccinated and 58 percent of the facility staff were vaccinated. The CDC guidance Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 (COVID-19) Spread in Nursing Homes dated 3/29/21, indicated nursing homes must sustain core infection prevention and control (IPC) practices and remain vigilant for SARS-CoV-2 infection among residents and healthcare personnel (HCP) to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death. People with COVID-19 had a wide range of symptoms reported - ranging from mild symptoms to severe illness. Symptoms appeared 2-14 days after exposure to the virus. Anyone could have mild to severe symptoms and may have COVID-19: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat,	F 880	The facility has implemented the following practices to identify other residents having the potential to be affected by the same or deficient practice: " Resident monitoring for signs and symptoms consistent with Covid is being completed three times per day by nursing while the facility is in outbreak investigation. " Residents exhibiting any Covid like symptoms will be immediately placed on TBP in a private room (if available) with cohorting to protect other residents not affected/ displaying no signs or symptoms. " Rapid testing for Covid will be completed for any symptomatic resident unless the provider orders otherwise. If the symptomatic resident had a roommate, roommate would be placed in Quarantine with TBP and increased monitoring. If the symptomatic resident tests positive for COVID the roommate will be tested immediately. " Dedicated equipment (med cart, lifts, vital sign equipment) will be used for those in quarantine/isolation. " When resident is placed in isolation or quarantine, objects that are touched frequently, (i.e., bed rails, tables, bathroom surfaces) will be cleaned and disinfected daily. The following changes were implemented by facility to ensure the deficient practice will not reoccur:	

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F 880	Continued From page 6 congestion or runny nose, nausea and/or vomiting, and diarrhea. Anyone with symptoms of COVID-19, regardless of vaccination status, should receive a viral test immediately. - Properly managed individuals with suspected or confirmed SARS-CoV-2 infection or who had contact with someone with suspected or confirmed SARS-CoV-2 infection: HCP should be excluded from work and should notify occupational health services to arrange for further evaluation. Residents with suspected SARS-CoV-2 infections should be prioritized for testing, should be cared for by healthcare personnel (HCP) using an N95 or higher-level respirator, eye protection (for example: goggles or a face shield that covers the front and sides of the face) gloves and a gown. Ideally, the resident should be moved to a single-person room with a private bathroom while test results were pending. In general, it was recommended the door to the room remain closed to reduce transmission of SARS-CoV-2. Increase monitoring of residents with suspected or confirmed SARS-CoV-2 infection, including assessment of symptom, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least three times daily and quickly manage serious infection. Symptomatic Residents: On 8/26/21, at 12:12 p.m. the resident area was observed. One wing was designated as the COVID-19 wing with the doors to the wing shut. There was a personal protective equipment (PPE) station set up for putting on and removing PPE. All residents were in their rooms and staff currently were wearing appropriate PPE including N95 respirators, eye goggles, gowns and gloves	F 880	" All licensed nursing staff have received training on Covid symptoms, isolation/quarantine requirements, and TBP. Initial Training completed on 9-2-21 and the remainder of licensed nursing staff (i.e. those who did not have a shift by 9-2-21) received the training upon arrival for their next scheduled shift. All staff were trained by as of 9-24-21. " All nursing staff providing direct care and entering resident rooms have received education and training on TBP, appropriate PPE use, and donning and doffing of PPE. " All staff have will participated in a facility training with competency testing session provided by the DON and IP by 10-5-21. Topics include: Principles of COVID-19 Virus, care of Resident and environment included TBP, symptom tracking, illness reporting, and appropriate donning and doffing practices. " Return demonstration of competency of PPE donning and doffing will be completed by 10-5-2021. " All staff have received education on staff screening requirements and return to work criteria utilizing standard work developed by Essentia Health long term care team. The standard work includes how to report a staff illness, what symptoms to report and when staff needs to be excluded from work. Standard work also describes process for screening and identification of symptoms of COVID prior to the beginning of the shift. " Facility completes a risk assessment weekly on Wednesdays to identify testing of staff frequency utilizing county	

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	245428	A. BUILDING _____ B. WING _____	C 08/31/2021

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F 880	Continued From page 7 on the unit. R17's discharge Minimum Data Set (MDS) dated 8/23/21, identified R17 was 82 years old. Diagnoses included respiratory disease, heart disease and Diabetes Mellitus. R17's medical record identified R17 was fully vaccinated. R17's progress notes identified the following: - 8/6/21, R17 complained of aching all over and a headache. - 8/9/21, R17's oxygen saturations (O2 sats) decreased to 90 percent (a average level of oxygen is 95 percent or higher) on room air. R17 had a productive cough, complained of feeling very tired and ate poorly. - 8/10/21, R17 complained of body aches, headache, and a cough. - 8/10/21, R17 tested positive for COVID-19. R17's medical record lacked evidence R17 was immediately quarantined and TBP were initiated after displaying COVID-19 symptoms on 8/6/21. R5's undated face sheet identified R5 was 73 years old. Diagnoses included lymphoma, malignant neoplasm of bladder, chronic obstructive pulmonary disease (COPD) and chronic kidney disease. Further, it was identified R5 was roommates with R1. R5's medical record identified R5 was fully vaccinated. R5's progress notes identified the following: - 8/7/21, R5's O2 sats decreased to 72-84 percent on room air. - 8/11/21, R5 tested positive for COVID-19 - 8/23/21, R5 expired at the facility. R5's medical record lacked evidence R5 was immediately quarantined and TBP initiated after displaying symptoms on 8/7/21. R1's undated face sheet identified R1 was 85	F 880	transmission rates. Testing will be completed on all unvaccinated staff weekly if rates are moderate, and on all unvaccinated staff twice weekly if rates are substantial or high. The testing schedule will be initiated with in the calendar week of the rate change. " Anyone entering the facility must be screened for signs and symptoms of COVID-19 at the point of entry. Anyone who does not meet the criteria will be restricted from entering the facility. " Education on the use of transmission-based precautions is reviewed with visitors prior to visits for residents on transmission-based precautions. " New admissions will be assessed for risk of COVID-19 and placed in a private room for at least 14 days. " The facility has implemented use of the Resident Symptom Tracking Log (MDH toolkit) Line Listing for Residents with Signs and Symptoms of COVID-19 as a tracking tool to monitor all residents for communicable, respiratory infection. " IPCWell virtual site visit with Dr. Buffy Lloyd-Krejci completed as of 9-23-21 to assure core infection control standards are in place. " Superior Health Quality Alliance, DON and IP completed Infection Prevention and control assessment tool for long term care facilities on 9/23/21. " Initial Root Cause Analysis (RCA) by facility DON and facilities IP identifying the issues that resulted in this deficient practice completed. Per the DPOC, facility has contracted with an Infection Control	

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	245428	A. BUILDING _____ B. WING _____	C 08/31/2021

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F 880	Continued From page 8 years old. Diagnoses included Parkinson's disease, heart disease, and chronic obstructive pulmonary disease (COPD). Further, it was identified R1 was roommates with R5. R1's medical record indicated R1 was fully vaccinated. R1's progress notes identified the following: - 8/8/21, R1 had a fever of 100.2 degrees Fahrenheit (F) in the afternoon and was medicated with Tylenol to bring his temperature down. - 8/9/21, R1 had a fever of 99.3 degrees F and was again medicated with Tylenol. R1 went to the dining room for his breakfast, where he became unresponsive at the breakfast table. R1 had low blood pressure and his O2 sats decreased to 78 percent on room air. R1 was transferred to the emergency room for evaluation, where he tested positive for COVID-19. R1's medical record lacked evidence R1 was immediately quarantined and TBP after displaying symptoms of COVID-19 on 8/8/21, or when R1's roommate R5 began displaying symptoms of COVID-19 on 8/7/21. R2's undated face sheet identified R2 was 89 years old. Diagnoses included kidney disease, Diabetes Mellitus, failure to thrive and weight loss. R2's medical record indicated R2 was not vaccinated for COVID-19. R2's progress notes identified the following: - 8/9/21, R2 had a fever of 99.6 degrees Fahrenheit, was coughing and complained of body aches. - 8/10/21, R2's O2 sats decreased to 94 percent and R2 had a cough. - 8/11/21, a COVID-19 test was obtained and R2 tested positive for COVID-19. - 8/17/21, R2 was admitted to the hospital where R2 expired.	F 880	Consultant to finalize the RCA and corrective action plan. " Staff follow up conversations have been completed for RN A, LPN B, and NA A.NA G to confirm their understanding of their responsibilities for illness reporting. " Residents and resident representatives have received education on the facilities infection prevention control program. Facility has implemented the following monitoring practices to ensure the deficient practice is being corrected and will not reoccur: " DON/designee will audit progress notes daily to ensure residents displaying symptoms consistent with COVID-19 are isolated/quarantined per protocol and testing for COVID-19 is completed as indicated. " DON/designee will verify resident location daily to ensure TBP are appropriately implemented for affected residents. Facility will decrease frequency of audits as compliance for TBP is achieved. Audit results will be reviewed by QAPI monthly for continued need to audit " DON/designee will conduct audits of donning/doffing PPE with TBP on all shifts four times weekly x 1 week, then twice weekly for one week until 100% compliance is met for staff, visitors, and residents. Audit results will be reviewed by QAPI monthly for continued need to audit. " DON/designee will conduct audits 3 times weekly on aerosolized generating procedures to ensure proper PPE is in	

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F 880	Continued From page 9 R2's medical record lacked evidence R2 was immediately quarantined and TBP initiated after displaying symptoms on 8/9/21. R3's undated face sheet identified R3 was 89 years old. Diagnoses included peripheral vascular disease, osteoarthritis and history of malignant neoplasm of breast. R3's medical record identified R3 was not vaccinated for COVID-19. R3's progress notes identified the following: - 8/13/21, R3 tested positive for COVID-19. - 8/14/21, R3's O2 sats were fluctuating in the 70 percent range. - 8/15/21, R3 had a fever of 102.2 degrees F. and later expired at the facility. R4's undated face sheet identified R4 was 81 years old. Diagnoses included pulmonary embolism, and Diabetes Mellitus. R4's medical record indicated R4 was not vaccinated for COVID-19. R4's progress notes identified the following: - 8/10/21, R4 was tested for COVID-19 with negative results and remained on the active COVID unit of the facility. - 8/12/21, R4 was tested for COVID-19 with negative results and remained on the active COVID unit of the facility. - 8/14/21, R4 had a fever of 99.6 degrees F. and R4's O2 sats decreased to 93 percent. Further R4 complained of discomfort and sore throat. - 8/15/21, R4 had a cough and complained of sore throat. - 8/16/21, R4 was tested for COVID-19 with positive results. - 8/25/21, R4 was hospitalized for respiratory symptoms related to COVID-19 and remained hospitalized. R4's medical record lacked evidence R4 was	F 880	use. Audit results will be reviewed by QAPI monthly for continued need to audit. " DON/designee will audit daily screening (signs and symptoms including vital signs out of range) for all residents daily x 7 days, then a sample of residents daily x 7 days, then daily until 100% compliance is met. Audit results will be reviewed at QAPI monthly for continued need to audit. " DON/designee will audit staff and visitor screening logs on all shifts daily x 7 days, then 4 times weekly x 7 days, then twice weekly x 7 days, and biweekly thereafter until 100% compliance is achieved to ensure return to work criteria is being followed for all staff who enter the facility. Audit results will be reviewed at QAPI monthly for continued need. " Weekly risk assessments will be reviewed by QAPI monthly to assure testing plan is in place. " Facility will decrease frequency of audits as compliance for TBD meets 100% compliance. All audit results will be reviewed by QAPI monthly for need to continue audits.	

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F 880	Continued From page 10	F 880		

immediately quarantined and TBP initiated after displaying COVID-19 signs and symptoms on 8/14/21, and remained on the COVID-19 unit without transmission based precautions initiated.

R6's undated face sheet identified R6 was 85 years old. Diagnoses included Diabetes Mellitus, heart disease and kidney disease. R6's medical record indicated R6 was fully vaccinated for COVID-19.
R6's progress notes identified the following:
- 8/10/21, R6 complained of pain and headache.
- 8/11/21, R6 complained of feeling freezing cold. R6 had a cough, body aches and hoarse voice. R6's temp was 101.4 degrees F. and R6's O2 sats decreased to 92 percent. R6 later left the facility to an orthotic appointment to be fitted for shoes, while having symptoms of COVID-19.
- 8/12/21, R6 was tested for COVID-19 with positive results.
R6's medical record lacked evidence R6 was immediately quarantined and TBP initiated after displaying COVID-19 symptoms on 8/10/21.

R15's undated face sheet identified R15 was 71 years old. Diagnoses included multiple sclerosis, kidney failure, and heart failure. R15's medical record identified R15 was fully vaccinated for COVID-19.
R15's progress note(s) dated 8/16/21, identified R15 developed a fever of 101.2 degrees F, had shortness of breath and R15's O2 sats decreased to 87-89 percent. R15 was tested for COVID-19 with positive results and was hospitalized for pneumonia due to COVID-19.

R9's undated face sheet identified R9 was 84 years of age. Diagnoses included heart failure, kidney disease and Diabetes Mellitus. R9's

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F 880	Continued From page 11	F 880		

medical record indicated R9 was fully vaccinated for COVID-19.
R9's progress notes identified the following:
- 8/12/21, R9 had a cough and increase confusion.
- 8/13/21, R9 tested for COVID-19 with positive results.
R9's medical record lacked evidence R9 was immediately quarantined and TBP initiated after displaying COVID-19 signs and symptoms on 8/12/21.

R10's undated face sheet identified R10 was 86 years old. Diagnoses included heart failure, systemic lupus, and chronic pulmonary embolism. R10's medical record identified R10 was full vaccinated for COVID-19.
R10's progress notes identified the following:
- 8/12/21, R10 had increased coughing episodes and was lethargic (sleepy or fatigued and sluggish).
- 8/13/21, R10 tested for COVID-19 with positive results.
R10's medical record lacked evidence R10 was immediately quarantined and TBP initiated after displaying COVID-19 signs and symptoms on 8/12/21.

R7's undated face sheet identified R7 was 73 years old. Diagnoses included malignant neoplasm of prostate and bone, heart failure, and Diabetes Mellitus. R7's medical record indicated R7 was fully vaccinated for COVID-19. R7's progress note(s) dated 8/11/21, identified R7 had a cough and tested positive for COVID-19.

R11's undated face sheet identified R11 was 87 years old. Diagnoses included kidney disease and Diabetes Mellitus. R11 medical record

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F 880	Continued From page 12	F 880		

identified R11 was fully vaccinated for COVID-19. R11's progress note dated 8/11/21, identified R11 tested positive for COVID-19.

R12's undated face sheet identified R12 was 96 years old. Diagnoses included heart disease, and malignant neoplasm of prostate. R12's medical record identified R12 was fully vaccinated for COVID-19.
R12's progress note dated 8/11/21, identified R12 tested positive for COVID-19.

R14's undated face sheet identified R14 was 76 years old. Diagnoses included septic pulmonary embolism, heart failure, Diabetes Mellitus and kidney disease. R14's medical record identified R14 was fully vaccinated for COVID-19. R14's progress note dated 8/11/21, identified R14 tested positive for COVID-19.

R8's undated face sheet identified R8 was 82 years of age. Diagnoses included heart disease, kidney disease and Diabetes Mellitus. R8's medical record indicated R8 was fully vaccinated for COVID-19.
R8's progress noted dated 8/13/21, identified R8 tested positive for COVID-19 on 8/12/21.

R16's undated face sheet identified R16 was 92 years old. Diagnoses included transient ischemic attack and cerebral infarct. R16's medical record identified R16 was fully vaccinated for COVID-19. R16's progress note dated 8/19/21, identified R16 tested positive for COVID-19.

During interview on 8/26/21, at 11:31 p.m. RN-B stated she was not sure when residents were quarantined and moved to the COVID-19 unit as she was out of the facility until a few days ago.

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F 880	Continued From page 13	F 880		

RN-B was aware many residents tested positive for COVID-19 when the facility initiated outbreak testing.

On 8/30/21, at 10:57 a.m. the administrator stated the facility started to do twice a day COVID-19 symptom monitoring after R1 tested positive for COVID-19. Any resident who exhibited symptoms of COVID-19 such as cough, diarrhea or any COVID-19 symptoms would be rapid tested. The administrator indicated residents should have been placed in quarantine and tested when first displaying signs and symptoms of COVID-19. She felt the nurses may have become complacent with the low community spread of COVID-19 and would administer Tylenol to treat the residents symptom of fever, instead of thinking potential COVID-19 symptoms.

On 8/30/21, at 4:15 p.m. LPN-A stated she checked R1's temperature on 8/8/21, and it was elevated at 100.4 degrees F. R1 complained of cough and runny nose, but LPN-A stated she felt a cough and runny nose were not symptoms of COVID-19. LPN-A did not place R1 in quarantine on transmission based precautions pending a COVID-19 test. Further, R1 went to the dining room for supper the evening of 8/9/21, and was not quarantined from other residents. LPN-A stated if a resident became ill on her shift, she would assess them, if LPN-A could not bring the temperature down with Tylenol or symptoms were severe, she would either notify the physician or send the resident to the emergency room. LPN-A had never initiated transmission-based precautions for any resident and did not know the process for testing a resident for COVID-19.

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 _____	C 08/31/2021

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ESSENTIA HEALTH - HOMESTEAD	**115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636**

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F 880	Continued From page 14 On 8/30/21, at 5:47 p.m. an interview was conducted with the DON and RN-B. It was not the facility's practice to quarantine, initiate TBP and test residents for COVID-19 unless there was a strong suspicion of COVID-19 or a cluster of symptoms. The facility would not conduct testing unless the resident had one or two severe symptoms that lasted more than 24 hours. The facility's practice prior to their outbreak on 8/10/21, was to administer Tylenol for a fever or headache and cough syrup for a resident with a cough. The facility was not placing residents on quarantine and initiating transmission based precautions when residents were displaying potential COVID-19 symptoms such as a fever or cough until after receiving a diagnosis of COVID-19. The undated facility policy Essentia Health Long Term Care (SNF/AL) Infection Prevention Interim Policy for Guidance during Pandemic and Suspected or Confirmed Coronavirus (COVID-19), identified prompt detection, triage and isolation of potentially infected residents was required. A resident with known or suspected COVID-19 , immediate infection prevention and control measures need to be put in to place. Residents should have contact and droplet precautions intiated. The policy had several links embedded into the document; however, did not identify symptoms of COVID-19 and when to quarantine and intiate TBP, until testing could be completed. Symptomatic Staff: The Centers for Medicare and Medicaid (CMS) Quality Safety and Oversite (QSO) memo	F 880		

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F 880	Continued From page 15 QSO-20-38-NH revised 4/27/21, directed staff with symptoms or signs of COVID-19, vaccinated or not vaccinated, must be tested immediately and are expected to be restricted from the facility pending the results of COVID-19 testing. If COVID-19 is confirmed, staff should follow Centers for Disease Control and Prevention (CDC) guidelines "Criteria for Return to Work for Healthcare Personnel with SARSCoV2 Infection." The CDC guidance Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 updated 11/23/20, indicated healthcare personnel (HCP) "with even mild symptoms of COVID-19 should be prioritized for viral testing with approved nucleic acid or antigen detection assays. When a clinician decides that testing a person for SARS-CoV-2 is indicated, negative results from at least one FDA Emergency Use Authorized COVID-19 viral test indicates that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected. A second test for SARS-CoV-2 RNA may be performed at the discretion of the evaluating clinician, particularly when a higher level of clinical suspicion for SARS-CoV-2 infection exists. If the second test is positive, consultation with an infectious disease expert should be considered to resolve the discrepant results. For healthcare personnel who were suspected of having COVID-19 but following evaluation another diagnosis is suspected or confirmed, return to work decisions should be based on their other suspected or confirmed diagnoses.A symptom-based strategy for determining when HCP with SARS-CoV-2 infection could return to work is preferred in most clinical situations."	F 880		

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F 880	Continued From page 16 - The criteria for the symptom-based strategy are: HCP with mild to moderate illness who are not moderately to severely immunocompromised: - At least 10 days have passed since symptoms first appeared and - At least 24 hours have passed since last fever without the use of fever-reducing medications and - Symptoms (e.g., cough, shortness of breath) have improved - HCP who were asymptomatic throughout their infection and are not moderately to severely immunocompromised: -At least 10 days have passed since the date of their first positive viral diagnostic test. - HCP with severe to critical illness or who are moderately to severely immunocompromised: - At least 10 days and up to 20 days have passed since symptoms first appeared and - At least 24 hours have passed since last fever without the use of fever-reducing medications and - Symptoms (e.g., cough, shortness of breath) have improved - Consider consultation with infection control experts During interview on 8/26/21, at 2:33 p.m. the DON stated she was responsible for COVID-19 routine and outbreak testing for staff and residents, but registered nurse (RN)-B was taking over the infection prevention program overall. The facility conducted routine COVID-19 staff testing on 7/19/21, and had no positive results. However, R1 was the first resident who tested positive, when R1 was transferred to the emergency department on 8/9/21. Additionally, two nurses called-in ill on 8/9/21, and were instructed to get	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 17	F 880		

tested as well due to a high-risk exposure. Both nurses tested, and the test results were positive. On 8/10/21, the facility began outbreak testing of all vaccinated and unvaccinated residents and staff that entered the nursing home unit.

On 8/27/21, at 10:47 a.m. the outbreak testing rosters, county positivity rate and staff work schedules dated 8/2/21 to 8/27/21, were reviewed with the DON who stated the facility had approximately twenty staff members and nine of those were positive for COVID-19; however, some staff met the CDC criteria to return to work. The DON identified the facility process for a confirmed COVID-19 staff member as: the staff member was removed from the work schedule and the staff member was instructed to call an offsite corporate workability call center for determination of work status. Once a workability assessment was completed, the DON received the staff member's workability form which identified the date the staff member was allowed to return to work. Additionally, if a staff member reported symptoms of COVID-19, the staff member was instructed to call an offsite corporate workability call center. An assessment was conducted and a COVID-19 test was obtained. The staff member was not allowed to work until instructed. The following was reviewed with the DON:

- LPN-B's COVID Employee Tracking (workability) form dated 8/11/21, indicated the following:
  - -Date of COVID-19 positive test: 8/11/21
  - -Employee symptom onset: 8/7/21
  - -Last day worked: 8/10/21
  - -Work restrictions start date: 8/7/21
  - -Work restriction end date: 8/17/21

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	245428	A. BUILDING _____ B. WING _____	C 08/31/2021

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F 880	Continued From page 18 -Return to work date: 8/18/21 - LPN-B's SARS-CoV-2 RNA (COVID-19), Molecular Detection laboratory report dated 8/10/21, identified the test was positive for COVID-19. The specimen was collected 8/10/21 and results were identified on 8/11/21. - LPN-B's workability form dated 8/11/21, indicated LPN-B returned to work on 8/18/21, and LPN-B reported she was symptomatic on 8/7/21. During interview on 8/26/21 at 2:33 p.m., the DON stated she was unaware LPN-B reported symptoms beginning 8/7/21; however, LPN-B's onsite daily active screenings dated 8/7/21, 8/8/21 and 8/9/21, indicated LPN-B reported no symptoms nor had displayed any fever. According to the facility schedules LPN-B worked in the facility on 8/7/21, 8/8/21 and 8/9/21 and was not removed from work until she tested positive on 8/11/21. During interview on 8/27/21, at 2:57 p.m. LPN-B stated she tested positive for COVID-19 on 8/10/21, during outbreak testing. LPN-B worked on 8/7/21 and 8/8/21, but was unsure if she worked 8/9/21. When LPN-B spoke with "workability", she told them her symptoms started on 8/7/21, when she had a "sore throat, sniffles and a weird cough"; therefore, workability told LPN-B she was able to return to work on 8/18/21. Further, LPN-B answered no to all screening questions, indicating she had no signs or symptoms of COVID-19, prior to all her shifts because she could not tell if it was allergies or not. Further "workability" told her that was "perfectly ok" that she did not report her symptoms earlier.	F 880		

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F 880	Continued From page 19	F 880		

On 8/27/21, at 3:03 p.m. the offsite corporate workability phone line was called and the staff member who answered the call declined to identify herself. She stated all staff were educated on the signs/symptoms of COVID-19 and were to report any symptoms. All symptomatic staff were to be tested prior to returning to work even if the staff member was unsure if the symptoms were related to allergies. Symptomatic staff were instructed to call ahead for testing prior to working their shift and not report to work even if testing was required daily. If positive, staff were instructed to isolate at home for ten to twenty days depending on the individual situation. Symptomatic individuals were instructed to quarantine at home for fourteen days depending on the individual situation.

During interview on 8/30/21, at 9:41 a.m. LPN-C stated all staff must screen themselves upon entry to the building at the front door. Their temperature was taken and the staff answered screening questions and, based on their answers, they were allowed entry. Staff were not allowed to work if they were symptomatic and were instructed to contact workability. Additionally, any symptoms including "sniffles" must be addressed by workability before the staff member was allowed to work.

During interview on 8/30/21, at 10:55 a.m. RN-F stated she was collecting staff test samples that day. However, staff were screened prior to entry into the building. The Health Unit Coordinator (HUC) or the charge nurse obtained the staff member's temperature and the staff member self answered the screening questions by filling out the screening tracking form. If a staff member reported symptoms, the HUC would have the

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F 880	Continued From page 20	F 880		

charge nurse assess the staff member and the staff member would be instructed to call workability. However, RN-F stated symptoms would need to be new onset. For example, if a staff member had allergies, they would have symptoms all the time. If there was any doubt, the staff member called workability. Additionally, the staff member was instructed to go home until they were instructed to return to work.

During interview on 8/30/21, at 10:25 a.m. the administrator stated any staff member who exhibited symptoms during onsite daily screening or tested positive for COVID-19 during routine or outbreak testing were instructed to contact workability. During the workability call, the staff member was assessed for symptoms and was removed from the work schedule for at least 10 days "no matter what"; however, some staff were kept away longer if they continued to exhibit symptoms or if there were other health considerations. The workability forms were then emailed to the staff member's supervisor. For the nursing home, the nursing staff workability forms were sent to the DON, while ancillary departments which serviced the nursing home such as laundry, dietary, or maintenance were departments of the hospital and received their own workability forms. Therefore, no one in the nursing home reviewed all workability forms for employee's reporting symptoms or return to work status. For example, the administrator stated, in the spring months, she tested negative for COVID but was instructed to stay home from work for 14 days due to a cough and that was the process they should follow. Because of this, the process for staff to call workability applied to all reports of illness; however, the administrator was unsure of any process to ensure a staff member

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F 880	Continued From page 21	F 880		

called workability, "it's more of a verbal communication".

The facility Employee Call-in Book, identified the following call ins:

-7/22/21, NA-A called-in ill stating "I don't feel good, and I won't be in". No further symptoms were documented.
-8/2/21, RN-A called-in ill due to a headache. No further symptoms were documented, or information provided.
- 8/22/21, NA-G called-in ill due to headache. No further symptoms were documented, or information provided.

During interview on 8/30/21, at 11:24 a.m. the administrator stated no workability assessments were completed for the three staff members NA-A, RN-A and NA-G who called-in ill as identified by the Employee Call- In Book. Further, there was no follow up on their symptoms as required, to ensure the signs and symptoms were not COVID-19 related. NA-A returned to work on 7/23/21. RN-A returned to work on 8/3/21, and continued to work 8/7/21, 8/8/21, 8/9/21 and 8/10/21. On 8/10/21, RN-A was identified to test positive for COVID-19 during outbreak testing. NA-G returned to work on 8/23/21. Further, all three staff members should have called the workability call center for an assessment to determine their work status prior to reporting for work.

On 8/30/21, at 2:00 p.m. the medical laboratory supervisor (MLS) stated the facility procedure to call workability applied to any staff member who missed shifts due to illness; however, if the call in was related to a possible COVID-19 symptom the

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F 880	Continued From page 22	F 880		

staff needed to be tested the day they called in or at least before they returned to work. Further, if a staff member had not called workability and had returned to work, they would be instructed to call, and a rapid test would be obtained.

On 8/30/21, at 2:25 p.m. NA-A stated she had called in on 7/22/21, due to a fever and sore throat but she didn't call the corporate workability call center. Instead, she went to Walgreens and purchased a "quick test" on her own, which she reported was negative. NA-A stated she sent a photo of the negative test to the DON and returned to work on 7/23/21. During the interview NA-A removed her eye protection and rubbed her eyes with her hand. NA-A' s face was flushed, and her eyes and surrounding skin were reddened and irritated. NA-A stated she had nasal congestion, and had mattery eyes and spoke in a harsh voice. NA-A stated she had allergies. However, she answered no to all the screening questions prior to her shift even though she was instructed these were possible symptoms of COVID-19. NA-A stated "I should have answered yes" on the screening questions but stated the nurses were aware of her symptoms and instructed her to keep her mask on.

-At 2:35 p.m. RN-A and licensed practical nurse (LPN)-C were notified by the survey team of the need to assess NA-A because she was displaying symptoms of possibly COVID-19. RN-A and LPN-C stated they were unaware of NA-A having symptoms; however, RN-A turned to LPN-C and stated, "if it's only allergies", but LPN-C replied any staff member who was showing symptoms should be pulled from the floor and the DON should be notified. Further, NA-A was tested

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F 880	Continued From page 23	F 880		

during outbreak testing, but those results would not be available for possibly two days and NA-A required a negative rapid test to return to work.

-At 2:37 p.m. RN-A called the DON to notify of NA-A's symptoms. RN-A did not assess or speak with NA-A prior to the call. NA-A was instructed to go to the DON's office.

-At 2:38 p.m. NA-A left the unit and met the DON in the administrative hallway. NA-A was instructed to take a seat in the beauty shop where testing was conducted. NA-A sat in the beauty chair, removed her eye protection and surgical mask, but continued to wear an N95.

-At 3:06 p.m. the DON instructed NA-A to go home because the lab was able to use the previously collected swab to conduct a rapid PCR test. The results were expected to be available in approximately one hour, but NA-A was instructed to not return to the facility until she was notified to do so.

During interview on 8/30/21, at 3:09 p.m. the DON stated she was unable to recall if NA-A sent her photos of a non-facility test on 7/22/21. Additionally, the health unit coordinator (HUC) screened NA-A for symptoms prior to her shift on 8/30/21, and NA-A responded no to all the questions regarding symptoms, even though she had congestion, itchy watery eyes, and harsh voice, but the DON "assumed she had allergies". When asked if a nurse would be notified to assess a symptomatic staff member during the screening process, the DON shrugged her shoulders and stated the HUC asked the questions, and the staff responded. Upon review of the facility policy regarding symptomatic staff

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F 880	Continued From page 24	F 880		

members, the DON stated symptomatic staff members should be tested; however, the symptoms of COVID-19 were not listed. At that time, the DON stated hindsight was always 20/20. NA-A was working double shifts and may have been exposed to COVID-19; however, NA-A did not disclose any symptoms during her screening. Further, the nurses were expected to evaluate any staff member showing potential symptoms of COVID-19 and any staff member reporting symptoms or called-in ill for any reason were directed to call workability to receive clearance to return to work.

The undated facility policy Essentia Health Long Term Care (SNF/AL) Infection Prevention Interim Policy for Guidance during Pandemic andSuspected or Confirmed Coronavirus (COVID-19), indicated the facility would identify employees, and actively screen and restrict them appropriately to ensure they did not place individuals in the facility at risk for COVID-19. The Infection Preventionist would identify exposures that would warrant restricting symptomatic employees from working based upon MDH and CDC guidance for exposures. The policy further indicated the facility would follow MDH COVID-19 recommendations for healthcare workers (HCW) updated 5/10/21 to include fully vaccinated HCW and unvaccinated HCW for returning to work and facility HCW would instruct HCW on the return-to-work process.

The IJ was removed on 8/31/21, at 5:15 p.m. when it could be verified through observation, interview and document review the facility implemented the following: The facility reviewed and reviewed their policies and procedures according to the CDC guidance; educated all staff

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F 880	Continued From page 25 regarding recognizing symptoms of COVID-19, when to report symptoms, and when to get tested; residents who exhibited any one symptom of COVID-19 illness were quarantined until COVID-19 could be confirmed or ruled out.; Educated the nurses on when to quarantine and initiate TBP for residents; Implemented a plan for the DON/designee to review the staff screening logs daily and the staff call ins for accuracy and to verify a workability assessment was conducted per facility policy.	F 880		
F 886 SS=L	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;	F 886		10/5/21

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F 886	Continued From page 26 (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure all staff	F 886	F886	

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F 886	Continued From page 27 completing self testing were trained and competency tested to ensure COVID-19 outbreak and routine testing was completed according to manufacturers testing instructions. This deficient practice resulted in an immediate jeopardy (IJ) situation which had the high likelihood to cause serious illness and/or death to all residents residing in the facility during the COVID-19 Focused Infection Control Survey; including 17 of 21 residents (R17, R5, R1, R2, R3, R4, R6, R15, R9, R10, R7, R11, R12, R14, R8, R16) residents who contracted COVID-19. This resulted in actual harm to R2, R3 and R5 who expired with COVID-19 and R4 and R15 who were hospitalized with COVID-19. In addition, the facility failed to ensure testing rosters were organized and tracked in real time; failed to increase testing frequency of unvaccinated staff per the Centers for Disease Control (CDC) county positivity rate. This had the potential to effect all residents residing in the facility along with staff and visitors. The IJ began on 8/27/21, when activity director (AD)-A and nursing assistant (NA)-A were observed to complete COVID-19 tests in a manner not consistent with manufacturers recommendations. In addition, the facility failed to ensure all staff responsible for testing were trained and competency tested per manufacturers recommendation to ensure accurate testing. The administrator, director of nursing (DON) and registered nurse (RN)-B were notified of the IJ on 8/27/21, at 4:35 p.m. The IJ was removed on 8/30/21, at 10:15 a.m. but noncompliance remained at the lower scope and severity level of F, widespread, which indicated no actual harm with potential for more than minimal harm that was not immediate jeopardy.	F 886	All residents and others with underlying conditions are at risk of suffering a serious adverse outcome if swab collection for COVID-19 testing is not obtained in the proper manner to prevent false or inconclusive test results. • The lab protocol for obtaining nasal swab sample has been reviewed by the lab supervisor and DON. • Swab collection train the trainer and return competency demonstration of a designated 1 RN and 1 LPN. was completed by the lab supervisor on 8/30/21. The trained RN trained the facilities IP who trained, and competency tested the remainder of the RN's and LPN's. The competencies were 100% completed 9-21-21 • All staff entering the facility prior to working have been educated on the testing procedure/swab collections by RN Supervisor. • Staff refusing to COVID test will be removed from the schedule and must have a documented negative test result prior to entering the facility. • Postings indicating the proper procedure for nasal swabbing are posted in the testing area. • Standard work for nasal swabbing for COVID testing was reviewed by lab director and System Essentia Health IP for use to educate and complete competency documentation. Competencies were complete 9-17-21. • DON/designee will track testing roster	

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F 886	Continued From page 28 Findings include: The CDC guidance People with Certain Medical Conditions dated 5/13/21, identified older adults were more likely to get seriously ill from COVID-19. More than 80 percent of COVID-19 deaths have occurred in people over the age of 65, and more than 95 percent of COVID-19 deaths have occurred in people older than 45. Further, among adults, the risk for severe illness from COVID-19 increases with age, with older adults at highest risk. Severe illness means that the person with COVID-19 may require hospitalization, intensive care, or a ventilator to help them breathe, or they may even die. STAFF TESTING: The CDC guidance Interim Guidelines for Collecting and Handling of Clinical Specimens for COVID-19 Testing dated 2/26/21, identified proper specimen collection was the most important step in the laboratory diagnosis of infectious diseases. A specimen not collected correctly may lead to false or inconclusive test results. During interview on 8/27/21, at 11:15 a.m. the administrator stated the facility entered outbreak testing frequency on 8/9/21, when a R1 tested positive for COVID-19. In addition, two staff members called in ill on 8/9/21, with symptoms of COVID-19. The staff members were directed to get tested for COVID-19 and both tested positive. The DON identified 98 percent of the facility residents and 58% of the facility staff were fully vaccinated against COVID-19. Currently nine residents were positive for COVID-19 in the	F 886	following scheduled testing to ensure all staff have completed testing as required. Staff that are non-compliant will be removed from the schedule until a negative test result is provided. Findings will be reviewed at QAPI monthly. • The Essentia Health system wide testing plan was updated to include when increased frequency of testing will be completed within the calendar week. Facility completes a risk assessment weekly on Wednesdays to identify testing of staff frequency utilizing county transmission rates. Testing will be completed on all unvaccinated staff weekly if rates are moderate, and on all unvaccinated staff twice weekly if rates are substantial or high. • Community Transmission rates will be tracked weekly on Wednesday utilizing the CDC Data Tracker which determines the transmission rate for the county and identifies the frequency for testing of unvaccinated staff. Increased testing frequency will be completed within the calendar week of the increase for all unvaccinated staff. • COVID-19 test results will be reviewed and entered on the facility testing log by DON/designee when returned. • Audits are completed twice weekly for 4 weeks of the swabbing process and documented. • Weekly risk assessments will be reviewed by QAPI monthly to assure testing plan is in place • Audits are completed twice weekly for	

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	245428	A. BUILDING _____ B. WING _____	C 08/31/2021

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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 886	Continued From page 29 facility, three residents expired, and three residents were currently hospitalized for COVID-19. R17's discharge Minimum Data Set (MDS) dated 8/23/21, identified R17 was 82 years old. Diagnoses included respiratory disease, heart disease and diabetes mellitus. R17's medical record identified R17 was fully vaccinated. R17's progress notes dated 8/10/21, identified R17 complained of body aches, headache and cough. R17 tested positive for COVID-19. R5's undated face sheet identified R5 was 73 years old. Diagnoses included lymphoma, malignant neoplasm of bladder, chronic obstructive pulmonary disease (COPD) and chronic kidney disease. R5's medical record identified R5 was fully vaccinated. R5's progress notes identified the following: - 8/11/21, R5 tested positive for COVID-19 - 8/23/21, identified R5 expired at the facility. R1's undated face sheet identified R1 was 85 years old. Diagnoses included Parkinson's disease, heart disease, and chronic obstructive pulmonary disease (COPD). Further, it was identified R1 was roommates with R5. R1's medical record indicated R1 was fully vaccinated. R1's progress notes dated 8/9/21, identified R1 had a fever of 99.3 degrees F and was again medicated with Tylenol. R1 went to the dining room for his breakfast, where he became unresponsive at the breakfast table. R1 had low blood pressure and his oxygen saturation level decreased to 78 percent on room air. R1 was transferred to the emergency room for evaluation, where he tested positive for COVID-19.	F 886	4 weeks of the staff testing roster to ensure everyone working was tested • Findings will be reviewed at QAPI monthly. The date that each deficiency will be corrected. 10/5/21	

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 _____	C 08/31/2021

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

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F 886	Continued From page 30	F 886		

R2's undated face sheet identified R2 was 89 years old. Diagnoses included kidney disease, diabetes mellitus, failure to thrive and weight loss. R2's medical record indicated R2 was not vaccinated for COVID-19. R2's progress notes identified the following: - 8/11/21, a COVID-19 test was obtained and R2 tested positive for COVID-19. - 8/17/21, R2 was admitted to the hospital where R2 expired.

R3's undated face sheet identified R3 was 89 years old. Diagnoses included peripheral vascular disease, and history of malignant neoplasm of breast. R3's medical record identified R3 was not vaccinated for COVID-19. R3's progress notes identified the following: - 8/13/21, R3 tested positive for COVID-19. - 8/15/21, R3 had a fever of 102.2 degrees F. and later expired at the facility.

R4's undated face sheet identified R4 was 81 years old. Diagnoses included pulmonary embolism, and diabetes mellitus. R4's medical record indicated R4 was not vaccinated for COVID-19. R4's progress notes identified the following: - 8/16/21, R4 was tested for COVID-19 with positive results.
- 8/25/21, R4 was hospitalized for respiratory symptoms related to COVID-19 and remained hospitalized.

R6's undated face sheet identified R6 was 85 years old. Diagnoses included diabetes mellitus, heart disease and kidney disease. R6's medical record indicated R6 was fully vaccinated for COVID-19.
R6's progress notes identified the following:- 8/11/21, R6 complained of feeling freezing cold. R6 had a cough, body aches and hoarse voice.

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 _____	C 08/31/2021

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

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F 886	Continued From page 31	F 886		

R6's temp was 101.4 degrees F. and R6's O2 sats decreased to 92 percent. R6 later left the facility to an orthotic appointment to be fitted for shoes, while having symptoms of COVID-19. - 8/12/21, R6 was tested for COVID-19 with positive results.

R15's undated face sheet identified R15 was 71 years old. Diagnoses included multiple sclerosis, kidney failure, and heart failure. R15's medical record identified R15 was fully vaccinated for COVID-19.
R15's progress note(s) dated 8/16/21, identified R15 developed a fever of 101.2 degrees F, had shortness of breath and R15's O2 sats decreased to 87-89 percent. R15 was tested for COVID-19 with positive results and was hospitalized for pneumonia due to COVID-19.

R9's undated face sheet identified R9 was 84 years of age. Diagnoses included heart failure, kidney disease and diabetes mellitus. R9's medical record indicated R9 was fully vaccinated for COVID-19.
R9's progress notes identified the following: - 8/12/21, R9 had a cough and increase confusion.- 8/13/21, R9 tested for COVID-19 with positive results.

R10's undated face sheet identified R10 was 86 years old. Diagnoses included heart failure, systemic lupus, and chronic pulmonary embolism. R10's medical record identified R10 was full vaccinated for COVID-19. R10's progress notes identified the following: - 8/12/21, R10 had increased coughing episodes and was lethargic (sleepy or fatigued and sluggish). - 8/13/21, R10 tested for COVID-19 with positive results.

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 _____	C 08/31/2021

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 886	Continued From page 32	F 886		

R7's undated face sheet identified R7 was 73 years old. Diagnoses included malignant neoplasm of prostate and bone, heart failure, and diabetes mellitus. R7's medical record indicated R7 was fully vaccinated for COVID-19. R7's progress note(s) dated 8/11/21, identified R7 had a cough and tested positive for COVID-19.

R11's undated face sheet identified R11 was 87 years old. Diagnoses included kidney disease and diabetes mellitus. R11 medical record identified R11 was fully vaccinated for COVID-19. R11's progress note dated 8/11/21, identified R11 tested positive for COVID-19.

R12's undated face sheet identified R12 was 96 years old. Diagnoses included heart disease, and malignant neoplasm of prostate. R12's medical record identified R12 was fully vaccinated for COVID-19.
R12's progress note dated 8/11/21, identified R12 tested positive for COVID-19.

R14's undated face sheet identified R14 was 76 years old. Diagnoses included septic pulmonary embolism, heart failure, diabetes mellitus and kidney disease. R14's medical record identified R14 was fully vaccinated for COVID-19. R14's progress note dated 8/11/21, identified R14 tested positive for COVID-19.

R8's undated face sheet identified R8 was 82 years of age. Diagnoses included heart disease, kidney disease and diabetes mellitus. R8's medical record indicated R8 was fully vaccinated for COVID-19.
R8's progress noted dated 8/13/21, identified R8 tested positive for COVID-19 on 8/12/21.

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 _____	C 08/31/2021

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 886	Continued From page 33	F 886		

R16's undated face sheet identified R16 was 92 years old. Diagnoses included transient ischemic attack and cerebral infarct. R16's medical record identified R16 was fully vaccinated for COVID-19. R16's progress note dated 8/19/21, identified R16 tested positive for COVID-19.

During observation on 8/27/21, at 2:18 p.m. AD-A entered the facility COVID-19 testing area, opened a testing vial and put her label on the vial, identifying the test sample was hers. AD-A did not complete hand hygiene prior to testing. AD-A inserted the wooden, long stemmed, cotton swab into their right nostril and swirled the swab in her nostril for 30 seconds, then placed the swab into the labeled vial. AD-A did not swab the other nostril. AD-A placed the cap on the vial and placed the vial into a biohazard bag. AD-A exited the room and delivered the sample to the attached hospital laboratory for processing. AD-A did not complete hand hygiene after testing or prior to delivering her sample to the laboratory.

When interviewed on 8/27/21, at 2:28 p.m. AD-A stated RN-D showed her how to do the COVID-19 test. AD-A only tested one nostril, as the current practice in the facility was to swab only one nostril and not both. Further, AD-A stated she did not complete hand hygiene prior or after self testing for COVID-19.

During observation on 8/27/21, at 2:56 p.m. NA-A entered the facility COVID-19 testing area, opened a testing vial and a wooden, long stemmed, cotton swab without completing hand hygiene. NA-A swabbed her right nostril for ten seconds, swirling it three or four times inside her nostril, placed the swab into the vial and closed the lid. NA-A failed to swab the other nostril.

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 _____	C 08/31/2021

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 886	Continued From page 34	F 886		

NA-A wrote her name, date and time on the adhesive label and attached it to the vial. NA-A exited the testing area with her sample and hand delivered the sample to the attached hospital laboratory without completing hand hygiene.

When interviewed on 8/27/21, at 3:05 p.m. NA-A stated she knew how to perform the COVID-19 test from having been swabbed numerous times since the COVID-19 pandemic started. The facility started out having someone else perform the test, but the staff were asked to self test soon after the pandemic began. NA-A stared she did not complete hand hygiene prior or after self testing for COVID-19.

During interview on 8/27/21, at 10:28 a.m. dietary aide (DA)-A stated she tested herself for COVID-19 at the nursing facility test area. Further, DA-A was never trained on the procedure. DA-A just "stuck the swab in her nose and stirred it around a few times and put it into the container", then walked the sample over to the hospital laboratory to be processed.

During interview on 8/27/21, at 10:31 a.m. housekeeper (HK)-A stated she tested herself for COVID-19 at the nursing facility test area and was never trained on the procedure. HK-A stated she was tested by another person in the past, so she knew how to complete the test.

On 8/27/21, at 11:18 a.m. the health unit coordinator (HUC)-C stated she tested herself for COVID-19 in the nursing facility test area. HUC-C indicated she was trained by RN-D, who instructed her to insert the cotton swab into one nostril and to swirl it around for ten seconds. RN-D walked her through the procedure and

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 _____	C 08/31/2021

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 886	Continued From page 35	F 886		

watched her perform the test.

During interview on 8/27/21, at 11:21 a.m. activity aide (AA)-B stated she tested herself for COVID-19 in the nursing facility test area; however, was never trained on the testing procedure. AA-B knew how to perform the test from being tested in the past.

During interview on 8/27/21, at 11:24 a.m. dietary supervisor (DS)-F indicated the facility directed the dietary staff to self test for COVID-19 and bring their sample to the hospital laboratory for processing. One of the facility registered nurses instructed them on how to perform the test and to swab one nostril for fifteen seconds.

On 8/27/21, at 12:01 p.m. the environmental services supervisor (EVS)-E stated he thought staff were instructed on how to self test at some point but was not sure when. They were to insert the cotton swab into their nostril, fairly deeply and swab it around for ten seconds and do the other nostril.

Facility staff COVID-19 testing training and competency tests were requested and not received.

During interview on 8/27/21, at 11:16 a.m. the administrator identified facility staff performed self testing for COVID-19. A laboratory employee trained one of the facility's registered nurses, who then taught the rest of the facility staff how to perform the test. The trained registered nurse left the facility after 4/16/21, and no longer worked at the facility. The administrator was unable to locate any documentation of any training and competency testing for self testing for COVID-19.

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 _____	C 08/31/2021

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 886	Continued From page 36	F 886		

When interviewed on 8/27/21, at 12:07 p.m. the medical laboratory supervisor (MLS) identified the procedure for obtaining a sample for a COVID-19 test included: insert the cotton swab just inside the nostril and to swirl it about for fifteen seconds and to repeat on the other nostril with the same swab. MLS was aware the facility staff were self testing; however, the laboratory personnel had not trained the facility staff. MLS indicated the test was only as good as the specimen collected, so there was always a chance the test was not performed correctly and could have inaccurate results.

The hospital laboratory procedure How To Collect Your Anterior Nasal Swab Sample For COVID-19 Testing dated 7/12/20, directed the tester to use hand sanitizer, remove the swab and insert the swab into nostril no more than a half an inch. Slowly twist the swab, rubbing it along the insides of your nostril for fifteen seconds and using the same swab, repeat in the other nostril. Place swab in the supplied vial and use hand sanitizer again. Place vial in a biohazard bag and give the bag to the laboratory. Use the hand sanitizer again.

The undated facility policy Essentia Health Long Term Care (SNF/AL) Infection Prevention Interim Policy for Guidance during Pandemic and Suspected or Confirmed Coronavirus (COVID-19), did not identify the process for obtaining COVID-19 testing.

The Minnesota Department of Health (MDH) guidance COVID-19 Specimen Collection for Point Prevalance Survey (PPS) dated 6/24/20, indicated health care providers and other

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 _____	C 08/31/2021

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 886	Continued From page 37	F 886		

medically trained staff could collect specimens for COVID-19 testing. Staff should be trained and competency evaluated by a registered nurse (RN) or other health care provider. Specimen collection and training should be conducted in accordance with the CDC: Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for COVID-19.

The IJ which began on 8/27/21, was removed on 8/30/21, at 10:15 a.m. when it could be verified through observation, interview and document review the facility : Stopped self testing immediately; MLS trained select facility nurses on obtaining COVID-19 tests until staff could be competency tested; Policies were reviewed and revised to reflect protocols for testing procedures to ensure all staff were tested for COVID-19 in a manner consistent with current standards of practice for conducting COVID-19 tests; Education was provided to all staff on current and updated COVID protocols for staff and would continue for continued outbreak testing; and Completion of testing and training would be tracked, analyzed, and acted on to ensure compliance with routine and outbreak testing.

ROUTINE TESTING:

On 8/26/21, at 10:28 a.m. the facility's outbreak testing rosters, staff schedules, call-in forms, and staff workability forms were requested. The DON provided the the requested documents from May 2021 to present.

On 8/26/21, at 11:16 a.m. the facility provided the routine and outbreak testing rosters for May 2021 through 8/26/21. The roster provided the following data: site name, site address, site phone number,

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 _____	C 08/31/2021

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

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F 886	Continued From page 38	F 886		

site fax number, site contact name, site contact email, site type (SNF), ordering provider name and indication for testing: conducting staff testing to meet CMS requirements (routine or outbreak) (Client bill) and date of collection. Staff names were listed, but the roster did not include the staff role, each roster was clipped to a stack of individual printed test results and the names of the staff were highlighted, circled, and/or had indiscriminate marks. The roster dates did not consistently correlate to the test result dates, not every name had a discernible notation to determine if the staff member required testing, nor did every name have printed results. Additionally, the rosters did not provide a consistent manner of tracking to ensure every staff member who required testing fulfilled testing requirements.

The Centers for Medicare and Medicaid Services (CMS) COVID-19 Viral (NAAT) Laboratory 14-Day Test Positivity Rates, by US County provided the following Itasca county positivity rates by the dates below:
- On 7/20/21, the county positivity was 1.8 percent indicating low positivity rate and were required to test monthly.
- On 7/27/21, the county positivity was 2.6 percent indicating low positivity rate and were required to test monthly.
- On 8/3//21, the county positivity was 5.2 percent indicating low positivity rate and were required to test weekly.
- On 8/10/21, the county positivity was 6.6 percent indicating low positivity rate and were required to test weekly.

The facility testing rosters indicated routine testing was last conducted on 7/19/21. Outbreak

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 _____	C 08/31/2021

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 886	Continued From page 39	F 886		

testing began on 8/10/21, and the facility continued outbreak testing frequency.

During interview on 8/26/21, at 2:33 p.m. the DON stated she was responsible for tracking COVID-19 testing for staff and residents. The facility last conducted routine COVID-19 staff testing on 7/19/21, until R1 tested positive during an emergency department evaluation on 8/9/21. Additionally, two nurses called-in ill on 8/9/21, and were instructed to get tested. Both nurses tested were tested and had positive results. On 8/10/21, the facility began outbreak testing of all vaccinated and unvaccinated residents and all staff that entered the nursing home unit.

- Upon review of the testing rosters, the DON was unable to determine if all staff members listed were required to test, had refused testing, had worked in the nursing home, or why some test results were not available. The DON was unable to explain the purpose of the roster and was unable to identify which staff completed testing without searching in the electronic test result system for a result. She indicated not everyone listed on the roster worked in the nursing home or was required to test but was unable to identify which staff members did not need to test without looking for a result in the electronic system, nor could she identify if the staff member worked without testing.

On 8/27/21, at 1:42 p.m. the DON stated the facility collected the county positivity rate once a week on Wednesday from the CMS website. If the county positivity rate went above a certain level, testing began that same week. Review of the DON's form Senior Care COVID-19 risk assessment dated 8/4/21, indicated the county

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 _____	C 08/31/2021

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

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F 886	Continued From page 40	F 886		

positivity rate was 5.2 percent on 8/4/21. The DON stated the facility should have increased routine testing to weekly beginning on 8/5/21 or 8/6/21. "We started outbreak testing on the 10th. I guess we delayed. I'm not recalling that I realized we should have increased routine testing" the Friday prior. Further, the DON stated the facility could potentially have lessened the impact of the COVID-19 outbreak if they implemented the increased testing as required. Review of the 8/17/21 nursing schedule identified registered nurse (RN)-C worked an emergency, fill-in shift at the facility. DON stated RN-C was a hospital employee and she did not know her vaccination status; however, hospital employees were not required to be vaccinated until a future date. DON reviewed RN-C's record and indicated she was never tested for COVID-19.

During interview on 8/27/21, at 3:47 p.m. the administrator stated she put trust in her staff to be compliant with testing requirements and followed all facility COVID-19 policies.

The undated facility policy Essentia Health Long Term Care (SNF/AL) Infection Prevention Interim Policy for Guidance During Pandemic and Suspected or Confirmed Coronavirus (COVID-19), indicated the facility would identify employees that work at multiple facilities, and actively screen and restrict them appropriately to ensure they do not place individuals in the facility at risk for COVID-19. Further, the policy directed staff to see COVID-19 Testing Recommendations for Long Term Care Facilities updated 11/20/20.

The CDC Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination dated

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 _____	C 08/31/2021

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 886	Continued From page 41	F 886		

4/27/21, identified expanded screening testing of asymptomatic HCP should be as follows:
-In nursing homes located in counties with >10% positivity of viral tests in the past week, unvaccinated HCP should have a viral test twice a week.
-If unvaccinated HCP work infrequently at these facilities, they should ideally be tested within the 3 days before their shift (including the day of the shift).
-In nursing homes located in counties with 5-10% positivity of viral tests in the past week, unvaccinated HCP should have a viral test once a week.
-In nursing homes located in counties with <5% positivity of viral tests in the past week, unvaccinated HCP should have a viral test once a month.

The Centers for Medicare and Medicaid (CMS) Quality Safety and Oversite (QSO) memo (QSO 20-38 NH) revised 4/27/21, directed routine testing of unvaccinated staff was based on the extent of the virus in the community. Facilities used their county positivity rate in the prior week as the trigger for staff testing frequency. The facility must test all unvaccinated staff at the frequency indicated based on the county positivity rate reported in the past week. Facilities monitored their county positivity rate every other week and adjust the frequency of performing staff testing accordingly.
- If the county positivity rate increased to a higher level of activity, the facility should begin testing staff at the frequency shown in the table above as soon as the criteria for the higher activity were met.
- If the county positivity rate decreased to a lower level of activity, the facility should continue testing

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 _____	C 08/31/2021

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 886	Continued From page 42 staff at the higher frequency level until the county positivity rate has remained at the lower activity level for at least two weeks before reducing testing frequency. Staff with symptoms or signs of COVID-19, vaccinated or not vaccinated, must be tested immediately and are expected to be restricted from the facility pending the results of COVID-19 testing. If COVID-19 is confirmed, staff should follow Centers for Disease Control and Prevention (CDC) guidelines "Criteria for Return to Work for Healthcare Personnel with SARSCoV2 Infection."	F 886		