Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 1, 2025

Administrator
Essentia Health Oak Crossing
1040 LINCOLN AVENUE
DETROIT LAKES, MN 56501

RE: CCN: 245212
Cycle Start Date: July 11, 2025

Dear Administrator:

On August 28, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

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October 1, 2025

Administrator
Essentia Health Oak Crossing
1040 LINCOLN AVENUE
DETROIT LAKES, MN 56501

Re: Reinspection Results
Event ID: NAB9-H2

Dear Administrator:

On 08/28/2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on 07/11/2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
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Saint Paul, MN 55164-0900
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An equal opportunity employer.

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July 29, 2025

Administrator
Essentia Health Oak Crossing
1040 LINCOLN AVENUE
DETROIT LAKES, MN 56501

RE: CCN:245212
Cycle Start Date: July 11, 2025

Dear Administrator:

On July 11, 2025, a survey was completed at your facility by the Minnesota Departments 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department

of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by October 11, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 11, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

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
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July 29, 2025

Administrator
Essentia Health Oak Crossing
1040 LINCOLN AVENUE
DETROIT LAKES, MN 56501

Re: State Nursing Home Licensing Orders
Event ID: NAB911

Dear Administrator:

The above facility was surveyed on July 11, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction

Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

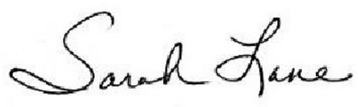
Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

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.

Please feel free to call me with any questions.

Sincerely,



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essentia Health Oak Crossing	1040 LINCOLN AVENUE , DETROIT LAKES, Minnesota, 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
F0000	INITIAL COMMENTS On 7/9/25 through 7/11/25, 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. The following complaint was reviewed: H52129050C (MN00114426) As a result of the investigation, a deficiency was cited at F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		08/25/2025
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F0880	Education and competency validation was provided for NA-A on the expectations related to hand hygiene with Resident care. All residents in the facility who receive assistance requiring direct contact are at risk for being affected by this deficient practice. Hand hygiene policy and standard work documents were reviewed. All clinical staff that provide clinical care or ADL assistance will receive updated education and competency validation on hand hygiene expectations. 30 hand hygiene audits will be conducted weekly by nursing leadership for 6 weeks to ensure that hand	08/25/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245212	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

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F0880 SS = D	Continued from page 1 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F0880	Continued from page 1 hygiene is being appropriately performed during resident care activities. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. The Director of Nursing will be responsible for ensuring this plan of correction is followed. the deficiency will be corrected by 8/25/25	

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F0880 SS = D	Continued from page 2 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure appropriate hand hygiene was performed during personal cares for 1 of 1 residents (R3) reviewed for hand hygiene. Finding include: R3's care plan dated 6/3/25, identified he had an activities of daily living (ADLS) deficit related to impaired cognition, impaired mobility, and incontinence. Staff were directed to offer and assist with toilet upon rising, before and after meals, check on him every two hours at night and assist to toilet on 1:00 a.m. rounds. Stay with resident while in bathroom, do not leave alone. Transfer with assist of one and walker. He required assist of one for personal hygiene and toileting. History of urinary tract infection. R3's quarterly Minimum Data Set (MDS) dated 6/6/25, identified R3 had severe impaired cognition and no behaviors. R3 required partial/moderate assistance chair/bed to chair transfer and substantial/maximal assistance with personal hygiene, shower/bathe, upper and lower body dressing, personal hygiene, lying to sitting, sit to stand, ambulation upto10 feet, toilet transfer, and used a manual wheelchair for mobility. R3 was frequently incontinent of bowel and bladder. He had diagnoses that included non-traumatic brain dysfunction, cancer, and dementia. During an observation on 7/9/25 at 2:41 p.m., R3 laid in bed covered with sheet and blanket. At 2:45 p.m., nursing assistant (NA)-A entered his room, asked if he needed to use the bathroom prior to going downstairs to activities, and he responded yes. NA-A did not sanitize her hands, assisted him up to the edge of the bed, applied a transfer belt, shoes over his gripper socks, and placed his walker in front of him. NA-A held onto	F0880		

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F0880 SS = D	Continued from page 3 the transfer belt with one hand and R3 stood up, grabbed his walker, pivoted, and lowered himself down on the wheelchair. R3's bottom sheet was moderately saturated with urine. NA-A grabbed the wheelchair handles, pushed R3 into the bathroom, and applied gloves. R3 placed his hands on the grab bar located on the wall and pulled himself up while NA-A held onto the transfer belt with one hand and with the other hand NA-A pulled down R3's pants and incontinent brief saturated with urine. R3 lowered himself onto the toilet. NA-A removed the soiled brief, R3's shoes, and urine soiled pants. NA-A placed the dirty brief in a garbage bag, soiled pants into another bag, applied a clean brief and pulled it up to R3's thighs while he sat on the toilet. Without changing gloves, NA-A walked from bathroom to R3's closet, grabbed a clean pair of pants, went back to bathroom, placed pants over R3's feet, pulled them up over the brief located on R3's thighs, and placed shoes back on R3's feet. NA-A removed the gloves, did not sanitize hands, grabbed her walkie with her left hand and requested clean sheets. While R3 sat on toilet NA-A walked over to the dresser, pulled open the drawer, and removed a package of wipes, and applied clean gloves. She cued R3 to stand up, held onto the transfer belt, R3 grabbed the bar on the wall and stood up by the toilet. NA-A wiped rectal area with wipes, did not wipe the front peri area, pulled up the brief and R3's pants. NA-A place her hand on his shoulder and other hand under transfer belt, as R3 lowered himself down onto the wheelchair, NA-A removed transfer belt and her gloves. NA-A did not sanitize her hands, flushed the toilet and hung transfer belt on bar located on the wall outside the bathroom. NA-A grabbed the footrests, placed them on the wheelchair, lifted R3's left foot up and onto footrest. NA-A bagged bathroom garbage, opened bottom drawer, placed the package of wipes inside, and closed the drawer. NA-B entered the room, sanitized his hands, applied gloves and stripped R3's soiled bed linens, wiped down the bed mattress, and placed linens in a bag. NA-A pushed R3 out of the bathroom, closed the bathroom door, and activated the door alarm. NA-A did not sanitize her hands and exited the room while she pushed R3 in the wheelchair down the hallway to the elevator. At 2:56 p.m., NA-A arrived back on second floor, walked over to the NA charting area and sanitized her hands. During an interview on 7/9/25 at 3:37 p.m., NA-A stated she entered R3’s room without sanitizing her hands and assisted R3 to the bathroom. She placed gloves on and removed R3's urine soiled pants and brief. With the same gloves on grabbed a pair of pants out of the closet, placed them on R1, removed the gloves, did not	F0880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essentia Health Oak Crossing	1040 LINCOLN AVENUE , DETROIT LAKES, Minnesota, 56501

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F0880 SS = D	Continued from page 4 sanitize hands, grabbed a package of wipes form the drawer and placed clean gloves on. She wiped R3's front peri area and rectal area with wipes, pulled up R3's pants, lowered R3 back into his wheelchair, removed the transfer belt, and removed the dirty gloves. Without sanitizing her hands, she pushed R3 out of his room in his wheelchair down the hallway to the elevator and brought R3 downstairs. She came back up to second floor and then realized she had not completed hand hygiene from the time she entered R3's room, completed cares, exited his room, went downstairs via elevator, until she came back upstairs. She felt she had messed up and should have sanitized her hands more often. NA-A stated staff were expected to have completed hand hygiene when entering and exiting a resident room, after removal of gloves, leaving the bathroom, and should have offered R3 hand hygiene prior to leaving his room. Good hand hygiene was expected for infection control and help prevent infections. During an interview on 7/11/25 at 10:18 a.m., infection preventionist, registered nurse (RN)-A stated staff were expected to use the foam hand sanitizer outside of the resident room, foam in and out and after gloving, between peri cares and other ADL's after going to potential body fluids. Hand hygiene was expected to prevent transmission of germs to animate objects, self, frequently touched areas, resident to resident, staff, and anyone else that became in contact with those surfaces. Without proper hand hygiene germs could have been spread and would lead to infections due to transmission of microbes and potential to cause illness and disease. During an interview on 7/11/25 at 10:45 a.m., director of nursing (DON) stated staff were expected to sanitize hand hygiene before entering and exiting a resident's room, with cares anytime they are finished cleaning a dirty area such as peri cares, assist with toileting or any hygiene, and after removal of gloves. Staff were expected to remove gloves as soon as they completed peri cares, made sure resident was safe, and then sanitize hands to prevent the spread of infection. Facility policy Hand Hygiene dated 11/10/23, identified hand hygiene practices for healthcare workers can help prevent the transmission of microbial pathogens and aid in the reduction of healthcare associated infections. All healthcare works must perform hand hygiene: before patient contact or contact with the patient's environment, before entering a patient's room, before	F0880		

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F0880 SS = D	Continued from page 5 touching a patient, before touching any object or furniture in the patient zone, after patient contact, after touching a patient or any object or furniture in the patient environment, before clean/aseptic procedure, after body fluid exposure, when moving form a contaminated body site to a clean body site during patient care, before putting on gloves, and after removing gloves or other personal protective equipment (PPE). Gloves are not to be used in place of hand hygiene.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/11/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essentia Health Oak Crossing	**1040 LINCOLN AVENUE , DETROIT LAKES, Minnesota, 56501**

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER 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. 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. 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. INITIAL COMMENTS: On 7/9/25 through 7/11/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		08/25/2025

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/11/2025**

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20000	Continued from page 1 The following complaint was reviewed. H52129050C (MN00114426) NO licensing order was issued. Additionally, as a result of the investigation, a licensing order was issued at 1375. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home	21375	see federal POC	08/25/2025

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21375	Continued from page 2 must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure appropriate hand hygiene was performed during personal cares for 1 of 1 residents (R3) reviewed for hand hygiene. Finding include: R3's care plan dated 6/3/25, identified he had an activities of daily living (ADLS) deficit related to impaired cognition, impaired mobility, and incontinence. Staff were directed to offer and assist with toilet upon rising, before and after meals, check on him every two hours at night and assist to toilet on 1:00 a.m. rounds. Stay with resident while in bathroom, do not leave alone. Transfer with assist of one and walker. He required assist of one for personal hygiene and toileting. History of urinary tract infection. R3's quarterly Minimum Data Set (MDS) dated 6/6/25, identified R3 had severe impaired cognition and no behaviors. R3 required partial/moderate assistance chair/bed to chair transfer and substantial/maximal assistance with personal hygiene, shower/bathe, upper and lower body dressing, personal hygiene, lying to sitting, sit to stand, ambulation upto10 feet, toilet transfer, and used a manual wheelchair for mobility. R3 was frequently incontinent of bowel and bladder. He had diagnoses that included non-traumatic brain dysfunction, cancer, and dementia. During an observation on 7/9/25 at 2:41 p.m., R3 laid in bed covered with sheet and blanket. At 2:45 p.m., nursing assistant (NA)-A entered his room, asked if he needed to use the bathroom prior to going downstairs to activities, and he responded yes. NA-A did not sanitize her hands, assisted him up to the edge of the bed, applied a transfer belt, shoes over his gripper socks, and placed his walker in front of him. NA-A held onto the transfer belt with one hand and R3 stood up, grabbed his walker, pivoted, and lowered himself down on the wheelchair. R3's bottom sheet was moderately saturated with urine. NA-A grabbed the wheelchair handles, pushed R3 into the bathroom, and applied gloves. R3 placed his hands on the grab bar located on the wall and pulled himself up while NA-A held onto the transfer belt with one hand and with the other hand	21375		

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21375	Continued from page 3 NA-A pulled down R3's pants and incontinent brief saturated with urine. R3 lowered himself onto the toilet. NA-A removed the soiled brief, R3's shoes, and urine soiled pants. NA-A placed the dirty brief in a garbage bag, soiled pants into another bag, applied a clean brief and pulled it up to R3's thighs while he sat on the toilet. Without changing gloves, NA-A walked from bathroom to R3's closet, grabbed a clean pair of pants, went back to bathroom, placed pants over R3's feet, pulled them up over the brief located on R3's thighs, and placed shoes back on R3's feet. NA-A removed the gloves, did not sanitize hands, grabbed her walkie with her left hand and requested clean sheets. While R3 sat on toilet NA-A walked over to the dresser, pulled open the drawer, and removed a package of wipes, and applied clean gloves. She cued R3 to stand up, held onto the transfer belt, R3 grabbed the bar on the wall and stood up by the toilet. NA-A wiped rectal area with wipes, did not wipe the front peri area, pulled up the brief and R3's pants. NA-A place her hand on his shoulder and other hand under transfer belt, as R3 lowered himself down onto the wheelchair, NA-A removed transfer belt and her gloves. NA-A did not sanitize her hands, flushed the toilet and hung transfer belt on bar located on the wall outside the bathroom. NA-A grabbed the footrests, placed them on the wheelchair, lifted R3's left foot up and onto footrest. NA-A bagged bathroom garbage, opened bottom drawer, placed the package of wipes inside, and closed the drawer. NA-B entered the room, sanitized his hands, applied gloves and stripped R3's soiled bed linens, wiped down the bed mattress, and placed linens in a bag. NA-A pushed R3 out of the bathroom, closed the bathroom door, and activated the door alarm. NA-A did not sanitize her hands and exited the room while she pushed R3 in the wheelchair down the hallway to the elevator. At 2:56 p.m., NA-A arrived back on second floor, walked over to the NA charting area and sanitized her hands. During an interview on 7/9/25 at 3:37 p.m., NA-A stated she entered R3’s room without sanitizing her hands and assisted R3 to the bathroom. She placed gloves on and removed R3's urine soiled pants and brief. With the same gloves on grabbed a pair of pants out of the closet, placed them on R1, removed the gloves, did not sanitize hands, grabbed a package of wipes form the drawer and placed clean gloves on. She wiped R3's front peri area and rectal area with wipes, pulled up R3's pants, lowered R3 back into his wheelchair, removed the transfer belt, and removed the dirty gloves. Without sanitizing her hands, she pushed R3 out of his room in his wheelchair down the hallway to the elevator and brought R3 downstairs. She came back up to second floor	21375		

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21375	Continued from page 4 and then realized she had not completed hand hygiene from the time she entered R3's room, completed cares, exited his room, went downstairs via elevator, until she came back upstairs. She felt she had messed up and should have sanitized her hands more often. NA-A stated staff were expected to have completed hand hygiene when entering and exiting a resident room, after removal of gloves, leaving the bathroom, and should have offered R3 hand hygiene prior to leaving his room. Good hand hygiene was expected for infection control and help prevent infections. During an interview on 7/11/25 at 10:18 a.m., infection preventionist, registered nurse (RN)-A stated staff were expected to use the foam hand sanitizer outside of the resident room, foam in and out and after gloving, between peri cares and other ADL's after going to potential body fluids. Hand hygiene was expected to prevent transmission of germs to animate objects, self, frequently touched areas, resident to resident, staff, and anyone else that became in contact with those surfaces. Without proper hand hygiene germs could have been spread and would lead to infections due to transmission of microbes and potential to cause illness and disease. During an interview on 7/11/25 at 10:45 a.m., director of nursing (DON) stated staff were expected to sanitize hand hygiene before entering and exiting a resident's room, with cares anytime they are finished cleaning a dirty area such as peri cares, assist with toileting or any hygiene, and after removal of gloves. Staff were expected to remove gloves as soon as they completed peri cares, made sure resident was safe, and then sanitize hands to prevent the spread of infection. Facility policy Hand Hygiene dated 11/10/23, identified hand hygiene practices for healthcare workers can help prevent the transmission of microbial pathogens and aid in the reduction of healthcare associated infections. All healthcare works must perform hand hygiene: before patient contact or contact with the patient's environment, before entering a patient's room, before touching a patient, before touching any object or furniture in the patient zone, after patient contact, after touching a patient or any object or furniture in the patient environment, before clean/aseptic procedure, after body fluid exposure, when moving form a contaminated body site to a clean body site during patient care, before putting on gloves, and after removing gloves or other personal protective equipment	21375		

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21375	Continued from page 5 (PPE). Gloves are not to be used in place of hand hygiene. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review and revise policies and procedures related to ensuring staff were following proper hand hygiene process. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are following guidance with hand hygiene. The Quality Assurance Performance Improvement (QAPI) committee could monitor ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one- (21) days	21375		