



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 8, 2023

Administrator
Essentia Health Oak Crossing
1040 Lincoln Avenue
Detroit Lakes, MN 56501

RE: CCN: 245212
Cycle Start Date: November 22, 2023

Dear Administrator:

On November 22, 2023, a survey was completed at your facility by the Minnesota Department(s) of Health 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 constituted immediate jeopardy (Level J)

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On November 11, 2023, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty, (42 CFR 488.430 through 488.444).

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the**

following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Essentia Health Oak Crossing is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 22, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40,

et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

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

**Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day

Essentia Health Oak Crossing

December 8, 2023

Page 4

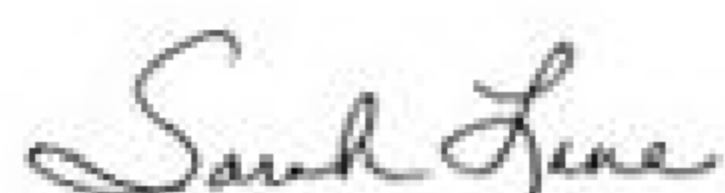
period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Sarah Lane".

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 8, 2023

Administrator
Essentia Health Oak Crossing
1040 Lincoln Avenue
Detroit Lakes, MN 56501

Re: Event ID: JYJ611

Dear Administrator:

The above facility survey was completed on November 22, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/22/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>On 11/20/23, to 11/22/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed.</p> <p>H52127027C (MN00098398) with a deficiency issued at F689 PAST NON-COMPLIANCE.</p> <p>IJ began on 11/7/23, when R1 eloped from the facility and was out of the facility for four hours and found by law enforcement approximately 2.4 miles away from the facility. The facility administrator and director of nursing (DON) were notified of the IJ at 5:30 p.m. on 11/22/23. The facility implemented immediate corrective action on 11/7/23, prior to the start of the survey and was issued as past non-compliance.</p> <p>H52127124C (MN00098485) with a deficiency issued at F689 PAST NON-COMPLIANCE.</p> <p>The IJ began on 11/11/23, when R2 was being transferred from the toilet with ceiling lift and a vital cord on the ceiling lift snapped, causing R2 to fall, land on the toilet bowl, resulting in bruising to R2's perineal and buttocks and have significant pain. The IJ was identified on 11/22/23, and the facility administrator and director of nursing (DON) were notified of the IJ at 5:30 p.m. on 11/22/23. The facility implemented immediate corrective action on 11/11/23, prior to the start of the survey and was therefore issued as Past Noncompliance.</p>	F 000		
-------	---	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

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.

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 2 and was issued as past non-compliance.</p> <p>R1's admission Minimum Data Baseline (MDS) dated 11/7/23, identified slightly impaired cognition, sometimes preferred social isolation, and behavioral symptoms not directed towards others such as pacing and yelling one of three days during the look back period. R1 also hallucinated (perceptual experiences in the absence of real external sensory stimuli) and had delusions (misconceptions or beliefs that are firmly held, contrary to reality). R1 exhibited daily wandering that placed him at significant risk of getting to a potentially dangerous place (e.g., stairs, outside facility) and significantly intruded on the privacy of activities of others. R1 required supervision/touching assistance with ambulation and personal hygiene and partial/moderate assistance with all transfers (toilet, sit to stand, chair/bed to chair). R1's diagnoses included Parkinson's, psychotic disorder, and shortness of breath or trouble breathing with exertion (walking and transferring). R1 was administered antipsychotic medications and had one fall since admission to facility with minor injuries. R1 had a door alarm in place to his room.</p> <p>R1's Care Area Assessment (CAA) dated 11/7/23, identified R1 had poor safety awareness, hallucinations and was forgetful. R1 required cues and reminders which were not always effective. R1 had delusions, hallucinations, paranoia, and wandering. R1 was placed on scheduled rounding, alarm on his door, and a wander guard. R1's behaviors are not new, hallucinated, paranoia, delusions which increased risk for falls. R1 had been wandering on the unit, made comments of leaving, taking and selling home and things, not agreeable to wander guard,</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 3</p> <p>alarm placed on door to alert staff if he left his room. One on one provided during the night and current fall interventions included hourly rounding.</p> <p>R1's Admission Nurse Intake - Nurse to Nurse Report document dated 11/1/23, identified alert and orientated, forgetful at times, no behaviors, and self-transfers.</p> <p>R1's care plan dated 11/2/23, identified R1 was at risk for elopement due to exit seeking, attempting to leave, cognitive impairment, wandering, impaired safety awareness, and physical capability to leave. Nursing interventions directed staff to have completed hourly rounding. Additionally, R1 displayed behaviors such as hallucinations and wandered into other resident rooms, exit seeking, packing belongings, and stating he was going to leave. Staff were directed to provide reassurance, redirection, and hourly rounding.</p> <p>R1's care plan updated 11/8/23 (following elopement), identified roam alert bracelet placed on right ankle. Staff were directed to have checked for placement and function every shift and in case the roam alert system failed, every 15-minute checks would be implemented. R1's picture posted at facility entrances and nurse's station to alert staff of elopement risk.</p> <p>R1's elopement assessment dated 11/1/23 at 9:11 a.m. identified R1 reported hallucinations and ambulatory, with no elopement risk factors identified.</p> <p>R1's fall risk assessment dated 11/1/23 at 1:24 p.m. identified R1 had altered awareness of immediate physical environment and lack of</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 4</p> <p>understanding of one's physical and cognitive limitations. R1 required assistance or supervision for mobility, transfers, and ambulation. R1 was identified as a moderate risk for falls.</p> <p>R1's Montreal Cognitive Assessment (MOCA) dated 11/3/23, revealed a score of 17/30 and indicated moderate cognitive impairment.</p> <p>R1's physician orders identified:</p> <p>-11/8/23, Roam alert bracelet to right ankle. Nursing to check daily for function and placement once a day 6:30 a.m. to 2:30 p.m.</p> <p>-11/11/23, Document in progress notes every shift on safety, wandering, exit seeking, behavior, and checks/rounding every shift, night, days, and evenings.</p> <p>R1's electronic treatment administration record (TAR) identified:</p> <p>-11/8/23, Roam alert bracelet to right ankle. Nursing to check daily for function and placement. Staff signed off TAR each day from 11/8/23, through 11/16/23, during the 6:30 a.m. through 2:30 p.m. shift.</p> <p>R1's progress notes identified:</p> <p>-11/1/23, at 7:08 p.m. R1 wandered on the unit, comments made about wanting to leave. R1 said people were selling his home and things and trying to steal his room, wanted to call cops. R1 found wandering in a resident's room across the hall sitting on the bed. R1 was not agreeable to a wander guard or agreeable to staying the night. Placed an alarm on R1's door so that staff were</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 5</p> <p>aware of when R1 left his room. Contacted R1's sister and indicated R1 had a history of confusion and hallucination, did not feel R1 was safe at home and felt he should remain in the facility for therapy.</p> <p>-11/1/23 at 8:02 p.m. R1 confused and wandering.</p> <p>-11/1/23 at 10:18 p.m. R1 demonstrated impaired balance, functional mobility, and activities of daily living.</p> <p>-11/2/23 at 12:46 a.m. R1 continued to be one on one assist, restless, exit seeking, and difficult to redirect. R1 attempted to pack items and bring them out to the car.</p> <p>-11/2/23 at 10:40 a.m. R1 was seen by provider due to hallucinations, behaviors, and confusion.</p> <p>-11/2/23 at 2:42 p.m. Occupational therapy (OT) recommended assist of one with front wheeled walker (FWW) with all ADLS and functional mobility.</p> <p>-11/2/23 at 4:49 p.m. Physical therapy (PT) daily note: R1 actively hallucinating, indicated he saw two people that sat underneath the sink. R1 cognition limited participation in PT today.</p> <p>-11/2/23 at 8:14 p.m. R1 transfers with assistance of one and FWW and frequently self- transfers. R1 required hourly rounding.</p> <p>-11/3/23 at 10:17 a.m. John Hopkins fall risk score of 9. Indicated moderate fall risk. Has been wandering the unit making comments about leaving, and refused wander guard. One on one</p>	F 689			

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 6 provided during the night.</p> <p>-11/5/23 at 5:29 a.m. R1 self-transferred out into hallway looking for his sister to pack up his belongings.</p> <p>-11/5/23 at 9:38 p.m. R1 required stand by assist while in hallway when distracted or performing turns, does demo some scissoring gait and instability when crossing legs over.</p> <p>-11/5/25 at 10:34 p.m. R1 started to get agitated with staff and not being able to leave.</p> <p>-11/6/23 at 12:54 a.m. R1 exit seeking, unable to redirect, and very agitated and tried to get through all exits. On-call nurse practitioner notified and prescribed Seroquel.</p> <p>-11/6/23 at 2:25 a.m. R1 continued to be one on one with staff, tried to find an exit to start his mail route as he was a retired mail carrier. Contacted nurse practitioner (NP). Gave Haldol, continue to monitor, and follow up with provider in morning.</p> <p>-11/6/23 at 8:35 a.m. R1 was confused at times, required frequent cues and reminders. R1 had poor safety awareness and exit seeks with redirection not always being effective. R1 required one on one staff supervision. R1 has Parkinson's with tremors and occasional hallucinations.</p> <p>-11/6/23 at 13:22 p.m. R1 continued to exit seek. Stand by assist in hallways needed. R1 was not easily directed.</p> <p>-11/6/23 at 6:21 p.m. attempted to place wander guard and R1 refused placement on self and</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 7</p> <p>walker. R1 continued to seek exits throughout the day, not easily redirected.</p> <p>-11/6/23 at 11:15 p.m. R1 tried to elope out of the exit door by room 122. R1 was able to open the door. Staff attempted to get R1 back inside. R1 was agitated and refused to come back in. R1 then agreed to come back into building and every 15-minute rounds were completed. Staff nurse attempted to place wander guard on and R1 refused.</p> <p>The hourly rounding sheet indicated hourly rounds were completed from 11/6/23 at 2:00 p.m. until 11/7/23 at a.m. but no documentation after that time. There was no documentation indicating 15 minute checks were completed during this time other than the above progress note.</p> <p>-11/7/23 at 1:32 p.m. OT daily note. R1 had an attempt elopement yesterday. R1 remembered leaving the building but then thought he did not want to get in trouble, so he came back in. R1 stated he wanted to go home. R1 unaware he was in Detroit Lakes and not in Pelican Rapids where he lived. OT had concerns and wanted R1 to have increased supervision due to his Parkinson's, balance, and impaired cognition. R1 and his sister were both open to higher level of care such as assisted living facility (ALF) than home upon discharge.</p> <p>-11/7/23 at 5:58 p.m. R1 was assist of one with FWW and continued to self-transfer often despite fall risk education. R1 had urinated in a mug then dumped it in the garbage can in his room. R1 unable to explain why he urinated in a mug. R1 stated, well I will be leaving here soon.</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 8</p> <p>The hourly rounding sheet indicated hourly rounds were completed from 11/7/23 at 12:00 a.m. until 11/8/23 at 6:00 a.m. and again at 10:30 p.m. when R1 returned back to facility after elopement. There was no documentation indicating 15 minute checks or hourly checks were completed during this time other than the above progress notes.</p> <p>-11/7/23 at 10:08 p.m. R1 was not seen in his room at 8:20 p.m. to give medications. Staff indicated they had seen him approximately one hour ago. Building was searched for 15 minutes, security, director of nursing, police department, and sister were called. Staff called R1's cell phone and no answer. The video footage showed R1 left the facility at 6:30 p.m.</p> <p>-11/7/23 at 10:50 p.m. Police had found R1 at the bowling alley in Detroit Lakes and now back in his room.</p> <p>-11/7/23 at 11:34 p.m. updated DON, house supervisor, and NP of R1's return to the facility.</p> <p>-11/8/23 at 1:26 a.m. R1 returned to facility at 10:50 p.m. reported he fell when he was walking outside of facility. R1 had a small abrasion on outer right hand 3 centimeters (cm) in length. R1 complained of minor mid rib pain on right side. R1 agree to a roam alert placement on his right ankle. Roam alert tested and was in working order after staff applied it. R1 was placed on every 15-minute checks throughout the night.</p> <p>The hourly rounding sheet indicated hourly rounds were completed on 11/7/23 from 10:50 p.m. until 11/8/23 at 6:00 a.m. There was no documentation indicating 15 minute checks were completed during this time other than the above</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 9 progress note.</p> <p>11/8/23 at 6:05 a.m. progress notes indicated slept all night in bed neurological ok.</p> <p>-11/8/23 at 8:38 a.m. explained risks and benefits of elopement prevention device.</p> <p>-11/8/23 at 11:36 a.m. NP visit on site with R1. Behaviors and exit seeking /elopement.</p> <p>-11/8/23 at 1:12 p.m. Referral to behavioral health, Mille Lacs behavioral health unit. May have a discharge tomorrow.</p> <p>-11/8/23 at 2:14 p.m. PT daily note. R1 had wander guard on and reported he fell three times while out last night. R1 felt the falls were caused by shortness of breath and general fatigue. Safety concerns come with cognition and mental health and licensed social worker (LSW) was going to look for an ALF with a locked door policy.</p> <p>-11/8/23 at 5:00 p.m. Place a sheet at nursing assistant (NA) desk for staff. Began written documentation of every 15-minute checks. Staff will write time R1 was last checked, location, as well as the staff member that checked on him.</p> <p>The hourly rounding sheet indicated hourly rounds were completed on 11/8/23 from 12:00 a.m. to 5:00 a.m. and from 2:00 p.m. through 8:00 p.m. Every 15 minute rounding sheet indicated 15 minute rounds were completed on 11/8/23 from 5:00 p.m. through 9:45 p.m. There was no documentation indicating 15 minute checks were completed between 5:00 a.m. and 2:00 p.m. (9 hours) and 9:45 p.m. until 12:00 a.m. during this time other than the above progress</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 10 note.</p> <p>Nurse practitioner (NP)-A admission visit on 11/2/23, identified R1 as alert, cooperative, and noted to have some cognitive impairment, unable to recall specific events. Last night R1 had hallucinations with increased behaviors, on-call provider contacted and gave order for low-dose Seroquel times two, which was effective. R1 had been on Seroquel prior to hospitalization, however noncompliant with taking it.</p> <p>NP-B visit on 11/6/23, identified R1 remained confused. Sister at bedside during visit and voiced concern about him going home and he had history of hallucinations. Over the weekend R1 became increasingly agitated, exit seeking, and hallucinated. R1 required a one-time dose as needed (PRN) of Haldol (rebalances dopamine to improve thinking, mood, and behavior) and did provide relief.</p> <p>NP-B visit on 11/8/23, identified on 11/7/23, R1 again became exit seeking and was able to leave the facility building. R1 walked across town. Local police department was notified, located R1, and brought him back to the facility. R1 stated he knew what he was doing, just wanted a walk, decided to walk to bowling alley, but stated he stopped there as he was unsure that this was where he was supposed to be. R1 may benefit from a memory care/security unit.</p> <p>NP-B visit on 11/15/23, identified nursing reported R1 seemed more stable but his behaviors became worse at night. A wander guard was placed on R1 so an alarm will sound if he left the facility without staff knowing.</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 11</p> <p>R1's care conference dated 11/8/23 at 10:03 a.m., identified R1 had periods of forgetfulness and hallucinations. R1 had wandering tendencies and exit seeking behaviors. R1 would like to return home but 24-hour supervision was needed at this time. R1's family member (FM) was concerned of a discharge home as his cognition had already declined prior to admission related to hallucinations and called law enforcement. Sister would like R1 to be moved to a memory facility.</p> <p>During an interview on 11/20/23 at 11:42 p.m., NA-B stated upon admission R1 was presented with cognitive impairment, forgetfulness, and possibly behaviors. NA-B stated R1 refused the wander guard, all NA's tried to get him to wear it, and knew R1 was going to escape, it was expected. NA-B stated they informed three of the nurses R1 was not appropriate for the transitional care unit (TCU) and facility was not staffed to complete frequent checks continuously for a long period of time. NA-B indicated she had set her alarm on her watch so that it would go off every hour and R1 would be checked on. NA-B indicated not sure what happened for those two hour prior to when the nurse realized R1 had left the building. NA-B stated hourly checks allowed him to leave because that was a lot of time in between checks but was hard to check on R1 more frequently when it had been so busy on the floor that night. NA-B stated last time R1 was seen was when NA-C completed evening cares and assisted him to the bathroom around 6:15 p.m. NA-B also stated once R1 had returned to the facility a wander guard was applied and every 15-minute checks were started.</p> <p>During an interview on 11/20/23 at 3:04 p.m., NA-A stated R1 was on hourly checks on 11/7/23,</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	Continued From page 12 when he left the facility. NA-A indicated NA-B had told her she had seen R1 last time around 6:30 p.m. NA-A stated she was the only NA on that floor that night that knew what R1 looked like. R1 had refused a wander guard and his picture was not posted in the book for identification. NA-A also stated the staff were expected to check on R1 hourly, document, and should have been competed as a team collectively but that was not being done. NA-A stated we were extremely busy that night and could have used more staff to monitor R1 frequently. NA-A stated staff had initialed the hourly rounding document indicated they had checked on R1 and trusted those staff. NA-A verified on 11/7/23, stayed at work until R1 was found and brought back to facility around 10:30 p.m. NA-A stated R1 had mixed cognition, knew he went for a walk, but was confused and did not recall where he went. NA-A also stated R1 was stand by assist with a wheeled walker for ambulation. NA-A indicated R1 was dressed appropriately for the weather with blue jeans, sweatshirt, and shoes but missed his Parkinson's medications so his hands shook. NA-A indicated they had worked with R1 two days after the elopement and every 15-minute checked were being completed diligently by staff. Additionally, NA-A stated on 11/6/23, R1 had gotten out of the facility through the exit door at around 2:00 p.m. when it was still light outside. NA-A stated R1 had been pretty restless, walked up and down the hallways, visited with the Chaplin, and then stated he wanted to go home. NA-A watched him open the exit door at the end of the hallway and walk outside. NA-A indicated along with staff nurse R1 was immediately brought back into the facility. Following that incident, NA-A indicated R1 had an alarm on his room door but refused to wear a wander guard. R1 did not like the door alarm so it	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 13</p> <p>was removed. No other interventions were added when the door alarm was removed, just hourly checks were continued.</p> <p>During an interview on 11/20/23 at 4:30 p.m., NA-C stated R1 was confused and unable to make his own decisions to leave the facility building safely by himself in the dark. NA-C stated they had worked 11/6/23, when R1 went out the exit door at the end of the hallway. NA-C stated a bunch of NA's ran to the door and talked R1 into coming back into the building. NA-C stated the temperature on 11/7/23, the evening R1 left the facility, was in the 30's and R1 wore a short-sleeved shirt, blue jeans, and a jacket. NA-C stated R1 sat on his bed at 6:00 p.m. in his room and that was the last time she saw him. NA-C indicated R1 had talked about leaving that day, kept saying he needed to go out and get the mail and check on his bank account. NA-C stated R1 was on rounding checks but not scheduled hourly. NA-C indicated they had checked on R1 approximately four times prior to him leaving the facility. NA-C stated she was stuck in one room with a resident from 6:30 p.m. to 7:30 p.m. and was not sure who completed the checks on R1 during that time. NA-C indicated she had returned to work the next day and R1 was on every 15-minute checks.</p> <p>During a telephone interview on 11/21/23 at 10:43 a.m., police officer (PO) stated he was notified on 11/7/23 at 8:46 p.m. R1 had left the facility and unknown as to whereabouts. PO stated it was approximately 40 degrees outside and dark. PO indicated during the search he was contacted around 9:05 p.m. by a nursing home across town and informed him a citizen had cited a male that matched R1's description, area was checked, and</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 14</p> <p>unable to locate him at that time. PO also stated the police department searched the entire town and found him at the bowling alley at 10:25 p.m. fully dressed in gray hooded sweatshirt, shoes, and jeans. PO stated his co-worker picked R1 up from the bowling alley and indicated he was slightly confused, pleasant, and tried to get to the airport. PO stated R1 was shaky and denied being cold.</p> <p>During an interview on 11/21/23 at 10:53 a.m. registered nurse (RN)-B stated R1 required supervision and a gait belt when out of his room ambulating due to unsteady gait. RN-B verified R1 was a risk for elopement, always talked about leaving the facility, and was able to physical exit the facility. RN-B stated R1 was on every two-hour check when first admitted to facility then changed within the first day to hourly checks when he got close to entry doors and tried to exit. RN-B stated R1 wanted to leave facility more after his sister visited. RN-B stated on 11/7/23, hourly checks had been completed on R1, refused wander guard, and wanted to check the mail. RN-B stated R1 was informed mail was not delivered on Sundays and was redirected easily. RN-B stated R1's door alarm was removed by maintenance a few days prior to his elopement and not sure of the exact reason and if any other interventions were implemented. RN-B indicated NA's were responsible to complete hourly checks and expected to document them. RN-B stated she trusted the NA's and did not check during the shift or at the end of the shift to see if they had been completed. RN-B also stated R1 was unable to make his own decisions, oriented to self only, disoriented to place thought he was in Moorhead or Park Rapids, lacked understanding of outside safety, and required redirection often.</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 15</p> <p>RN-B stated R1 would not be considered safe outside by himself in the dark. RN-B stated last time she saw R1 on 11/7/23, was at 6:00 p.m. located in the dining room eating supper. RN-B indicated R1 was switched from hourly checks on 11/8/23, around 12:00 p.m. to every 15-minutes checks. RN-B made a document in which staff could document every 15-minute checks and that documentation started at 5:10 p.m. RN-B stated R1 allowed staff to apply a wander guard to his ankle following the elopement incident.</p> <p>During an interview on 11/21/23 at 2:21 p.m. nurse manager (RN)-A stated R1 required assist of one and supervision during ambulation outside his room. RN-A indicate R1's cognition early morning clear and towards evening had gotten worse, like sundowners. RN-A stated R1 talked about leaving the facility when he was admitted, elopement assessment was completed earlier in the day 11/1/23 during admission process and later in the day R1's cognition changed and started to wander. RN-A stated R1 was placed on hourly rounding and offered a wander guard the first day or two and refused. RN-A stated staff were expected to document hourly rounds were completed in the progress notes each shift to assure they were being completed and keep R1 safe. RN-A verified R1 became more confused, wandered, and increased exiting seeking within a couple days after admission. RN-A stated NP saw R1 added Seroquel and Depakote (mood stabilizer) and should have helped with behaviors and seemed to have helped some. RN-A stated eventually a referral was completed to move R1 to a behavioral unit but no bed available. RN-A stated R1 was on Seroquel prior to admission to the facility and NP followed him closely to get him back on track. RN-A indicated staff were</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 16</p> <p>expected to have completed frequent checks on R1, not sure how often that was maybe hourly rounding. RN-A verified R1 attempted to exit the fire door on 11/6/23, then eloped from facility on 11/7/23. RN-A stated R1's progress notes indicated on 11/7/23, last seen by staff was around 6:00 p.m. urinated in a cup and stated I'll be leaving here soon. RN-A stated nothing more was documented after that until more than two hours later and when staff nurse went to administer R1's medications and he could not be located. RN-A stated she would have expected staff to have completed one on ones after that last entry on 11/7/23 at 6:00 p.m. and it may have provided distraction and could have possibly prevented the elopement that evening. RN-A verified R1 had impaired cognition and was unsafe being outside by himself in the dark. RN-A stated R1's was placed on 15 minute checks following the elopement but his care plan was not updated until 11/8/23 because she was not working and was the one who changed the care plan.</p> <p>During an interview on 11/21/23 at 3:27 p.m., licensed practical nurse (LPN)-A stated she attempted to locate R1 to administer medications around 8:30 p.m. on 11/7/23 but was unable to find him. LPN-A stated an NA indicated they last saw R1 approximately one and one-half hours ago and a building search was initiated and DON, police department (PD), on call NP, and FM were notified. LPN-A stated she provided a picture and description of R1 to the police department. LPN-A stated R1 was located at the local bowling alley across town and dropped off at the facility after 10:00 p.m. by the PD. LPN-A stated R1 was talkative, friendly, tired from his walk, and not sure what his orientation was, another nurse</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 17</p> <p>completed his assessment while she went to assist in another area of the facility. LPN-A also stated every 15-minute checks were initiated, and staff were expected to document those checks to ensure he was safe.</p> <p>During a telephone interview on 11/22/23 at 10:20 a.m., FM stated R1 had gotten weaker during his hospital stay and once he moved to the nursing home, he seemed more confused and had increased hallucinations. FM stated R1 did not want to go to the nursing home and had to be reminded he needed to get stronger in order to go back home. FM stated when she visited R1, she noticed an increase in restlessness, heightened agitation, and wanted to go home with her. FM stated she had concerns about R1 being out in the community by himself with the increase in confusion, hallucinations, poor balance with a chance of falling, was dark and cold out, and could have gotten really hurt. FM stated she thought the facility would keep a closer eye on him and he would be safe there.</p> <p>During an interview on 11/22/23 at 11:32 a.m. licensed social worker (LSW) verified R1 scored a 17 out of 30 on the MOCA assessment and on the Brief Interview for Mental Status (BIMS) showed a score of 10. LSW stated both fell in line with R1 required oversight, cueing, reminders, and unable to make appropriate or safe decisions on his own. LSW verified R1 could possibly function at a higher level if he had remained in the same environment but when he came to a new town and indicated he was going for a walk could not manage his way back to point A where he started without cues. LSW stated R1 had a history that was more severe and was not initially disclosed to us, however the hallucinations and</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 18</p> <p>forgetfulness were disclosed upon admission and reason why the door alarm was placed, wander guard was offered and refused, and hourly rounds were to be completed. LSW also stated R1's hallucinations were more prominent in the evenings and after the first four days at this facility R1 had an increase of hallucinations. LSW stated R1 could have a conversation and does understand but during the conversation it would be appropriate then all of a sudden, he would say he saw children under the sink, would be variable, and got worse in the evening, like sundowners.</p> <p>During an interview on 11/22/23 at 1:01 p.m. DON indicated as soon as staff identified R1 as an elopement risk his picture should have been placed on the list at the nurse's station but never occurred to staff to do this because it was not a standard thing to do unless they had the roam alert. DON stated R1 refused the roam alert and at the end of the first day (11/1/23) R1 was identified to be at risk for elopement (said he wanted to leave). DON stated a door alarm was placed on R1's room door so that staff knew where he was at and when he exited his room. DON also stated staff were expected to complete hourly checks on R1 and document them on a work sheet, nurse was responsible to assure those checks were being done and then ultimately me. DON stated the staff nurse was expected to document a summary progress note for every shift indicating the hourly rounds were being completed. DON indicated she had spoken to staff and was told the hourly rounding was completed but do not have the documentation to prove that it was. DON stated obviously on 11/7/23 there was a gap of 2 ½ hours where it had not been done and not sure why. DON verified that was when R1 exited the front door</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 19</p> <p>without alarms. DON stated no changes in care plan on checks were made until after the elopement because we thought what we were doing was working. DON also stated R1 continued to wander and talked about leaving the facility and redirection had been effective until 11/7/23. We were able to keep him kept calm and safe. DON stated after R1 was located and returned back to the facility, every 15-minute checks should have been completed by staff and documented in the progress notes by the nurse to keep R1 safe. DON verified R1's care plan changes occurred: 11/2/23, hourly rounding, 11/8/23, changed to every 15 minute checks, roam alert applied to right ankle, posted picture, 11/8/23, every 15-minute rounding.</p> <p>Facility policy titled Skilled Nursing Facility Elopement Prevention dated 12/2022, identified elopement as resident who leave the facility or care/area unit unattended or without prior authorization that are at risk for injury or harm will be considered to have eloped. All residents will be assessed through the admission process. Information used in this evaluation process includes orientation, ability to follow directions, decision making ability, any observed restlessness, wandering, or exit seeking behaviors. Residents with dementia or impaired cognition will be placed on a secured neighborhood whenever possible.</p> <p>The past noncompliance immediate jeopardy began on 11/7/23. The immediate jeopardy was removed, and the deficient practice corrected by 11/09/23, after the facility implemented a systemic plan that included the following actions: R1 was re-assessed for elopement risk and a Wander Guard was placed on 11/7/23; 15 minute</p>	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 20</p> <p>checks were started on 11/8/23. The facility re-educated staff on knowledge of residents who are high risk for elopement, to alert the director of nursing if resident refused the use of the roam alert so an alternative method to protect the resident could be initiated, and to complete hourly or 15 minute checks if care planned. Education verified through interview and training records.</p> <p>ACCIDENTS</p> <p>Based on interview, observation and document review, the facility failed to maintain routine maintenance per manufacturer's guidelines on resident ceiling lifts for 1 of 3 residents (R2) reviewed for transfers using a ceiling lift. This failure resulted in an Immediate Jeopardy (IJ) when R2's ceiling lift malfunctioned during a transfer, causing R2 to drop from a ceiling lift during a transfer, which resulted in bruising and increased pain.</p> <p>The IJ began on 11/11/23, when R2 was being transferred from the toilet with ceiling lift and a vital cord on the ceiling lift snapped, causing R2 to fall, land on the toilet bowl, resulting in bruising to R2's perineal and buttocks and have significant pain. The IJ was identified on 11/22/23, and the facility administrator and director of nursing (DON) were notified of the IJ at 5:30 p.m. on 11/22/23. The facility implemented immediate corrective action on 11/11/23, prior to the start of the survey and was therefore issued as Past Noncompliance.</p> <p>Manufacturer's Guidelines for Ceiling lifts used at facility indicated: Owner's manual 2022, version of the C-625 ceiling lift manual identified general inspection</p>	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 21 and preventive maintenance guidelines:</p> <p>EACH USE -Prior to each use the C625 lift and associated track, accessories, and slings must be visually inspected (e.g. no signs of fraying or breaking along the entire length of the strap, the stitching on lift strap where it connects to the carry bar, slings will show no signs of unusual wear and tear, hand control cable was not kinked, twisted, knotted, disconnected or damaged, all functions on hand control work correctly, no cuts, dents, or sharp edges on the carry bar that may damage the sling straps, lift has no unusual sounds when the carry bar was moved up or down or lift moved left to right, and ensure end stops were installed at each end of the track).</p> <p>MONTHLY -To be completed by user visual inspection as noted in the "Each Use" section above. With no one in the sling nor attached to the lift, check that the lift moves freely along the entire length of the track.</p> <p>SEMI-ANNUALLY -To be completed by user in high frequency transfer areas (more than 1500 lifts per year) or situations where heavier than normal clients are regularly lifted, maintenance should be also completed every six months. It is recommended that this service history be documented (e.g. all areas visually inspected in the each use section above and additionally check emergency stopping and lowering functions using the red emergency cord, lower the lift strap all the way out of the unit and verify there were no signs of fraying or breaking along itsentire length, let the strap out all the way to ground and motor should stop before</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 22</p> <p>the strap begins to wind backwards, check that the unit charges properly, check the lifts LED light indicates green when on, dark when off, and orange when charging.</p> <p>ANNUALLY -to be completed by a qualified service technician as authorized by Handicare. Complete the inspection as noted in the monthly section above. Complete the preventive maintenance procedures as outlined in the C-Series Service/Parts Manual.</p> <p>Note: Do not perform any inspection or maintenance while the lift was in use with a patient. Should any of these items fail the inspection do not use the lift. Contact your local authorized dealer for service. If the audible/visual prevention maintenance alert sounds, complete the preventive maintenance form before setting the lift counter.</p> <p>Preventative Maintenance (PM) - the lift will recommend preventive maintenance if it has not had a service for 1000 lifts or five total working hours of operation whichever occurs first. When the lift alerts you that PM was recommended the lift will beep every five seconds complete the semi-annual inspection, PM procedure, and reset the lift counter.</p> <p>Review of facility PM and routine maintenance records indicated: -R2's annual inspection check list dated 6/6/23, identified the ceiling lift located in her room was inspected for the following: rail system, electrical connections, hoist, strap, and lifting hanger. Comments indicated the case was broken.</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 23</p> <p>R2's Engineering (maintenance) request work orders identified:</p> <p>-4/11/23 at 2:28 p.m. ceiling lift beeping says maintenance.</p> <p>-5/10/23 at 3:02 p.m. handle for the remote on the ceiling lift was broke off.</p> <p>-11/11/23 at 11:27 p.m. ceiling lift strap snapped while attempting to transfer R2. Either entire lift or strap needed to be replaced as soon as possible.</p> <p>Work orders lacked evidence of repair/response to concern, including date of inspection.</p> <p>R2's quarterly Minimum Data Set (MDS) dated 10/22/23, identified R2 had intact cognition and no behaviors. R2 had impairment on both upper and lower extremities and required the use of a wheelchair for mobility. R2 was dependent on staff for all transfers, personal hygiene, showers, and toileting. R2 was frequently incontinent of bladder and always continent of bowel. R2 diagnoses included heart failure, depression, arthritis, and osteoporosis.</p> <p>R2's fall risk assessment dated 10/17/23, identified moderate risk for falls.</p> <p>On 11/19/23 at 7:45 R2's weight was 352 pounds.</p> <p>Review of R2's care plan revised 10/25/23, revealed R2 had an activity of daily living (ADL) deficit and high risk for falls related to history of left ankle fracture, decreased mobility, morbid obesity, rheumatoid arthritis, and high risk for bleeding and bruising due to Coumadin (anticoagulant that reduces the formation of blood clots). The care plan revealed interventions which</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 24</p> <p>included assist of two staff, one located on each side of R2 when transferred with ceiling lift for toileting, bathing, and all transfers, center ceiling lift on the track straight not swinging, and blue arrow lined up on lift track to have provided correct position over the toilet to prevent injury.</p> <p>R2's physical therapy (PT) summary dated 4/6/23, identified R2 as severely obese with a weight of 370 pounds. R2 had not made significant progress in PT with trial of PAL (sit to stand portable lift), not safe due to impaired activity intolerance and functional strength. R2 will continue transfers with the ceiling lift and no changes made to care plan.</p> <p>R2's progress notes identified:</p> <p>-11/11/23 at 12:35 a.m. R2 was being toileted with assist of two via ceiling lift. Staff reported that while R2 was raised up using the ceiling lift the strap broke. R2 was approximately 8 to 12 inches above the toilet when she fell onto the toilet seat. Both staff and R2 reported only hitting her buttocks on the toilet seat. R2 was assisted to bed with the Hoyer lift and assist of three staff. R2 had an 18 centimeter (cm) by 2 cm vertical bruise on the right inner buttock, below the coccyx that was purple and blue in color. R2 complained of pain in the bruised area. Ice pack was applied, Tylenol was given and rested in bed.</p> <p>-11/14/23 at 1:55 p.m. R2 complained of pain to bottom where bruising was. R2 stated it was almost like a burning feeling. Education provided that the bruise was deep and most likely when R2 sat on that area caused the slight burning sensation. R2 asked about an x-ray and staff encouraged R2 to take the scheduled Tylenol, allow time for that to work, and follow up with</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 25</p> <p>provider on rounds tomorrow if pain worsens or other signs that indicated an injury appear. At this time symptoms are not consistent with a fracture. R2 agreed to Tylenol and wait to see if pain resolved.</p> <p>-11/17/23 at 12:04 p.m. R2 complained of her tailbone hurting. Wanted to go from wheelchair to recliner. R2 requested and received an ice pack.</p> <p>-11/17/23 at 12:58 p.m. R2 had reported complaints of pain to her tailbone area and requested an x-ray to be done to see if it was broken. R2 was currently sitting on ice pack. New order received for x-ray of sacrum/coccyx. Imaging called and aware of transfer status.</p> <p>-11/17/23 at 5:19 p.m. x-ray came back negative and R2 was aware.</p> <p>During an observation on 11/20/23 at 12:30 p.m., NA-F and NA-G entered R2's room. NA-F pulled ceiling lift machine down the track located on the ceiling to R2 as she sat in the wheelchair and lowered the ceiling lift machine strap down in front of her with remote control. NA-F and NA-G attached the sling loops to the ceiling lift. Ceiling lift machine appeared intact and strap that hung from machine down to the lift bar was black, without fraying or tears, and moved in and out of machine with ease and no rubbing noises heard. Together NA-F and NA-G guided R2 to other side of the room and then into the bathroom on the ceiling lift/track. R2 was placed on top of the toilet and hung slightly towards the door (R2's right side), NA-F pulled the lift sling over to R2's left side to ensure she was centered on the toilet as she lowered her down with the remote. R2 was provided privacy in bathroom and sling was left</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 26</p> <p>attached to the ceiling lift while both NA-F and NA-G waited in her room. At 12:45 p.m. R2 stated I'm ready and NA-F and NA-G entered the bathroom and NA-G placed gloves on her hands. NA-G raised R2 off the toilet approximately 12 to 18 inches with the ceiling lift remote while NA-F completed R2's peri cares. R2 was centered in the sling and no swinging was noted during the transfer. NA-F and NA-G moved R2 from bathroom back into her room with the ceiling lift rails until she was positioned above her recliner. NA-F lowered R2 onto her recliner and both NAs removed the sling loops from ceiling lift machine. NA-F used the remote to retract the strap partially back up into the machine without difficulty and moved the machine back down the ceiling railing into the bathroom.</p> <p>During an observation on 11/20/23 at 1:00 p.m., NA-H and NA-I entered R2's room, NA-H moved ceiling lift machine down the rail from bathroom and placed over R2 as she sat in her recliner, both NAs hooked up lift sling loops to ceiling lift. NA-H raised R2 up off the recliner with the ceiling lift remote. R2 was centered in the sling and no swinging was noted. Together NA-H and NA-I moved R2 from recliner to bathroom on the ceiling lift rails without difficulty. NA-H lowered R2 onto the toilet with the remote. R2 was allowed privacy. NA-I applied gloves and NA-H raised R2 off the toilet with the ceiling lift remote approximately 12 inches and NA-I completed peri cares. R2 was then moved away from the toilet and surveyor was allowed to assess her bottom. R2's labia majora (fleshy outer folds located on each side of the vaginal opening) was swollen and approximately 80 percent covered with black, blue, and slightly yellow bruising. Additionally, R2 had a moderate sized vertical bruise (black and</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 27</p> <p>blue) on the right inner buttock, below the coccyx. No open areas were observed. NA-I confirmed she observed the same bruises and stated R2's bottom finally started to look better since the incident. NA-I pulled up R2's pants and together NA-H and NA-I slide R2 on the ceiling lift rails out of the bathroom and above her recliner. NA-H lowered R2 onto the recliner with the ceiling lift remote and then removed the sling loops from the lift bar.</p> <p>During an interview on 11/20/23 at 11:00 a.m., R2 stated was unable to stand or walk since her ankle fracture (healed now) and staff used a ceiling lift or Hoyer to transfer her from one place to another. R2 indicated she had an accident a little over one week ago where she was dropped onto the toilet from the ceiling lift during a transfer. R2 stated the strap/belt that comes out of the ceiling lift machine, was slightly discolored in the middle of the cord, like a gray color. R2 stated there were times when she could hear the strap rub on the inside of the machine and she had told staff about it and nothing was done. R2 was unable to recall the names of the staff. R2 stated staff lifted her off the toilet with the ceiling lift approximately 12 inches, and the strap snapped and dropped her onto the toilet. R2 stated she was thankful she did not land on the floor as she could have really been hurt bad. R2 stated maintenance came in and removed the ceiling lift, strap, and the sling they used that night.</p> <p>During an interview on 11/20/23 at 1:54 p.m., NA-F stated R2 was dropped from the ceiling lift onto the toilet and had worked the day after it happened. NA-F stated she had checked R2's strap prior to her transfers, prior to the incident</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 28</p> <p>and it was not brand new. Adding, she could see the edges of the cord that went into the lift which appeared used, but not frayed. NA-F stated the ceiling lift machines used to beep and the word "MAINT" would appear that reminded maintenance to check them, which NA-F indicated they do not do that anymore and may have changed how often the inspection was completed. NA-F stated maintenance replaced R2's ceiling lift with the one located in the tub room at the time when hers had not worked properly. NA-F indicated she notified maintenance any time she saw something wrong and placed a ticket through the system at the facility. NA-F stated when it was a more urgent concern maintenance was to be paged on their phones directly. NA-F stated R2 ended up with a large bruise on her bottom, complained of pain, and then the following day she had increased pain.</p> <p>During an interview on 11/21/23 at 9:10 a.m., plant operations supervisor (POS) stated the facility ceiling lifts were installed from 2014 to 2016 by a local company. POS stated all ceiling lifts were inspected annually by the vendor. POS stated when a ticket was submitted, they were inspected at that time also. POC indicated the expectation would have been monthly inspections completed by a trained user (maintenance staff) but since COVID-19, monthly inspections had not been done. POS stated there had been no way to track the monthly inspections and no documentation was found. POS stated only annual checks were completed and the last one was on June 2023 which was completed by the vendor. POS added, during the vendor visit in June of 2023, all maintenance staff were crossed trained, provided a refresher class and monthly</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	Continued From page 29 user inspections will be completed going forward. POS stated R2's strap snapped, and she was dropped onto the toilet on 11/11/23. POS stated the ceiling lift consisted of a carrier and the motor lift was connected by a strap, the motor turned a drum and released the strap up and down by remote control. POS also stated when R2 was lifted off the toilet the strap snapped in the center. POS stated R2's strap was not frayed and was black prior to the transfer however once the strap snapped the middle of the strap was then frayed and a gray color located in the middle of the strap where it snapped. POS verified on July 17, 2023, was the last time maintenance checked R2's ceiling lift and the track was changed in the bathroom from a turn table to a straight shot into the bathroom that provided a sharper radius to go directly over the toilet. POS verified there had been two tickets submitted on R2's ceiling lift in the past year (4/11/23 and 5/11/23) with minimal maintenance required, and no open tickets pending on R2's lift prior to the incident on 11/11/23. POS verified the request work orders had been completed but had not identified what the maintenance response was to the concern and no additional documentation was available. POS stated R2's monthly ceiling lift maintenance inspection by user were not completed four months in 2023: August, September, October, and November. POS stated that held true also for all 27 ceiling lifts in the facility, no documentation was found. POS stated going forward he planned on implementing assigned tagging and each lift will be assigned a barcode, incorporate that number into the work order system to assure proper maintenance was being completed. POS stated semi-annual inspections and monthly user inspections should have been completed according to the manufacture recommendations	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 30</p> <p>to ensure another set of eyes inspected the lifts to help prevent accidents. POS confirmed the particular unit R2 resided on was considered a higher use unit for the ceiling lifts and semi-annual and monthly inspections would have been needed especially on that unit. POS stated he expected staff to inspect the ceiling lifts, straps, lift slings each time prior to and during the transportation of a resident. POS stated R2's ceiling lift machine, strap, and sling lift were all removed from her room on 11/11/23 after the incident and sent back to vendor for evaluation. POS indicated there were no results from the vendor yet. POS verified facility staff technician for maintenance completed the monthly ceiling lift inspection on all ceiling lifts in the facility on 11/11/23, and logged information on the monthly ceiling lift inspection document with no concerns.</p> <p>During an interview on 11/21/22 at 12:35 p.m., NA-E stated along with NA-J toileted R2 and used a ceiling lift for the transfer on 11/11/23. NA-E stated they attached the loops of the sling to the ceiling lift and when R2 was lifted off the toilet approximately 6 to 12 inches the cord snapped like a foot up the strap from the bar. NA-E verified the strap was intact without any discoloration and not twisted prior to the incident then afterwards the strap was light gray colored and a lot of fraying where it had snapped. NA-E stated she notified the nurse immediately. NA-E stated R2 was then transferred from toilet to bed with the Hoyer lift and assist of three staff safely. NA-E stated maintenance was notified, came in and removed the ceiling lift along with the attachments and replaced all of it with another one. NA-E verified we are expected to examine the ceiling lift, cord, machine, and sling prior to any transfer and if anything looks abnormal a</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 31</p> <p>ticket should be submitted to maintenance letting them know. NA-E stated R2 was able to use a Hoyer lift until her ceiling lift was replaced. NA-E verified R2 ended up with a really large deep bruise to her inner right butt cheek and also a bruise on the upper left thigh from the bar that came down when she landed on the toilet.</p> <p>During a telephone interview on 11/21/23 at 3:16 p.m. Prism Medical service manager (SM) indicated the manufacturer guidelines were updated in 2022 for the C625 model. When the C625 ceiling lift was used daily in a room with a heavier person over 300 pounds, more maintenance was needed and recommended semi-annual inspections be completed by the vender. SM stated heavier used ceiling lifts wore out faster and additional wear occurred more often than expected. SM stated monthly inspections by the user were recommended to ensure the ceiling lift is in good working condition and the lift runs smoothing along the track.</p> <p>During an interview on 11/22/23 at 1:01 p.m. DON stated R2's strap discoloration was noticed after the strap broke only and not prior to that incident. DON stated they were unsure if the monthly and semi-annual inspections were completed. DON indicated some residents in the facility used their ceiling lifts less and some used it more than others. DON stated unsure if the vendor was contacted about the frequency of the required vendor and user inspections of the ceiling lift. DON stated staff were expected to inspect the ceiling lifts, slings, and straps prior to use to assure safety. DON verified the user manual currently being used by this facility for ceiling lifts was dated 2014 and would have been nice to know there was an updated one in 2022.</p>	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 32</p> <p>The past noncompliance immediate jeopardy began on 11/11/23. The immediate jeopardy was removed and the deficient practice corrected by 11/11/23, after the facility implemented a systemic plan that included the following actions:</p> <ul style="list-style-type: none"> -Monthly Ceiling Left Inspection dated 11/11/23, identified the following areas were assessed on all 27 ceiling lifts in the facility: -Lift straps showed no signs of fraying or breaking along the entire length. -Stitching on lift strap where it connected to the carry bar showed no signs of fraying an breaking. -Hand controller cable was not kinked, twisted, knotted, disconnected, or damaged. -All functions on the hand controller worked correctly (e.g. up/down/left/right). -No cuts, dents, or sharp edges on the carry bar that may damage the sling straps. -Lift had no unusual sounds when the carry bar was moved up and down or lift was moved right or left. -Without a resident in the sling or attached to the ceiling lift, the lift moved freely along the entire length of track. -Ensured end stops are installed at each end of track. <p>Additionally, a new maintenance process was developed to ensure ongoing requested and</p>	F 689		

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

PRINTED: 12/08/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/22/2023
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	Continued From page 33 recommended maintenance would be tracked and completed promptly and/or as scheduled. All staff were re-trained on the new maintenance request process and safe use of lifts, including inspection of lift equipment before transfer use.	F 689			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00907	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/22/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS: On 11/20/23, to 11/22/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.</p> <p>The following complaints were reviewed. No</p>	2 000		
-------	--	-------	--	--

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00907	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/22/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
2 000	<p>Continued From page 1</p> <p>licensing orders were issued.</p> <p>H52127027C (MN00098398)</p> <p>H52127124C (MN00098485)</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		