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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: WPH9

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 **10/13/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **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):

17. SURVEYOR SIGNATURE — Date :
Gail Anderson, Unit Supervisor — 10/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 10/23/2014 (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
Posted 10/27/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/15/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245212

October 23, 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 September 30, 2014, 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

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	10/13/2014

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/30/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/30/2014**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **09/30/2014**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **09/30/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GA/mm	10/23/2014	28034	10/13/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/21/2014			

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

October 23, 2014

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

RE: Project Number S5212023

Dear Ms. Brinkman:

On September 5, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 21, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), hereby corrections were required.

On October 13, 2014, 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 August 21, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 30, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 21, 2014, effective September 30, 2014 and therefore remedies outlined in our letter to you dated September 5, 2014, 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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5212r14

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: WPH9

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: **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 **08/21/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **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):

17. SURVEYOR SIGNATURE — Date :
Christina Martinson, HFE NEII — 09/30/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 10/09/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
Posted 10/15/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 6481

September 5, 2014

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

RE: Project Number S5212023

Dear Ms. Brinkman:

On August 21, 2014, a standard survey was completed at your facility by the Minnesota Department of Health and on August 27, 2014 by the Department of Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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, Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us

Phone: (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 September 30, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 30, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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.

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 November 21, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and

1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 21, 2015 (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 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5212s14

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 _____	08/21/2014

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 verification 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 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to immplement the care plan to monitor the hemodialysis access site for 1 of 1 residents (R152) who received dialysis treatment. Findings include: R152's care plan revised 3/31/14, identified R152 had a fistula (internal access imbedded under the skin) in the left forearm and identified the goal as the access would be patent and free of signs and symptoms of infection. The care plan directed staff to "check for blood flow each day by feeling for a vibration, also known as pulse or thrill. If you	F 282	On 8/22/2014, the medication/treatment record was updated for R152 to indicate a daily check for the dialysis fistula for thrill, redness, warmth, and signs of infection. There are no other dialysis patients in the facility at this time. In the future, as a dialysis patient is admitted to the facility or a resident begins dialysis, the dialysis site check will be care planned and added to the medication/treatment record. The RN Clinical Coordinator in either TCU or LTC will be responsible for this task.	9/30/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 9/15/14

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

RECEIVED
SEP 22 2014
MN Dept of Health
Fergus Falls

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 _____	08/21/2014

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 282	Continued From page 1 do not feel this daily, or if there is a change, call the doctor or dialysis center." The Nursing Home Plan of Care for Dialysis Patients form directed "A daily check of the extremity access should be performed by the facility staff. This includes feeling for a pulsation in the access, listening for a bruit via stethoscope in the access and assessing for redness, warmth or signs of infection. An absence of pulsation or bruit or any abnormal findings should be reported to the dialysis unit promptly." Review of R152's Medication/Treatment Administration Record for August 2014, 1st thru 21st, revealed R152 received various treatments which included to encourage to elevate legs as much as possible, monitor sleep patterns, however, lacked documentation of monitoring R152's access site for presence/absence of pulse, signs and symptoms of infection or dressings at access site. On 8/20/14, at 11:28 p.m. R152 was observed seated in a recliner chair in her room with a black cloth sling which covered her left lower arm. Two beige colored tape like bandages were observed to cover the hemodialysis access site located on R152's upper left arm. During interview on 8/20/14, at 11:30 a.m. R152 confirmed she had a hemodialysis access in her left upper arm. She indicated she had currently had a graft in her upper arm, and had previous access site failures prior to the current location. R152 stated sometimes she would remove the dressings from her access after her dialysis treatments and sometimes the dialysis staff would remove the old dressings from the access site when she reported for her next treatment.	F 282	DON updated the dialysis policy on 9/11/2014 to require daily checks (once every 24 hours) which aligns with the policies of the Sanford Dialysis Center in Detroit Lakes. Nursing Staff (RN's and LPN's) will be educated on this policy on 9/11/14 at monthly nurses meeting. DON will conduct a quarterly audit to determine a full listing of residents on dialysis. She will then audit the care plans and the medication/treatment records for these residents to assure that the resident(s) are receiving daily checks. The results of the audit will be reported out at the quarterly QAPI meeting.	

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 _____	08/21/2014

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 282	Continued From page 2 R152 stated the facility staff "don't do anything" with the graft site. During interview on 8/20/14 , at 1:07 p.m. licensed practical nurse (LPN)-A confirmed staff did not routinely check R152's access site and indicated staff reminded R152 to keep the left arm in a sling, other than that, did not monitor "on a.m. shift besides that." During a second interview on 8/21/14, at 10:32 a.m. LPN-A confirmed the undated and untitled dialysis care plan was provided from the R152's dialysis unit to direct appropriate care for R152. She confirmed the medication/treatment records lacked documentation of routine monitoring of the access site. During a second interview on 8/21/14, at 10:36 a.m. R152 stated she did not check the dialysis site for presence/absence of pulse or signs of infection. She confirmed facility staff did not monitor the access site for presence/absence of pulse, did not monitor the dressings or status of the access site. During interview on 8/21/14, at 1:07 p.m. registered nurse (RN)-A confirmed staff did not routinely monitor R152's access site. She indicated R152 removed the dressings and would let facility staff know if there were problems with the access site. RN-A confirmed the dialysis care plan included instructions of care of R152's access , and confirmed the care plan included direction for facility staff to check the site for blood flow and infection daily. RN-A confirmed staff should follow the care plan instructions, and confirmed staff had not routinely monitored the access site.	F 282		

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ESSENTIA HEALTH OAK CROSSING	1040 LINCOLN AVENUE DETROIT LAKES, MN 56501

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F 282	Continued From page 3 During interview on 8/21/14, at 4:06 p.m. the assistant director of nursing (ADON) confirmed staff were expected to provide the care as dialysis center directed, and indicated the care would include staff to remove the dressing, and to check for any" redness or bulging and check for a thrill (pulse) every shift." Staff would then notify dialysis of any negative findings. Review of the undated facility policy titled Dialysis Protocol identified "fistulas will be checked each shift," directed staff to refer to the dialysis care plan and directed nursing staff to contact the dialysis unit for any dialysis related problems.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services to monitor the hemodialysis site for pulse and for signs and symptoms of infection for 1 of 1 residents (R152) receiving dialysis treatment. Findings include:	F 309	On 8/22/2014, the medication/treatment record was updated for R152 to indicate a daily check for the dialysis fistula for thrill, redness, warmth, and signs of infection. There are no other dialysis patients in the facility at this time. In the future, as a dialysis patient is admitted to the facility or a resident begins dialysis, the dialysis site check will be care planned and added to the medication/treatment record. The RN Clinical Coordinator in either TCU or LTC will be responsible for this task.	9/30/14

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F 309	Continued From page 4 R152 had diagnoses which included hemiplegia (paralysis of one side of the body), type 2 diabetes, peripheral neuropathy (impaired movment and feeling in extremities), and end stage renal disease. The quarterly Minimum Data Set (MDS) dated 5/29/14, identified R152 had intact cognition, required assistance with bed mobility, dressing, personal hygiene, and received dialysis treatments. R152's care plan revised 3/31/14, identified R152 had a fistula (internal access imbedded under the skin) in the left forearm and identified the goal as the access would be patent and free of signs and symptoms of infection. The care plan directed staff to "check for blood flow each day by feeling for a vibration, also known as pulse or thrill. If you do not feel this daily, or if there is a change, call the doctor or dialysis center." The Nursing Home Plan of Care for Dialysis Patients form directed "A daily check of the extremity access should be performed by the facility staff. This includes feeling for a pulsation in the access, listening for a bruit via stethoscope in the access and assessing for redness, warmth or signs of infection. An absence of pulsation or bruit or any abnormal findings should be reported to the dialysis unit promptly." Review of R152's Medication/Treatment Administration Record for August 2014, 1st thru 21st, revealed R152 received various treatments which included to encourage to elevate legs as much as possible, monitor sleep patterns, however, lacked documentation of monitoring R152's access site for presence/absence of pulse, signs and symptoms of infection or dressings at access site.	F 309	DON updated the dialysis policy on 9/11/2014 to require daily checks (once every 24 hours) which aligns with the policies of the Sanford Dialysis Center in Detroit Lakes. Nursing Staff (RN's and LPN's) will be educated on this policy on 9/11/14 at monthly nurses meeting. DON will conduct a quarterly audit to determine a full listing of residents on dialysis. She will then audit the care plans and the medication/treatment records for these residents to assure that the resident(s) are receiving daily checks. The results of the audit will be reported out at the quarterly QAPI meeting.	

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F 309	Continued From page 5 On 8/20/14, at 11:28 p.m. R152 was observed seated in a recliner chair in her room with a black cloth sling which covered her left lower arm. Two beige colored tape like bandages were observed to cover the hemodialysis access site located on R152's upper left arm. During interview on 8/20/14, at 11:30 a.m. R152 confirmed she had a hemodialysis access in her left upper arm. She indicated she had currently had a graft in her upper arm, and had previous access site failures prior to the current location. R152 stated sometimes she would remove the dressings from her access after her dialysis treatments and sometimes the dialysis staff would remove the old dressings from the access site when she reported for her next treatment. R152 stated the facility staff "don't do anything" with the graft site. During interview on 8/20/14 , at 1:07 p.m. licensed practical nurse (LPN)-A confirmed staff did not routinely check R152's access site and indicated staff reminded R152 to keep the left arm in a sling, other than that, did not monitor "on a.m. shift besides that." During a second interview on 8/21/14, at 10:32 a.m. LPN-A confirmed the undated and untitled dialysis care plan was provided from the R152's dialysis unit to direct appropriate care for R152. She confirmed the medication/treatment records lacked documentation of routine monitoring of the access site. During a second interview on 8/21/14, at 10:36 a.m. R152 stated she did not check the dialysis site for presence/absence of pulse or signs of infection. She confirmed facility staff did not	F 309		

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F 309	Continued From page 6 monitor the access site for presence/absence of pulse, did not monitor the dressings or status of the access site. During interview on 8/21/14, at 1:07 p.m. registered nurse (RN)-A confirmed staff did not routinely monitor R152's access site. She indicated R152 removed the dressings and would let facility staff know if there were problems with the access site. RN-A confirmed the dialysis care plan included instructions of care of R152's access , and confirmed the care plan included direction for facility staff to check the site for blood flow and infection daily. RN-A confirmed staff should follow the care plan instructions, and confirmed staff had not routinely monitored the access site. During interview on 8/21/14, at 4:06 p.m. the assistant director of nursing (ADON) confirmed staff were expected to provide the care as dialysis center directed, and indicated the care would include staff to remove the dressing, and to check for any" redness or bulging and check for a thrill (pulse) every shift." Staff would then notify dialysis of any negative findings. Review of the undated facility policy titled Dialysis Protocol identified "fistulas will be checked each shift," directed staff to refer to the dialysis care plan and directed nursing staff to contact the dialysis unit for any dialysis related problems.	F 309		
F 334 SS=C	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that --	F 334		

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F 334	Continued From page 7 (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse	F 334	On 9/9/2014, the DON and Infection Control RN updated the facility's policy and procedure for immunizations to include pneumococcal immunizations. The policy specifically addresses resident or resident representative education about the risks vs. benefits. The education given is from the CDC (Pneumococcal Vaccine Information Statement). Each resident, prior to receiving the pneumococcal vaccine, will receive the CDC Vaccine Information (which includes the risks and benefits) and will be asked to read and sign the Resident Pneumococcal consent form. If the resident cannot complete the consent form, facility nursing staff will contact the representative via phone, will provide oral education and obtain a verbal consent. This will be documented on the consent form.	9/30/14

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F 334	Continued From page 8 immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview, document review the facility failed to ensure develop and implement policy to provide education for residents or resident personal representative on risks vs benefits for Pneumococcal immunizations in the facility. This deficient practice had the potential to affect all 93 residents residing in the facility. Findings include: Review of the facility policy titled Essentia Health St. Mary's TCU/Oak Crossing LTC Routine Orders, revised 7/28/14 revealed the policy	F 334	The DON will educate the nurses (RN's, LPN's) on this policy and procedure at the monthly nurses meeting on 9/11/2014. The DON will conduct a quarterly audit x 4 of residents receiving the pneumococcal vaccine to assure the policy and procedure is being followed. The audits will be reviewed at the facility's quarterly QAPI meeting.	

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F 334	Continued From page 9 identified routine orders utilized for all residents. The policy included various routine orders for medications, diet and immunizations. The policy directed facility staff to administer the pneumovax (pneumonia vaccine), unless contraindicated, standard dosage to residents 65 years or older. However, the policy for routine orders did not include direction for staff to provide education of risks versus benefits to residents or legal representative regarding the Pneumococcal vaccine. On 8/21/14, at 1:01 p.m. the assistant director of nursing, (ADON) confirmed the routine order for administration of the Pneumovax to all residents per facility policy. She confirmed the policy did not address education to be provided to residents and/or legal representative.	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:	F 356	The Administrator updated the daily staffing sheet on 8/27/2014. The staffing sheet was updated to include totals for RN, LPN, C.N.A. and T.M.A., by job category by shift. The staffing sheet is hung on a magnetic board. The board was moved from the Transitional Care Unit to the wall outside of the Administrative offices on 9/4/2014. This is now centrally located in the facility.	9/30/14

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F 356	Continued From page 10 o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the required nursing staff posting information included the total number of hours worked for each discipline, and failed to post the required nursing staffing posting information was posted in a prominent area readily accessible of the facility. This had the potential to affect all 93 residents residing in the facility and visitors. Findings include: On 8/18/14, 1:00 p.m. on initial tour of the facility the required nursing staff information form was observed affixed on a wall in the hallway across from the nursing station of the transitional care unit (TCU). The TCU was located in a separate wing of the facility, down the hall from the main entrance. There was no observed sign/information directing visitors or residents by the main entrance to where the nursing staff information was located in the facility. The form titled, Essentia Health, revealed the date of	F 356	Administrator and DON developed a facility policy and procedure for the requirements of the daily nursing staff posting. Nurses will be educated on the new staffing posting and how to update/modify it at the monthly nurses meeting on 9/11/2014. The DON will conduct a quarterly audit x 4 of the daily staffing sheets to assure that the daily staffing sheets meets the nurse staffing posting requirements. The results of the audit will be reviewed in the quarterly QAPI meetings.	

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F 356	Continued From page 11 8/18/14, facility census of 93, number of staff responsible for direct resident care, category of staff, actual hours worked and number of staff in each discipline responsible for resident care. However, the required nursing staff posting lacked the total number of hours worked by each discipline responsible for resident care. On 8/21/14, 9:56 a.m. the assistant director of nursing (ADON) confirmed the facility routinely utilized the Essentia Health form for posting the required nursing staff information. The ADON confirmed the required nursing staff information did not include the total numbers of hours worked by each discipline of nursing staff. The ADON verified the location of the staff posting was routinely in the TCU across from the nursing station. The ADON also confirmed the main entrance was routinely used by visitors. A policy was requested from the facility, none was provided.	F 356		

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

F521022

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 _____	**08/27/2014**

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ESSENTIA HEALTH OAK CROSSING	**1040 LINCOLN AVENUE DETROIT LAKES, MN 56501**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Essentia 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 The facility was surveyed as two buildings: 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.

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	245212	A. BUILDING **02 - EXISTING BUILDING 02** B. WING _____	**08/27/2014**

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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 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 90 at the time of the survey. . The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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	245212	A. BUILDING **03 - 2008 SOUTH** B. WING _____	**08/27/2014**

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 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 The facility was surveyed as two buildings 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
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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 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 90 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		