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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: TJS1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00907

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245212**

2.STATE VENDOR OR MEDICAID NO.
(L2) **623840800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH OAK CROSSING**
(L4) **1040 LINCOLN AVENUE**
(L5) **DETROIT LAKES, MN** (L6) **56501**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/03/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **96** (L18)

13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

Post Certification Revisit by review of the facility's plan of correction was completed on December 3, 2014 and verified correction as of October 29, 2013. Please refer to the CMS 2567B.
Effective October 29, 2013, the facility is certified for 96 skilled nursing facility beds.

17. SURVEYOR SIGNATURE — Date :
Gail Anderson, Unit Supervisor — 12/03/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 2/10/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1976
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/02/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5212

February 10, 2014

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

Dear Ms. Brinkman:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 29, 2013, the above facility is certified for:

96 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 96 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 23, 2014

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

RE: Project Number 00907

Dear Ms. Brinkman:

On November 7, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 19, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On December 3, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 19, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 29, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 19, 2013, effective October 29, 2013 and therefore remedies outlined in our letter to you dated November 7, 2013, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Gail Anderson/BH

Gail Anderson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 218-332-5140 Fax: 218-332-5196

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245212	A. Building B. Wing	12/3/2013

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA HEALTH OAK CROSSING	1040 LINCOLN AVENUE DETROIT LAKES, MN 56501

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	10/29/2013	ID Prefix F0329 Reg. # 483.25(l) LSC	10/29/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GA/KJ	2/10/2014	28034	12/3/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
9/19/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: TJS1

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(L1) **245212**
2.STATE VENDOR OR MEDICAID NO.
(L2) **623840800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH OAK**
(L4) **CROSSING 1040 LINCOLN AVENUE**
(L5) **DETROIT LAKES, MN** (L6) **56501**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/19/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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From (a) :
To (b) :

12.Total Facility Beds **96** (L18)

13.Total Certified Beds **96** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Angie Hofmann, HFE Nursing Eval. II — 11/25/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Enforcement Specialist — 12/02/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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11/01/1976
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/02/2013
(L33)

DETERMINATION APPROVAL

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

CCN # 245212

At the time of the standard survey completed September 19, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

November 7, 2013

Certified Mail # 7011 2000 0002 5143 7364

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

RE: Project Number S5212022

Dear Ms. Brinkman:

On September 19, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537

Telephone: (218)332-5140
Fax: (218)332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 29, 2013 the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 19, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 19, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure (s)

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verifcation of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	For R33, the Pharmacy consultant requested information from R33's primary care physician regarding indications for use of the hypnotic. A sleep study was completed for R33 to establish effectiveness of use of hypnotic, assessed results and added to the R33's plan of care. The facility audited all Residents to determine who uses a hypnotic and for those residents with these medications, audited for indications of use and whether the resident's care plan was appropriate. Care plans have been updated as needed. For R33 and other residents with hypnotics, sleep studies will be scheduled quarterly with assessments. Licensed staff will complete documentation on a monthly basis, which will be scheduled, regarding continued need for the hypnotic.	10/29/13

RECEIVED
NOV 18 2013
MN Dept of Health
Fergus Falls

11/25/13 approved email addendum

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

LNHA — 11/14/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 1 by: Based on interview and document review, the facility failed to develop a comprehensive plan of care related to a sleep medication for 1 of 5 residents (R33) reviewed in the sample for unnecessary medications. Findings include: R33 was prescribed a sleep medication (Trazodone) for insomnia; however, the plan of care lacked identification of the problem and lacked non-pharmacological interventions to use for the problem of insomnia. The plan of care, revised 9/13/13, included a focus related to an antidepressant medication for depression, the plan of care did not identify use of an antidepressant to aid with sleep, nor did the plan of care include sleep monitoring or documentation of sleep patterns, or did not include any non-pharmaceutical interventions related to trouble sleeping. On 09/18/13 at 12:30 p.m., registered nurse (RN)-A confirmed the care plan lacked mention of a focus related to a sleep medication and/or any non-pharmaceutical interventions. On 9/19/13 at 8:32 a.m., the Director of Nursing (DON) confirmed the nursing staff could have done a better job with documentation on R33's sleep medication and she confirmed this was not included on the plan of care. A facility policy related to Care Planning was requested but not received.	F 279	The facility will have the RN clinical coordinator review all new orders to alert her of need to assess for appropriateness of hypnotic medications and to care plan if needed. Nurses were educated on the need to document non-pharmacological interventions to assist with sleep, and need for continued use of hypnotic. The facility has updated its medication policy and procedure to reflect necessary changes. Facility will audit quarterly for 2 quarters (starting October 1, 2013) and report findings to QAPI. QAPI will determine after 2 quarters if audits need to be continued or can be discontinued as a result of findings. Pharmacy consultants will continue to review for compliance monthly, and this information will also be reviewed through QAPI.	10/29/13
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329 SS=D	Continued From page 2 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify adequate indications for use of a sleep medication and failed to identify any non-pharmaceutical interventions for 1 of 5 residents (R33) reviewed for unnecessary medications. Findings include:	F 329	For R33, the Pharmacy consultant requested information from R33's primary care physician regarding indications for use of the hypnotic. A sleep study was completed for R33 to establish effectiveness of use of hypnotic, assessed results and added to the R33's plan of care. The facility audited all Residents to determine who uses a hypnotic and for those residents with these medications, audited for indications of use and whether the resident's care plan was appropriate. Care plans have been updated as needed. For R33 and other residents with hypnotics, sleep studies will be scheduled quarterly with assessments. Licensed staff will complete documentation on a monthly basis, which will be scheduled, regarding continued need for the hypnotic.	10/29/13

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	245212	A. BUILDING _____ B. WING _____	09/19/2013

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

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F 329	Continued From page 3 R33 was prescribed a sleep medication (Trazodone) on 1/2/13; however, R33 had not been assessed for sleep patterns nor had non-pharmacological interventions been developed to aid in insomnia. R33 had diagnoses which included osteoarthritis and depression. An annual Minimum Data Set (MDS) dated 7/2/13, identified R33 had intact cognitive status. The Care Area Assessment (CAA) undated, identified R33 received an antidepressant due to depression and to aid in sleep; and received an anti-anxiety medication for depression and anxiousness. The plan of care, revised 9/13/13, included a focus related to an antidepressant medication for depression; however, the plan of care did not identify use of an antidepressant to aid with sleep, nor did the plan of care include sleep monitoring or documentation of sleep patterns, nor did the plan of care include any non-pharmaceutical interventions related to trouble sleeping. A physician order dated 11/28/12, indicated R33 was prescribed Prozac (antidepressant) 40 milligram (mg) capsule daily for depressive disorder. A physician order dated 1/2/13, indicated R33 was prescribed Trazodone HCl (antidepressant, which also has an anti-anxiety and sleep-inducing effect) 50 mg tablet daily at bedtime for insomnia. Lastly, a physician order dated 1/2/13, indicated R33 was prescribed Trazodone HCl 50 mg tablet PRN (as needed): may repeat x1 in one hour if not sleeping. Review of the medical record revealed a lack of documentation of an analysis of R33's sleep patterns.	F 329	The facility will have the RN clinical coordinator review all new orders to alert her of need to assess for appropriateness of hypnotic medications and to care plan if needed. Nurses were educated on the need to document non-pharmacological interventions to assist with sleep, and need for continued use of hypnotic. The facility has updated its medication policy and procedure to reflect necessary changes. Facility will audit quarterly for 2 quarters (starting October 1, 2013) and report findings to QAPI. QAPI will determine after 2 quarters if audits need to be continued or can be discontinued as a result of findings. Pharmacy consultants will continue to review for compliance monthly, and this information will also be reviewed through QAPI.	10/20/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING _____ B. WING _____	09/19/2013

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F 329	Continued From page 4 A psychiatry progress note dated 9/6/12 indicated R33 was sleeping well with Trazodone and follow-up on the medication would occur at the next visit in March; however, the following psychiatry progress note dated 3/13/13, did not mention R33's sleep patterns or Trazodone but included a recommendation to continue taking Prozac. A nurse note dated 12/29/12 indicated R33 was sleeping well. A nurse note dated 1/2/13 read as follows: Orders received to give Trazodone 50 mg HS and may repeat in 1 hour if not sleeping. A Care Conference note dated 4/2/13 indicated R33 had reported being unhappy but there was no documentation or complaints of inability to sleep. On 09/18/13 at 12:30 p.m., registered nurse (RN)-A stated the facility did not usually have residents on sleep medications. She confirmed R33 had not had an analysis of sleep patterns and she verified the care plan lacked mention of a focus related to a sleep medication and/or any non-pharmaceutical interventions. RN-A also verified the medical record did not contain any sleep monitoring documentation. On 9/19/13 at 8:32 a.m., the Director of Nursing (DON) confirmed the nursing staff could have done a better job with documentation on R33's sleep medication. She stated R33 kept her own cell phone in her room and frequently would call her physician's office with various complaints; the DON learned R33 had called her physician on 1/1/13 and indicated that she was not able to sleep; her physician then called with a telephone	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING _____ B. WING _____	09/19/2013

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

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F 329	Continued From page 5 order for Trazodone on 1/2/13. An undated policy entitled, "Medication Administration," included, "monthly medication reviews shall consist of writing recommendations to providers and reviewing for unnecessary medication usage."	F 329		

Anderson, Gail (MDH)

From: Brinkman, Christy M <Christy.Brinkman@EssentiaHealth.org>
Sent: Monday, November 25, 2013 3:58 PM
To: Anderson, Gail (MDH)
Subject: Addended POC for Essentia Health Oak Crossing

Gail,

This email is to communicate an addendum to the Plan of Correction (2567) for the survey conducted at Essentia Health Oak Crossing, exit date 9/19/2013:

- For F279 and F329, the facility identified 3 residents on medications for sleep. These 3 residents have a current sleep study, and the care plan has been reviewed and updated.

Please let me know if you have further questions. Thank you.

Christy Brinkman, MBA, LNHA
Senior Administrative Leader
Essentia Health
St. Mary's
1027 Washington Avenue | Detroit Lakes, MN 56501
Phone: 218-844-0700 | Fax: 218-844-0780

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING **02 - EXISTING BUILDING 02** B. WING _____	**09/18/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 03006 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Essentia Health Oak Crossing 02 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 02 Main Building Essentia Health Oak Crossing is a 2-story building with a basement. The building was constructed at 3 different times. The original building (02) was constructed in 1968, is 2-story building with a small basement and was determined to be of Type II(000) construction due to the on going remodeling of this building. In 1999 an Administration / Entrance addition was constructed south of the original building and an addition to the hospital north of the original building. The entrance addition is Type V (111) construction, 2-stories without a basement and the hospital addition is Type II (111) construction, 1-story without a basement. In 2008 a 2-story building, without a basement, separated with two 2-hour fire barriers south of the entrance addition and was determined to be Type II (111) construction. The buildings are divided into 12 smoke zones (6 per floor) by 2- hour and 30 minute fire barriers. The facility has a complete automatic fire	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING **02 - EXISTING BUILDING 02** B. WING _____	**09/18/2013**

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

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K 000	Continued From page 1 sprinkler system in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition with 2 systems. The facility has a fire alarm system with manual pull station near each exit door, smoke detection in the corridor system properly spaced and all common areas in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). The resident sleeping rooms have smoke detection that are hard wired and connected to the fire alarm system. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 96 beds and had a census of 91 at the time of the survey. The facility was surveyed as two buildings, 02-Main Existing Building (1968 building and the 1999 Administration / Entrance additions) as an Existing Health Care and 03 South Building (2008 building) as New Health Care. The requirement at 42 CFR, Subpart 483.70(a) is MET in building 02 Main Building.	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING **03 - 2008 SOUTH** B. WING _____	**09/18/2013**

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

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K 000	INITIAL COMMENTS Surveyor: 03006 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Essentia Health Oak Crossing 03 South Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. 03 South Building Essentia Health Oak Crossing is a 2-story building with a basement. The building was constructed at 3 different times. The original building (02) was constructed in 1968, is 2-story building with a small basement and was determined to be of Type II(000) construction due to the on going remodeling of this building. In 1999 an Administration / Entrance addition was constructed south of the original building and an addition to the hospital north of the original building. The entrance addition is Type V (111) construction, 2-stories without a basement and the hospital addition is Type II (111) construction, 1-story without a basement. In 2008 a 2-story building, without a basement, separated with two 2-hour fire barriers south of the entrance addition and was determined to be Type II (111) construction. The buildings are divided into 12 smoke zones (6 per floor) by 2- hour and 30 minute fire barriers. The facility is completely protected with an	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING **03 - 2008 SOUTH** B. WING _____	**09/18/2013**

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

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K 000	Continued From page 1 automatic fire sprinkler system in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition with 2 systems. The facility has a fire alarm system with manual pull station near each exit door, smoke detection in the corridor system properly spaced and all common areas in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). The resident sleeping rooms have smoke detection that are hard wired and connected to the fire alarm system. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 96 beds and had a census of 91 at the time of the survey. The facility was surveyed as two buildings, 02-Main Existing Building (1968 building and the 1999 Administration / Entrance additions) as an Existing Health Care and 03 South Building (2008 building) as New Health Care. The requirement at 42 CFR, Subpart 483.70(a) is MET in building 03.	K 000		