DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

January 9, 2026

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

RE: CCN: 618245301
Cycle Start Date: December 17, 2025

Dear Administrator:

On December 17, 2025, survey was completed at your facility by the Minnesota Department 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.

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

REMOVAL OF IMMEDIATE JEOPARDY

On December 17, 2025, the situation of immediate jeopardy to potential health and safety cited at F726 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 24, 2026.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 24, 2026, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 24, 2026, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 24, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

If you have not achieved substantial compliance by January 24, 2026 the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, ESSENTIA HEALTH HOMESTEAD will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 24, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further,

this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 17, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this

process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

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

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

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 Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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January 9, 2026

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

Re: State Nursing Home Licensing Orders
Event ID: 1DF1A7-H1

Dear Administrator:

The above facility survey was completed on December 17, 2025 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 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/17/2025**

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

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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 12/12/25 through 12/17/25, 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. The following complaint was reviewed during the survey. H54289082C (2680030) with a licensing order issued at 0830.	20000		01/11/2026

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/17/2025**

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20000	Continued from page 1 As a result of the investigation,1650 was also issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure staff utilized the proper sling sizes when performing transfers via mechanical lift for 4 of 5 residents (R1, R2, R4, R5) who utilized a mechanical lift for transfers. Findings include: R1's annual Minimum Data Set dated 9/22/25, identified intact cognition and diagnosis of fractures, heart disease, obesity and dependence on enabling machines. R1's care plan dated 12/18/25, identified an alteration in mobility related to fracture of lumbar spine, weakness and pain. The care plan directed staff to transfer R1 using a mechanical lift but lacked evidence of a sling size. R1's Essentia Lift and Move Profile dated 9/20/25 indicated the need for a full body lift, indicated he was not able to lift himself into a standing position and indicated he did not weigh less than 265 pounds (lb.) The assessment indicated sling size LL (purple), 220-350 lbs. R1's care plan dated 10/8/25, identified an alteration in physical mobility related to fracture to lumbar spine with surgical fixation, weakness, pain and medications. The care plan directed staff to assist with transfers using a mechanical lift but lacked evidence of a sling size.	20830	Corrected	01/16/2026

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20830	Continued from page 2 R1's Progress Notes identified the following: 10/15/25, Bruise noted to R1's right inner thigh measuring 9.7 centimeters (cm) x 5.8 cm. Very dark in color and is swollen enough to see dimples where each piece of hair inserts into the skin. Swelling, hard and approximately the size of a softball. The skin surrounding the contusion was reddish blue/purple and measured 25 cm x 26.5 cm. R1 stated pain rated 3-5 out of 10 resting but increased to 7-9 out of 10 when area was touched. R1 stated it was from the lift sling. Bruise was consistent with where the sling crossed under the right thigh and where it hooked to the machine. R1's records lacked evidence the facility to any further action to reduce the likelihood of another injury such as, assessment of possible sling or lift concerns, or addressing staff training. During interview on 12/16/25 at 9:50 a.m., R1 stated when he was injured during a transfer, and said sometime between the transfer from the bed to the shower chair he ended up getting a bruise on the inside of his right thigh that was "gigantic." R1 said it was very painful and said a couple days later a nurse looked at it and called the physician right away to look at it. R1 said the bruise prevented him from getting out of bed for several days. During observation on 12/16/25 at approximately 11:15 a.m., nursing assistant (NA)-A and NA-B prepared to transfer R1 using the mechanical lift. The lift sling applied had royal blue edging (according to the size chart on the assessment indicated XL (308-440lbs.). A sling with orange edges (XXL, 440-550 lbs.) was on the chair next to R1's bed. R2's Resident Face Sheet indicated diagnosis of respiratory disease, dementia with mood disturbance, chronic pain and delusions. R2's Essentia Lift and Move Profile dated 11/15/25, indicated the use of a mechanical lift. The profile did not identify a sling size. R2's care plan dated 9/25/25, identified an alteration in mobility related to obesity, weakness, age and back pain. The care plan directed staff to transfer R2 with a mechanical lift but lacked evidence of a sling size. During observation on 12/16/25, at 11:30 a.m., R2 was seated in a wheelchair. Underneath R2 was a sling with	20830		

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20830	Continued from page 3 purple edges, size LL according to the sizing chart. R2's weight on 12/12/25 indicated 138 lbs. According to the sizing chart on the lift and move profile 138lbs. indicated a medium sling. R4's Resident Face Sheet indicated diagnosis of Parkinson's disease, dementia, artificial knee joint and osteoarthritis. R4's Essentia Lift and Move Profile dated 11/29/25, indicated the need for a mechanical lift, indicated she was unable to stand and weighed less than 256 lbs. The profile indicated a sling size M (yellow) 121-165 lbs. R4's care plan dated 11/26/25, identified an alteration in physical mobility related to weakness, advanced age, Parkinson's disease and dementia. The care plan indicated the use of a mechanical lift for all transfers but lacked evidence of a sling size. During observation on 12/16/25 at 11:30 a.m., R4 was seated in the dining room in her wheelchair. R4 had a sling underneath her with purple edges (LL) 220-350 lbs. R5's Resident Face Sheet identified diagnosis that included diabetes, heart failure, end stage renal disease and above knee amputation. R5's care plan dated 11/18/25, identified impaired mobility and indicated use of a mechanical lift with amputee sling for all transfers but lacked evidence of a sling size. R5's Essentia Lift and Move Profile dated 10/14/25, indicated the use of a mechanical lift and a Green sling (large) 166-219 lbs. During interview on 12/16/25 at 12:41 p.m., NA-A stated the sling size should be on the care plan. NA-A said they used the purple sling for R2 and said it was a size medium. For R1, they used an orange sling because it was a little bigger and had more padding, and staff used the purple edged sling to transfer R4. NA-A said he did not know where to look to determined what slings should be used and stated R5 also used a mechanical lift with a Yellow (medium) edged sling. During interview on 12/16/25 at 12:55 p.m., the interim director of nursing (DON) stated sling sizes were based on weight. The Interim DON said the lift and move assessment was used to determine size. The interim DON said each resident had their own sling in their rooms.	20830		

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20830	Continued from page 4 During observation on 12/17/25 at 10:28 a.m., R5 was wheeled into the facility following an appointment. R5 was seated in a wheelchair with a sling with yellow edges underneath him. (Profile indicated Green) During interview on 12/17/25 at 10:34 a.m., the interim DON stated she did not think anyone came up with a root cause related to R1's bruise. The interim DON said the sling did put pressure on the thigh and felt it was an isolated incident but said she was unsure if anyone had assessed to ensure the correct sling size had been used. During interview on 12/17/25 at 1:57 p.m., the quality partner registered nurse (RN) said the facility policy was to follow manufacturers recommendations for proper sling size. The quality partner RN said the potential repercussions of using the incorrect sling included injury to the resident. Facility Lift Program Policy and Guide, updated, indicated all resident care would be provided in a safe, appropriate and timely manner in accordance with the care plan. The care plan team used the Essentia Health Lift Program Guide to determine the means for providing transfer and mobility assistance for residents. SUGGESTED METHOD OF CORRECTION: The administrator and director of nursing (DON) could review, revise, or create policies and procedures for assessing proper slings size and use for all residents utilizing mechanical lifts to ensure staff are utilizing the proper slings for resident transfers. All staff could be trained on proper sling sizes including where to find the appropriate sling size. The results of those audits could be taken to QAPI ongoing to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		
21650	Administration - Meds by Unlicensed Personnel CFR(s): MN Rule 4658.1360 Subp. 2 A.B. 1-6 Subp. 2. Training. Unlicensed nursing personnel who administer medications in a nursing home must: A. have completed a nursing assistant training program approved by the department; and B. have completed a standardized medication administration training program for unlicensed	21650	Corrected	01/16/2026

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(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
21650	Continued from page 5 personnel in nursing homes which is offered through a Minnesota postsecondary educational institution that includes, at a minimum, instruction on the following: (1) the complete procedure of checking the resident's medication record; (2) preparation of the medication for administration; (3) administration of the medication to the resident; (4) assisting residents with self-administration as necessary; (5) documentation after administration of the date, time, dosage, and method of administration of all medications, or the reason for not administering the medication as ordered, and the signature of the nurse or authorized person who administered and observed the same; and (6) the type of information regarding medication administration reportable to a nurse. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure an un-licensed nursing student (NS) was supervised during resident medication administration, including significant medication such as insulin, liquid morphine and other controlled substances for 4 of 4 residents (R2, R3, R6, R7). In addition, NS did not possess a nursing license, competencies, or skills set to provide necessary resident nursing services nor other certification required for medication administration. Findings include: R2's Resident Face Sheet indicated diagnosis of respiratory disease, dementia with mood disturbance, chronic pain and delusions. R2's care plan dated 9/25/25, identified a risk for alteration in comfort related to pain and identified the use of antipsychotic medication and indicated medications per orders. R2's Physician's Order Report dated 12/17/25, identified the following order: -12/26/23, Hydromorphone- schedule II (controlled substance) liquid; 1 milligram (mg)/milliliter (ml). Amount 2 ml's by mouth every hour as needed. Up to 24 times per day. R2's Individual Narcotic Record identified hydromorphone 1 mg/ml. The record indicated the NS administered the medication on 11/10/25. R2's Medication Administration Record (MAR) dated December 2025, indicated the NS administered R hydromorphone 1 mg/ml medication on 12/5/25 and	21650		

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21650	Continued from page 6 12/12/25. R6's Resident Face Sheet indicated diagnosis of pain, hypertension, respiratory failure and diabetes. R6's care plan dated 11/26/25, identified altered endocrine function related to type II diabetes. The care plan directed staff to monitor blood glucose per physician orders and monitor signs and symptoms of hypo or hyperglycemia. The care plan further directed staff to administer medications and ordered. R6's Physician Order Report dated 12/17/25, identified the following orders: -3/26/25, hydrocodone- acetaminophen- schedule II tablet 5 mg-325 mg. Amount 1 tab twice daily as needed. -9/9/24, Accuchecks, notify certified nurse practitioner if below 70 readings are noted. -4/3/25, Humolog KwikPen Insulin (insulin lispro) pen; 100 unit/ml; amount eight units subcutaneous (sq) (fatty tissue just under the skin). Give eight units three times daily with meals. -4/4/25, Lantus U-100 Insulin (insulin glargine) solution; 100 unit/ml. Amount 40 units sq. Once daily between 6:00 a.m. and 10:00 a.m. R6's Individual Narcotic Record identified hydrocodone/acetaminophen- schedule II 5mg/ 325mg, one tab as needed. The record indicated NS administered the medication on 11/10/25. R6's Medication Administration Record (MAR) dated December 2025, indicated the NS performed accuchecks and administered medication, including insulin, to R6 on 12/5/25 and 12/12/25. During observation on 12/12/25 at 11:34 am., the NS administered insulin to R6 via insulin pen, unsupervised. When interviewed, the NS stated she was working at the facility as part of an apprenticeship program and said she was still in school. The NS stated, /“I can do basically almost anything except a select few things.” /The NS stated she did not perform treatments but passed medications, completed blood glucose checks and gave insulin. NS said she normally checked with the nurse when giving insulin because she was not comfortable with it but acknowledged she had not checked with the nurse when she gave R6's insulin during observation. NS also indicated the program was newer and there were a lot of things that were not clear regarding skills she was allowed to perform. When asked how she knew what skills she could and could not perform, NS said she had a /“sheet somewhere” /but did not have it with her. At 12:36 p.m., the NS confirmed she was not a trained medication aide. On 12/12/25 at 12:06 p.m., the NS was observed performing a blood glucose check independently, without supervision. It was noted during all observations of NS medication administration, Registered Nurse (RN)-A was seated in a glass enclosed office, located behind the nurse station, not in sight of NS during her task. R7's Resident Face Sheet indicated diagnosis of Alzheimer's,	21650		

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21650	Continued from page 7 dementia, anxiety, depression and chronic pain. R7's care plan dated 12/16/25, identified pain and directed staff to administer medications per orders and monitor and record effectiveness. The care plan identified the use of psychotropic medications and directed staff to monitor for effectiveness and adverse consequences. R7's Physician Order Report dated 12/17/25, identified the following medications: -10/23/25, Tramadol- schedule IV tablet 25 mg. Amount: 75 mg by mouth two times daily. -11/12/25, Lorazepam- schedule IV tablet; 0.5 mg by mouth. Can take 0.5 mg every four hours as needed for agitation/anxiety/restlessness. -10/23/25, Morphine concentrate- schedule II solution; 100 mg/5 ml (20mg/ml). Amount 0.5 ml by mouth every hour as needed up to 24 times per day. R7's Individual Narcotic Record identified Morphine 100 mg/ 5 ml. take 1/2 ml every hour as needed. The record indicated the NS administered the morphine twice on 11/17/25 and once on 12/8/25. R7's MAR dated December 2025 indicated the NS administered the morphine medications to R7 on 12/5/25 and 12/12/25. During interview on 12/12/25 at 2:10 p.m., RN-A was asked what duties the NS was able to perform. RN-A pointed to a list taped to a cabinet that indicated the NS could administer medications after competency was verified and said she had not seen the competencies (completed by NS) but said they should have been completed prior to being released to work on the floor. During interview on 12/16/25 at 9:21 a.m., the director of the associate degree programs for the college where the NS was a student, stated the apprenticeship program utilized the Essentia Health intern student guidelines and according to Essentia the student was supposed to be supervised. The director said the student was supposed to be paired with a preceptor and said the NS was assigned to RN-A and two other nurses. The director stated the apprenticeship program was not designed to have the students working as a nurse on the floor without supervision. During interview on 12/16/25 at 2:33 p.m., the administrator stated her understanding of the nurse apprentice was once they had competencies completed, they could treat the students like new nurses on orientation. The administrator further stated she had spoken to the DON who said she had not completed competencies with the NS. The administrated believed NS started at the building around September of 2025, adding she was never “on the schedule” but could not provide a date as to when NS may have started passing medications unsupervised. During interview on 12/17/25 at 3:02 p.m., RN-A stated she had not been given guidance regarding what the NS was able to with or without supervision. RN-A said she kept asking so the director of nursing posted a list on the cabinet	21650		

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21650	Continued from page 8 that outlined what tasks the NS could perform after a competency had been completed. RN-A stated she was unable to attend the training to be a preceptor, so she did not believe she had been assigned. RN-A confirmed she was not NS preceptor on 12/12/25 (onsite survey date) and was the only RN on duty. An Essentia Health document titled Nursing Student Guidelines dated 9/2024, indicated medication administration by mouth, sq, intramuscular, inhaled or topical could only be administered under direct supervision. During interview on 12/29/25 at 5:01 p.m., the medical director stated he had concerns about staff working outside the scope of practice and said insulin and controlled substances had a higher risk for negative patient impact and diversion. SUGGESTED METHOD OF CORRECTION: The administrator and director of nursing (DON) could review, revise, or create policies and procedures for ensuring staff who administer medications have adequate training/license/certification. All staff could be trained on state laws related to medication administration. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21650		

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F0000	INITIAL COMMENTS On 12/12/25 through 12/17/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed.H54289082C (H54289082C) with a deficiency issued at F689 and F585. As a result of the investigation, a deficiency was also issued at F726. The survey also resulted in an Immediate Jeopardy (IJ) at F726 when the facility failed to supervise and unlicensed staff member, (nurse apprentice) during resident medication administration, which included significant medications such as insulin and liquid morphine. The IJ began on 12/12/25, and the immediacy was removed on 12/17/25 at 3:10 p.m. 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		01/11/2026
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity	F0585	F-tag 0585- Grievance Process Corrective Action for the Resident Identified (R1) On 10/14/25, a bruise to R1's right inner thigh was identified and documented.	01/16/2026

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

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F0585 SS = D	Continued from page 1 that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F0585	Continued from page 1 On 10/15/25, the provider was notified of the injury. A Doppler study of the right thigh was completed with no abnormalities identified. On 10/16/25, an ultrasound of the right thigh was completed with no evidence of blood clot. Interventions were implemented to prevent further injury, including: Placement of a protective towel between the sling and the right thigh during transfers to reduce friction and pressure. Positioning pillows were supplied and maintained in R1’s room to support proper alignment and comfort while seated. Resident measured for proper sling sizing Sling size documented in care plan and on group sheets R1 is not to be refused transfer out of bed. If immediate transfer is not possible, staff must: Communicate a clear and reasonable timeframe to the resident. Ensure transfers are completed as scheduled. Root Cause Analysis The facility determined the following contributing factors: Staff did not consistently recognize written resident concerns (email) as a grievance requiring formal documentation and tracking. The grievance process was not consistently initiated or tracked when concerns were reported to leadership. Communication gaps existed between leadership and interdisciplinary team members regarding follow-up and resolution. Staff education regarding grievance identification,	

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F0585 SS = D	Continued from page 2 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to implement a grievance process for 1 of 8 residents reviewed who expressed care concerns to the facility. Findings include: R1's annual Minimum Data Set dated 9/22/25, identified intact cognition and diagnosis of fractures, heart disease and dependence on enabling machines. R1's care plan dated 12/18/25, identified an alteration in mobility related to fracture of lumbar spine,	F0585	Continued from page 2 documentation, and response expectations was insufficient. Systemic Changes to Prevent Recurrence The facility has reinforced that any resident concern—verbal, written, or electronic—must be evaluated for grievance criteria and logged accordingly. A standardized Grievance Intake and Tracking Log has been implemented. Emails or written complaints received are now routed immediately to the grievance officer for review and determination. Clear accountability was established for acknowledgment, investigation, documentation, response, and closure of grievances. Staff Education All Nursing Home were re-educated on: Resident grievance rights Identification of grievances (including emails and informal complaints) Documentation and tracking requirements Timely acknowledgment and resolution expectations Education included review of grievance procedure and grievance form Staff education was completed by Deb Meyer, LNHA and Lena Nesset, Interim DON and attendance records are maintained. Monitoring and Auditing The Administrator or designee will review the grievance log weekly for 4 weeks, then monthly for 3 months, to ensure:	

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F0585 SS = D	Continued from page 3 weakness and pain. The care plan directed staff to transfer R1 using a mechanical lift. An electronic (e)-mail from R1 to the director of nursing (DON) and administrator dated 11/12/25, indicated the following: R1 wrote, "Asking for help with two issues." On 10/12/25, during transfer to the shower chair something went wrong and R1 ended up with a giant and very painful bruise on the inside of his leg. After the incident for approximately two plus weeks, it was too painful to transfer, so other than two times he did not get up for lunch and except for shower days he remained in bed. Recently at 3:00 p.m., R1 asked to transfer from the bed to the recliner and was told staff would be too busy to transfer him back to bed until around 8:00 p.m. R1 wrote that he recently asked five times to be transferred into his recliner for lunch and had been turned down because staff could not fit him in. R1 also identified a concern related to a pillow that was missing from his room that enabled him to sit up straight in his chair. During interview on 12/16/25 at 9:50 a.m., R1 stated he sustained an injury related to a transfer from his bed to a shower chair. R1 said after he recovered from the injury that left him unable to transfer due to the pain, one of the staff told him he had "lost his spot" and not enough staff were available to help him out of bed. R1 further stated he had concerns related to a pillow that was missing and said he needed to the pillow to remain upright when seated in his chair. R1 said he sent an e-mail to the DON and the administrator expressing concerns about not getting transferred from the bed and also about the pillow. R1 said neither had responded and said it had been very disappointing. R1 said by chance someone from Essentia came by to see him and asked how things were going and he reported the concerns to her. R1 said a few days later someone from therapy came and brought him a pillow and when he asked for a transfer, he was transferred out of bed. During interview on 12/17/25, at 8:44 a.m., Essentia Health care coordinator (CC) stated she had visited with R1 on 11/17/25, and he expressed concerns about wanting to get up during the day, and about a missing pillow. The CC stated she had spoken with the DON about R1's concerns. The CC said R1 sent her an e-mail on 11/19/25, and said nothing had happened so she had reached out to the social worker. The CC said she received another e-mail from R1 on 11/20/25, that the	F0585	Continued from page 3 Grievances are identified and logged Acknowledgment is documented Investigation and resolution are completed Resident communication is documented Responsible Parties Grievance Oversight: Administrator Implementation and Monitoring: Administrator and DON Staff Education: DON or designee	

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F0585 SS = D	Continued from page 4 concerns had been taken care of. During interview on 12/17/25 at 2:05 p.m., the administrator stated the facility grievance officer was the DON. The administrator said she had received an e-mail from R1 that had been sent to the DON and herself about transfer times and staff reporting they were too busy and also about the pillow. The administrator said the DON had told her she would handle it. The administrator said the concern should have been written up as a grievance and said she did not know why it had not happened. Facility policy Resident Grievances dated 4/12/24, indicated a resident's right to voice a grievance orally or submit a formal, written grievance or an anonymous grievance. The facility will take prompt efforts to respond to and resolve grievances, including facility acknowledgment of the grievance and actively working toward a resolution. The grievance official or designee may assign the investigation, evaluation and determination of action steps to a member of the interdisciplinary team. The grievance official or designee will oversee the process and review all information and action steps and if needed, will work with the Interdisciplinary team member to formulate a response to the resident or resident representative. The grievance official or a member of the team will communicate the findings and grievance decision to the resident or resident representative. The grievance official or designee will track the grievance through to conclusion.	F0585		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the	F0689	F-Tag: 0689 Accident Hazards / Proper Use of Mechanical Lifts & Slings Corrective Action for Residents Identified R1: R1 was reassessed for correct sling size. Sling size was added to the care plan and group sheet. Staff were re-educated on correct sling use prior to transfers. No further injuries related to lift use have been identified.	01/16/2026

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F0689 SS = D	Continued from page 5 facility failed to ensure staff utilized the proper sling sizes when performing transfers via mechanical lift for 4 of 5 residents (R1, R2, R4, R5) who utilized a mechanical lift for transfers. Findings include: R1's annual Minimum Data Set dated 9/22/25, identified intact cognition and diagnosis of fractures, heart disease, obesity and dependence on enabling machines. R1's care plan dated 12/18/25, identified an alteration in mobility related to fracture of lumbar spine, weakness and pain. The care plan directed staff to transfer R1 using a mechanical lift but lacked evidence of a sling size. R1's Essentia Lift and Move Profile dated 9/20/25 indicated the need for a full body lift, indicated he was not able to lift himself into a standing position and indicated he did not weigh less than 265 pounds (lb.) The assessment indicated sling size LL (purple), 220-350 lbs. R1's care plan dated 10/8/25, identified an alteration in physical mobility related to fracture to lumbar spine with surgical fixation, weakness, pain and medications. The care plan directed staff to assist with transfers using a mechanical lift but lacked evidence of a sling size. R1's Progress Notes identified the following: 10/15/25, Bruise noted to R1's right inner thigh measuring 9.7 centimeters (cm) x 5.8 cm. Very dark in color and is swollen enough to see dimples where each piece of hair inserts into the skin. Swelling, hard and approximately the size of a softball. The skin surrounding the contusion was reddish blue/purple and measured 25 cm x 26.5 cm. R1 stated pain rated 3-5 out of 10 resting but increased to 7-9 out of 10 when area was touched. R1 stated it was from the lift sling. Bruise was consistent with where the sling crossed under the right thigh and where it hooked to the machine. R1's records lacked evidence the facility to any further action to reduce the likelihood of another	F0689	Continued from page 5 R2, R4, and R5: Each resident received a lift and sling reassessment. Resident sling size verified and compared to the manufacturer’s sling sizing chart. Correct sling size was placed in each resident’s room Care plans were updated to clearly identify mechanical lift type and sling size. Improperly sized slings were removed from resident rooms. Systemic Changes to Prevent Recurrence Sling size to be documented in two locations: Care Plan Group sheets Appropriate sling size will be determined and verified: At time of admission After Significant change in weight Following any injury associated with resident transfer Each resident is now assigned one dedicated sling, stored in the resident’s room. Staff Education and Competency All nursing staff (RNs, LPNs, and NAs) received mandatory re-education on: Manufacturer sling sizing guidelines How to locate sling size information	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = D	Continued from page 6 injury such as, assessment of possible sling or lift concerns, or addressing staff training. During interview on 12/16/25 at 9:50 a.m., R1 stated when he was injured during a transfer, and said sometime between the transfer from the bed to the shower chair he ended up getting a bruise on the inside of his right thigh that was "gigantic." R1 said it was very painful and said a couple days later a nurse looked at it and called the physician right away to look at it. R1 said the bruise prevented him from getting out of bed for several days. During observation on 12/16/25 at approximately 11:15 a.m., nursing assistant (NA)-A and NA-B prepared to transfer R1 using the mechanical lift. The lift sling applied had royal blue edging (according to the size chart on the assessment indicated XL (308-440lbs.). A sling with orange edges (XXL, 440-550 lbs.) was on the chair next to R1's bed. R2's Resident Face Sheet indicated diagnosis of respiratory disease, dementia with mood disturbance, chronic pain and delusions. R2's Essentia Lift and Move Profile dated 11/15/25, indicated the use of a mechanical lift. The profile did not identify a sling size. R2's care plan dated 9/25/25, identified an alteration in mobility related to obesity, weakness, age and back pain. The care plan directed staff to transfer R2 with a mechanical lift but lacked evidence of a sling size. During observation on 12/16/25, at 11:30 a.m., R2 was seated in a wheelchair. Underneath R2 was a sling with purple edges, size LL according to the sizing chart. R2’s weight on 12/12/25 indicated 138 lbs. According to the sizing chart on the lift and move profile 138lbs. indicated a medium sling. R4's Resident Face Sheet indicated diagnosis of Parkinson's disease, dementia, artificial knee joint and osteoarthritis.	F0689	Continued from page 6 New hires will receive lift and sling education prior to independent assignment. Monitoring and Ongoing Compliance The DON or designee will complete: Weekly audits x 4 weeks, then Monthly audits x 3 months Audits will verify: Sling size accurately reflected in care plan and group sheets Use of appropriate sling size Mechanical lift transfer compliance Audit results will be reviewed through QAPI, with corrective action taken as indicated. 5. Responsible Parties and Completion Dates Responsible Staff: Interim Director of Nursing/designee Completion Date: All corrective actions and education completed by 1/16/2026	

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F0689 SS = D	Continued from page 7 R4's Essentia Lift and Move Profile dated 11/29/25, indicated the need for a mechanical lift, indicated she was unable to stand and weighed less than 256 lbs. The profile indicated a sling size M (yellow) 121-165 lbs. R4's care plan dated 11/26/25, identified an alteration in physical mobility related to weakness, advanced age, Parkinson's disease and dementia. The care plan indicated the use of a mechanical lift for all transfers but lacked evidence of a sling size. During observation on 12/16/25 at 11:30 a.m., R4 was seated in the dining room in her wheelchair. R4 had a sling underneath her with purple edges (LL) 220-350 lbs. R5's Resident Face Sheet identified diagnosis that included diabetes, heart failure, end stage renal disease and above knee amputation. R5's care plan dated 11/18/25, identified impaired mobility and indicated use of a mechanical lift with amputee sling for all transfers but lacked evidence of a sling size. R5's Essentia Lift and Move Profile dated 10/14/25, indicated the use of a mechanical lift and a Green sling (large) 166-219 lbs. During interview on 12/16/25 at 12:41 p.m., NA-A stated the sling size should be on the care plan. NA-A said they used the purple sling for R2 and said it was a size medium. For R1, they used an orange sling because it was a little bigger and had more padding, and staff used the purple edged sling to transfer R4. NA-A said he did not know where to look to determined what slings should be used and stated R5 also used a mechanical lift with a Yellow (medium) edged sling. During interview on 12/16/25 at 12:55 p.m., the interim director of nursing (DON) stated sling sizes were based on weight. The Interim DON said the lift and move assessment was used to determine size. The interim DON said each resident had their own sling in their rooms.	F0689		

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F0689 SS = D	Continued from page 8 During observation on 12/17/25 at 10:28 a.m., R5 was wheeled into the facility following an appointment. R5 was seated in a wheelchair with a sling with yellow edges underneath him. (Profile indicated Green) During interview on 12/17/25 at 10:34 a.m., the interim DON stated she did not think anyone came up with a root cause related to R1's bruise. The interim DON said the sling did put pressure on the thigh and felt it was an isolated incident but said she was unsure if anyone had assessed to ensure the correct sling size had been used. During interview on 12/17/25 at 1:57 p.m., the quality partner registered nurse (RN) said the facility policy was to follow manufacturers recommendations for proper sling size. The quality partner RN said the potential repercussions of using the incorrect sling included injury to the resident. Facility Lift Program Policy and Guide, updated, indicated all resident care would be provided in a safe, appropriate and timely manner in accordance with the care plan. The care plan team used the Essentia Health Lift Program Guide to determine the means for providing transfer and mobility assistance for residents.	F0689		
F0726 SS = K	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan	F0726	F-tag 0726- Competent Nursing Staff Corrective Actions for Continued Compliance Competency Verification for Nurse Apprentices: No nurse apprentice will administer medications without documented RN Preceptor-verified competency. Competency checklist for medication administration, including high-risk medications (insulin, opioids, controlled substances), implemented and reviewed by RN preceptor prior to supervision by Floor RN Supervision Requirements: Nurse apprentices must always be under direct supervision of an RN when performing patient care tasks, including medication administration.	01/16/2026

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F0726 SS = K	Continued from page 9 of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(d) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure an un-licensed nursing student (NS) was supervised during resident medication administration, including significant medication such as insulin, liquid morphine and other controlled substances. In addition, NS did not possess a nursing license, competencies, or skills set to provide necessary resident nursing services nor other certification required for medication administration. This had the likelihood for a serious adverse outcome and placed 4 of 4 residents (R2, R3, R6, R7) in immediate Jeopardy (IJ). The IJ began on 12/12/25, /when the NS was observed administering insulin to a resident without direct supervision by a licensed nurse. The administrator was notified of the immediate jeopardy at 5:05 p.m. on 12/16/25. The immediate jeopardy was removed on 12/17/25, but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R2's Resident Face Sheet indicated diagnosis of respiratory disease, dementia with mood disturbance, chronic pain and delusions. R2's care plan dated 9/25/25, identified a risk for alteration in comfort related to pain and identified the use of antipsychotic medication and indicated medications per orders. R2's Physician's Order Report dated 12/17/25, identified the following order: -12/26/23, Hydromorphone- schedule II (controlled substance) liquid; 1 milligram (mg)/milliliter (ml). Amount 2 ml's by mouth every hour as needed. Up to 24 times per day. R2's Individual	F0726	Continued from page 9 RN must remain in direct line of sight and available for immediate intervention for all high-risk medications. Staff Education: All licensed nursing staff educated on: Apprentice program expectations Supervision requirements Delegation and scope of practice Education completion is documented and tracked. Monitoring and Auditing: Audits daily x 30 days, weekly x 4 weeks, monthly x3 months- post-IJ removal to ensure compliance with: Supervision of nurse apprentices Competency documentation Medication administration practices Audit results reported to DON and Administrator for review and corrective action if needed. Oversight: DON/ RN Apprentice preceptor responsible for ongoing review of apprentice competencies prior to floor assignment. Responsible Parties: DON/ RN Apprentice preceptor: competency review, monitoring, and education	

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F0726 SS = K	Continued from page 10 Narcotic Record identified hydromorphone 1 mg/ml. The record indicated the NS administered the medication on 11/10/25. R2's Medication Administration Record (MAR) dated December 2025, indicated the NS administered R hydromorphone 1 mg/ml medication on 12/5/25 and 12/12/25. R6's Resident Face Sheet indicated diagnosis of pain, hypertension, respiratory failure and diabetes. R6's care plan dated 11/26/25, identified altered endocrine function related to type II diabetes. The care plan directed staff to monitor blood glucose per physician orders and monitor signs and symptoms of hypo or hyperglycemia. The care plan further directed staff to administer medications and ordered. R6's Physician Order Report dated 12/17/25, identified the following orders: -3/26/25, hydrocodone- acetaminophen- schedule II tablet 5 mg-325 mg. Amount 1 tab twice daily as needed. -9/9/24, Accuchecks, notify certified nurse practitioner if below 70 readings are noted. -4/3/25, Humolog KwikPen Insulin (insulin lispro) pen; 100 unit/ml; amount eight units subcutaneous (sq) (fatty tissue just under the skin). Give eight units three times daily with meals. -4/4/25, Lantus U-100 Insulin (insulin glargine) solution; 100 unit/ml. Amount 40 units sq. Once daily between 6:00 a.m. and 10:00 a.m. R6's Individual Narcotic Record identified hydrocodone/acetaminophen- schedule II 5mg/ 325mg, one tab as needed. The record indicated NS administered the medication on 11/10/25. R6's Medication Administration Record (MAR) dated December 2025, indicated the NS performed accuchecks and administered medication, including insulin, to R6 on 12/5/25 and 12/12/25. During observation on 12/12/25 at 11:34 am., the NS administered insulin to R6 via insulin pen, unsupervised. When interviewed, the NS stated she was working at the facility as part of an apprenticeship program and said she was still in school. The NS stated, /“I can do basically almost anything except a select few things.” /The NS stated she did not perform treatments but passed medications, completed blood glucose checks and gave insulin. NS said she normally checked with the nurse when giving insulin because she was not comfortable with it but acknowledged she had not checked with the nurse when she gave R6's insulin during observation. NS also indicated the program was newer and there were a lot of things that were not clear regarding skills she was allowed to perform. When asked how she knew what skills she could and could not perform, NS said she had a /“sheet somewhere” /but did not have it with her. At 12:36 p.m., the NS confirmed she was not a trained medication aide. On 12/12/25 at 12:06 p.m., the NS was observed performing a blood glucose check independently, without supervision. It	F0726	Continued from page 10 Floor RN: direct supervision and documentation after competency completed Nurse Apprentices: adherence to program expectations and supervision requirements Completion Date: 1/16/2026	

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F0726 SS = K	Continued from page 11 was noted during all observations of NS medication administration, Registered Nurse (RN)-A was seated in a glass enclosed office, located behind the nurse station, not in sight of NS during her task. R7's Resident Face Sheet indicated diagnosis of Alzheimer's, dementia, anxiety, depression and chronic pain. R7's care plan dated 12/16/25, identified pain and directed staff to administer medications per orders and monitor and record effectiveness. The care plan identified the use of psychotropic medications and directed staff to monitor for effectiveness and adverse consequences. R7's Physician Order Report dated 12/17/25, identified the following medications: -10/23/25, Tramadol- schedule IV tablet 25 mg. Amount: 75 mg by mouth two times daily. -11/12/25, Lorazepam- schedule IV tablet; 0.5 mg by mouth. Can take 0.5 mg every four hours as needed for agitation/anxiety/restlessness. -10/23/25, Morphine concentrate- schedule II solution; 100 mg/5 ml (20mg/ml). Amount 0.5 ml by mouth every hour as needed up to 24 times per day. R7's Individual Narcotic Record identified Morphine 100 mg/ 5 ml. take 1/2 ml every hour as needed. The record indicated the NS administered the morphine twice on 11/17/25 and once on 12/8/25. R7's MAR dated December 2025 indicated the NS administered the morphine medications to R7 on 12/5/25 and 12/12/25. During interview on 12/12/25 at 2:10 p.m., RN-A was asked what duties the NS was able to perform. RN-A pointed to a list taped to a cabinet that indicated the NS could administer medications after competency was verified and said she had not seen the competencies (completed by NS) but said they should have been completed prior to being released to work on the floor. During interview on 12/16/25 at 9:21 a.m., the director of the associate degree programs for the college where the NS was a student, stated the apprenticeship program utilized the Essentia Health intern student guidelines and according to Essentia the student was supposed to be supervised. The director said the student was supposed to be paired with a preceptor and said the NS was assigned to RN-A and two other nurses. The director stated the apprenticeship program was not designed to have the students working as a nurse on the floor without supervision. During interview on 12/16/25 at 2:33 p.m., the administrator stated her understanding of the nurse apprentice was once they had competencies completed, they could treat the students like new nurses on orientation. The administrator further stated she had spoken to the DON who said she had not completed competencies with the NS. The administrated believed NS started at the building around September of 2025, adding she was never “on the schedule” but could not provide a date as to when NS may have started	F0726		

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F0726 SS = K	Continued from page 12 passing medications unsupervised. During interview on 12/17/25 at 3:02 p.m., RN-A stated she had not been given guidance regarding what the NS was able to with or without supervision. RN-A said she kept asking so the director of nursing posted a list on the cabinet that outlined what tasks the NS could perform after a competency had been completed. RN-A stated she was unable to attend the training to be a preceptor, so she did not believe she had been assigned. RN-A confirmed she was not NS preceptor on 12/12/25 (onsite survey date) and was the only RN on duty. An Essentia Health document titled Nursing Student Guidelines dated 9/2024, indicated medication administration by mouth, sq, intramuscular, inhaled or topical could only be administered under direct supervision. During interview on 12/29/25 at 5:01 p.m., the medical director stated he had concerns about staff working outside the scope of practice and said insulin and controlled substances had a higher risk for negative patient impact and diversion. The immediate jeopardy that began on 12/12/25 /was removed on 12/17/25, after the facility implemented a systemic plan that included the following actions: The nurse apprenticeship program was reviewed. Nurse apprentice to receive re-education on program expectations prior to returning to work. All staff responsible for administering medications and/or supervising a nurse apprentice were educated on the bure apprentice program and have reviewed the orientation education agenda. All resident records were reviewed for medication errors.	F0726		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 3, 2026

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

RE: CCN: 245428
Cycle Start Date: December 17, 2025

Dear Administrator:

On January 9, 2026 we notified you a remedy was imposed. On January 30, 2026 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 16, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 24, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 9, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 24, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 16, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement

Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 3, 2026

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

Re: Reinspection Results
Event ID: 1DF1A7-H2

Dear Administrator:

On January 30, 2026 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 December 17, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
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Office: 651-201-4112