CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 0LNZ

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I	- TO BE COMP	LETED BY T	THE STA	TE SURVEY A	AGENCY	Fac	cility ID: 00907		
MEDICARE/MEDICAID PROVID (L1)		3. NAME AND AD (L3) ESSENTIA I	DDRESS OF FACI		NG		4. TYPE OF ACTION:	_2 (L8) 2. Recertification		
2.STATE VENDOR OR MEDICAID N (L2) 623840800	О.	(T. 4)	LN AVENUE		(L6)	56501	3. Termination 5. Validation 7. On-Site Visit	4. CHOW 6. Complaint 9. Other		
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU	PPLIER CATEGO 05 HHA	ORY 09 ESRD	02 13 PTIP (L7)) 22 CLIA	8. Full Survey After Con			
6. DATE OF SURVEY 8. ACCREDITATION STATUS: 12	2/08/2011 (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 IMR	14 CORF 15 ASC			FISCAL YEAR ENDING DATE: (L35) 06/30		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE		00/30			
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED A	S:						
From (a):		A. In Complian					ne Following Requirements:	<u> </u>		
To (b):			Requirements ace Based On:		2. Technical Personnel6. Scope of Services Limit3. 24 Hour RN7. Medical Director					
12.Total Facility Beds	96 (L18)	1. 4	Acceptable POC		4. 7-D	Day RN (Rural SNF e Safety Code				
13.Total Certified Beds	96 (L17)		mpliance with Progents and/or Applied		* Code:	A	(L12)			
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY N	MEETS				
18 SNF 18/19 SNF	F 19 SNF	ICF	IMR		1861 (e) (1) or	1861 (j) (1):	(L15)			
96 (L38)	(L39)	(L42)	(L43)							
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICABL	E SHOW LTC CANCI	ELLATION DATE	E):						
See Attached Remarks										
17. SURVEYOR SIGNATURE		Date :			18. STATE SU	RVEY AGENCY A	APPROVAL	Date:		
Candy Bourassa, HFE NEII 12/21/2011				(L19)	Colleen B. Leach, Program Specialist 01/19/2012 (L20)					
	PART II - TO BE	E COMPLETED	BY HCFA R	EGIONA	L OFFICE OF	R SINGLE STA	ATE AGENCY			
19. DETERMINATION OF ELIGIBIL			MPLIANCE WITH GHTS ACT:	CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) 					
_X 1. Facility is Eligible to	-				3.	Both of the Above	:			
2. Facility is not Eligib	(L21)									
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEN	MENT	26. TERMINA	ATION ACTION:	(L3	30)		
OF PARTICIPATION 11/01/1976	BEGINNING	DATE	ENDING DAT	ΓE	VOLUNTARY 01-Merger, Close			ARY et Health/Safety		
(L24)	(L41)		(L25)			n W/ Reimburseme	***	et Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:			03-Risk of Involution 04-Other Reason	untary Termination for Withdrawal	<u>OTHER</u> 07-Provider St	tatus Change		
(L27)	B. Rescind Sus	spension Date:	(L44)				00-Active			
			(L45)							
28. TERMINATION DATE:	29	. INTERMEDIARY/O	CARRIER NO.		30. REMARKS					
03001				Posted 1/17/2012 ML.						
(L28)				(L31)	1 Obcea 1	., . , , 2012				
31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE					1					
		11/03/2011								
	(L32)			(L33)	DETERMIN	ATION APPR	OVAL			

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00907

C&T REMARKS - CMS 1539 FORM

CCN: 24-5212

A standard OTC survey was completed at this facility on 10/3/2011 and the most serious deficiency was cited at a S/S level of G.

A PCR of the LSC deficiencies was completed on 10/31/2011 and all the deficiencies were found corrected. A PCR of the health deficiencies was completed on 11/09/2011 and one deficiency was found not corrected. As a result of the revisit findings, this Department recommended imposition of the following remedy to the CMS RO:

- Mandatory DOPNA, effective 12/15/2011

In addition, the facility was subject to a loss of NATCEP beginning 12/15/2011 for two years based on the imposition of mandatory DOPNA.

On 12/9/11, a 2nd PCR was completed and the health deficiency was found corrected effective 12/7/11. As a result of the PCR findings, this Department recommended the following to the CMS RO:

- Mandatory DOPNA, effective 12/15/2011 be rescinded.

The facility is no longer subject to a loss of NATCEP.

Please refer to the CMS 2567B.

Effective 12/7/2011, the facility is certified for 96 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5212

January 9, 2012

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

Dear Ms. Brinkman:

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

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

Effective December 7, 2011 the above facility is certified for:

96 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Colleen B. Leach, Program Specialist

Colleen Feach

Program Assurance Unit, Licensing and Certification Program

Division of Compliance Monitoring

Minnesota Department of Health

P.O. Box 64900, St. Paul, MN 55164-0900

Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

December 21, 2011

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

RE: Project Number S5212020

Dear Ms. Brinkman:

On November 23, 2011, we informed you that we would recommend the following enforcement remedy to the Centers for Medicare and Medicaid Services (CMS) for imposition:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective December 15, 2011. (42 CFR 488.417 (b))

We also notified you that in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 15, 2011.

This was based on the deficiencies cited by this Department for a standard survey completed on September 15, 2011, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on November 9, 2011. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On December 8, 2011, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on November 9, 2011. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 25, 2011. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on November 9, 2011, as of December 7, 2011.

This Department is recommending to the CMS Region V Office the following actions related to the remedies outlined in our letter of .November 23, 2011 The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 15, 2011, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective December 15, 2011, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective December 15, 2011, is to be rescinded.

In our letter of November 23, 2011, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 15, 2011, due to denial of payment for new admissions. Since your facility attained substantial compliance on December 7, 2011, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Feel free to contact me if you have questions.

Sincerely,

Pam Kerssen, Assistant Program Manager Licensing and Certification Program

Division of Compliance Monitoring

Telephone: (218)308-2129 Fax: (218)308-2122

um Keessee

Enclosure

cc: Licensing and Certification File

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245212	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/8/2011
Nam	e of Facility		Street Address, City, State, Zip Code	
ES	SENTIA HEALTH OAK CROSSING		1040 LINCOLN AVENUE DETROIT LAKES, MN 56501	

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

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y	(5)	Date
ID Prefix	F0431	Correction Completed 12/07/2011	ID Prefix		Correction Completed		ID Prefix			Correction Completed
	483.60(b), (d), (e)									
			ID Prefix Reg. # LSC		Correction Completed		Reg. #			Correction Completed
ID Prefix Reg. # LSC					Correction Completed					Correction Completed
Reg. #					Correction Completed					Correction Completed
Dog #			5 "				Dag #			
Reviewed E	DI	ewed By K/cbl	Date: 12/21/2011	Signature of Sur	veyor:	2	9436	I	Date:	12/08/2011
Reviewed E	-,	ewed By	Date:	Signature of Sur	veyor:			4	Date:	
Followup t	o Survey Complete 9/15/2011		c	theck for any Uncor Uncorrected Defic	rected Deficiencies (CN	cienci 1S-256	es. Was a 67) Sent to	Summary of the Facility?	YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 0LNZ

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I	- TO BE COMP	LETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00907			
MEDICARE/MEDICAID PROVIDER NO. (L1)		3. NAME AND AE (L3) ESSENTIA I (L4) 1040 LINCO (L5) DETROIT L	HEALTH OAK DLN AVENUE		NG (L6) 56501	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other			
5. EFFECTIVE DATE CHANGE OF OWNE (L9)		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	<u>O2</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint			
6. DATE OF SURVEY 11/09/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2011 ^(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 IMR 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30			
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds	96 (L18) 96 (L17)	Complian1 B. Not in Con		gram	And/Or Approved Waivers Of T 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SN)5. Life Safety Code * Code: B *	6. Scope of Services Limit7. Medical Director			
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 96 (L37) (L38)	19 SNF (L39)	ICF	IMR (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)			
16. STATE SURVEY AGENCY REMARKS See Attached Remarks 17. SURVEYOR SIGNATURE	(IF APPLICABL	E SHOW LTC CANCI	ELLATION DATE	Ξ):	18. STATE SURVEY AGENCY	APPROVAL Date:			
Edith Hasskamp, HFE NEII		11/2	1/2011	(L19)	(E20)				
PAR 19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Partic 2. Facility is not Eligible		20. COM	BY HCFA R MPLIANCE WITH GHTS ACT:			ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)			
OF PARTICIPATION 11/01/1976 (L24) 25. LTC EXTENSION DATE: 27			4. LTC AGREEM ENDING DATE (L25)		26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement			
(L27) 28. TERMINATION DATE:	B. Rescind Sus	spension Date:	(L45)		30. REMARKS				
	(L28)	03001		(L31)	Posted 1/17/2012	2 ML.			
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION (OF APPROVAL D	DATE (L33)	DETERMINATION APPR	ROVAL			

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00907

C&T REMARKS - CMS 1539 FORM

CCN: 24-5212

A standard OTC survey was completed at this facility on 10/3/2011 and the most serious deficiency was cited at a S/S level of G.

A PCR of the LSC deficiencies was completed on 10/31/2011 and all the deficiencies were found corrected. A PCR of the health deficiencies was completed on 11/09/2011 and one deficiency was found not corrected. As a result of the revisit findings, this Department recommended imposition of the following remedy to the CMS RO:

- Mandatory DOPNA, effective 12/15/2011

In addition, the facility was subject to a loss of NATCEP beginning 12/15/2011 for two years based on the imposition of mandatory DOPNA.

Please refer to the CMS 2567B for both health and life safety code and the CMS 2567 along with the facility's plan of correction.

Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 9170

November 23, 2011

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

RE: Project Number S5212020

Dear Ms. Brinkman:

On October 3, 2011, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 15, 2011. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On November 9, 2011, the Minnesota Department of Health and on October 31, 2011, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 15, 2011. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 9, 2011. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on September 15, 2011. The deficiency(ies) not corrected is/are as follows:

F0431 -- S/S: D -- 483.60(b), (d), (e) -- Drug Records, Label/store Drugs & Biologicals

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 15, 2011. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective December 15, 2011. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 15, 2011. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Essentia Health Oak Crossing is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective December 15, 2011. 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. If this prohibition is not rescinded, 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.

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

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

APPEAL RIGHTS

If you disagree with this determination, 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 at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Oliver Potts, Chief 330 Independence Avenue, SE Cohen Building, Room G-644 Washington, DC 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.

DEPARTMENT CONTACT

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

Pam Kerssen Minnesota Department of Health 705 5th Street Northwest, Suite A Bemidji, Minnesota 56601-2933

Telephone: (218) 308-2129

Fax: (218) 308-2122

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 March 15, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Pam Kerssen, Assistant Program Manager

Licensing and Certification Program Division of Compliance Monitoring

Pan Kusac

Telephone: (218) 308-2129 Fax: (218) 308-2122

Enclosure

cc: Licensing and Certification File 5212r111.rtf

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245212	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/9/2011
Nam	e of Facility		Street Address, City, State, Zip Code	
ES	SENTIA HEALTH OAK CROSSING		1040 LINCOLN AVENUE DETROIT LAKES, MN 56501	

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix	<u>F0272</u>	Correction Completed 11/09/2011	ID Prefix	F0314)	Correction Completed 11/09/2011		ID Prefix	(F0371)		Correction Completed 11/09/2011
Reg. # LSC	483.20(b)(1)	=	Reg. # 48		-		Reg. # LSC	483.35(i)		_ _
Reg.#		Correction Completed	Reg.#		Correction Completed					Correction Completed
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed		Reg. #			Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed					Correction Completed
Reg.#			Reg. #							
Reviewed B	sy Reviewed	d By	Date:	Signature of Su	rvevor:				Date:	
State Agend	DIZ/G	-	11/21/201	_	,					/09/2011
Reviewed B	-	і Ву	Date:	Signature of Sur	rveyor:				Date:	2011
Followup to	9/15/2011	n:		Check for any Unco Uncorrected Defic					YES	NO

		I AND HUMAN SERVICES & MEDICAID SERVICES		(OV , 2 F , max) F	ITED: 11/21/201 ORM APPROVE 3 NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION (X3) D	ATE SURVEY OMPLETED
		245212	B. WING		R 11/09/2011
	PROVIDER OR SUPPLIER	PSSING	Ş	STREET ADDRESS, CITY, STATE, ZIP CODE 1040 LINCOLN AVENUE DETROIT LAKES, MN 56501	• 6 3
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	GOMPLETION E DATE
{F 000}	INITIAL COMMENT	-S	{F 000	D)	5 7 Ed 117
SS=D	The facility must emalicensed pharmac of records of receipt controlled drugs in saccurate reconciliating records are in order controlled drugs is neconciled. Drugs and biological labeled in accordance professional principal appropriate accessor instructions, and the applicable. In accordance with Sacility must store all locked compartment controls, and permit have access to the kind of the controls.	ploy or obtain the services of st who establishes a system and disposition of all sufficient detail to enable an on; and determines that drug and that an account of all naintained and periodically as used in the facility must be see with currently accepted es, and include the ry and cautionary expiration date when state and Federal laws, the drugs and biologicals in sunder proper temperature only authorized personnel to	{F 43·	The medication label on the insulin pen identified by the survey team was corrected immediately, on November 9, 2011, during the survey. A 100% audit will be completed of all medication labels to assure no other residents are affected. The label will be checked against the order and the medication administration record to assure all 3 match and are correct. Any medication labels with a discrepancy to the order will either be replaced with a correct label or will receive a direction label change.	13/2/11

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

controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can

Paristran

12/2/201

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

FORM CMS-2567(02-99) Previous Versions Obsolete

be readily detected.

Event ID: 0LNZ12

Facility ID: 00907

If continuation sheet Page 1 of 3

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

PRINTED: 11/21/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
		245212	B. Wii	1G	The state of the s	11/6	R 09/2011
	PROVIDER OR SUPPLIER IA HEALTH OAK CRO			10	REET ADDRESS, CITY, STATE, ZIP CODE 040 LINCOLN AVENUE DETROIT LAKES, MN 56501		03/2011
PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES: 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
	by: Based on interview the facility failed to a labels were current orders for 1 of 4 res medications were refindings include: At 9:15 a.m. on 11/0 Nurse (LPN)-A indicinsulin 10 units befor R300. The pharmac directed staff to give breakfast. LPN-A stand the resident was before breakfast. Liknow why the pharm changed, however, thad been put on the the physician's order 05/06/11, the primar morning Novolog insulin and November's, Merecord (MAR) direct of Novolog insulin andministered each make sure that all nepharmacy regardless.	and documentation review, ensure pharmacy prescription and consistent with physician idents (R300) whose eviewed for correct labels. 19/11, Licensed Practical ated she gave Novolog re breakfast via FlexPen for y label on the insulin FlexPen 7 units of insulin before ated the order had changed is to receive 10 units of insulin PN-A indicated she did not hacy label had not been he "direction change" label insulin FlexPen. Review of its with LPN-A confirmed on y physician had changed the fulin FlexPen from 7 units to go). Lugust, September, October indication Administration ed the staff to give 10 units and recorded 10 units were forning before breakfast.	{F 4:	31}	Results of the 100% audit evaluated, summarized, an to identify issues with the facility's medication policy procedure. The policy and procedure was revised and approved on 12/2/2011. As of the revised policy and procedure, a new process h been initiated around medic check-in as medications are received from a pharmacy. (purple) binder has been plain each of the 4 nursing stat As a new order is transcribe medication is re-ordered/ref a copy of the documentation be made and placed in the p binder. When the medication arrive from the pharmacy, the nurse will check them in, assuring the label, order, and medication administration reall match, and then sign the documentation to indicate the medication was received and label is correct.	d used y and s part as cation A aced ions. ed or a filled, n will urple ns ne	10/7/// 1/2011 1

to:#s

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

PRINTED: 11/21/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	MULTIPLE CONSTRUCTION	(X3) DATE	SURVEY
	245212	B. WII		-	R 10
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CRO	OSSING		STREET ADDRESS, CITY, STATE, ZIP 1040 LINCOLN AVENUE DETROIT LAKES, MN 56501	CODE	/09/2011
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF I	CORRECTION ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
medication or just the ensure that the next ordered the correct label. LPN-A signed her unit had the correct label. LPN-A signed her unit had the correct label. LPN-A signed her unit had the correct label. LPN-A the Prese from the pharmacy had not rechange for the Nove breakfast as of 11/0 LPN-A confirmed at she had signed a not pharmaceuticals had bottle/package. LPN sure if she had informorning Novolog Flebe changed. At approximately 10: Director of Nursing (FlexPen morning inschanged. She confirmed and they only get the original confirmed the Month dated October 2011,	em know if they need the he label changed. This was to the label changed on the labels on them on the labels of the labels	{F 4	The facility (DON, Normanager, RN Clinical Coordinators) will ed of regularly scheduler LPNs on the revised repolicy and procedure, 12/2/2011, to be complicated a copy of the policy and procedure and before their next shift, will receive a formal discussion with the Normanager of DON. The Nurse Managers of Clinical Coordinators the purple binders at leper week for the next and then audit 1 time/normal time to the next 9 months. The the audits will be reviewed quarterly by the facility Assurance Committee.	ucate 100% d RNs and medication beginning pleted by es will revised via mail scheduled llow-up urse and RN will audit east 2 times 90 days, month for e results of ewed y's Quality	13/30

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245212	(Y2) Multiple Con A. Building B. Wing	STING BUILDING 02	(Y3) Date of Revisit 10/31/2011
Name of Facility		Street Address, City, State, Zip Code	
ESSENTIA HEALTH OAK CROSSING		1040 LINCOLN AVENUE	
		DETROIT LAKES MN 56501	

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

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4)	Item	(Y5)	Date
		Correction			Correction				Correction
ID Prefix		Complete 10/25/20			Completed 10/25/2011		ID Prefix		Completed
	NFPA 101			NFPA 101			Reg. #		
LSC	K0011		LSC	K0050			LSC		_
		Correction	on		Correction				Correction
		Complete			Completed				Completed
	-		ID Prefix				ID Prefix		
Reg. # LSC			Reg. #		<u></u>		Reg. # LSC		
		Correction	on		Correction				Correction
ID Profiv		Complete			Completed		ID Profiv		Completed
Reg. # LSC			Reg. # LSC				Reg. # LSC		
		Correction			Correction				Correction
ID Prefix		Complete	ed ID Prefix		Completed		ID Prefix		Completed
Reg.#			Reg.#				D 4		_
LSC							LSC		
		Correction	nn		Correction				Correction
		Complete			Completed				Completed
ID Prefix			ID Prefix				ID Prefix		`
Reg.#			Reg. #				Reg. #		<u> </u>
LSC			LSC				LSC		
Reviewed I	By Re	viewed By	Date:	_	e of Surveyor:			Date:	
State Agen	cy P	K/SNL	11/21/20	11	03006				10/31/2011
Reviewed B	Зу Re	eviewed By	Date:	Signatur	e of Surveyor:			Date:	
Followup t	o Survey Compl				y Uncorrected Defi ed Deficiencies (CI			Facility?	
	9/13/20	11		Unconect	ed Deliciencies (Ci	10-200	, Jeni to the	racility? YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245212	(Y2) Multiple Constru A. Building B. Wing	uction 03 - 2008 SOUTH	(Y3) Date of Revisit 10/31/2011
Name of Facility		Street Address, City, State, Zip Co	ode
ESSENTIA HEALTH OAK CROSSING		1040 LINCOLN AVENUE	
		DETROIT LAKES MN 565	in1

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

(Y4) Item		(Y5) Da	te	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
ID Profix		Correc Comp (10/25/	leted	ID Brofiv		Correction Completed		ID Profiv		Correction Completed
	AIEDA 404	10/23/	2011			-				
	NFPA 101 K0050			Reg.# LSC				Reg. # LSC		
								-		
		Correc	ction			Correction				Correction
ID Profiv		Comp	leted	ID Profix		Completed		ID Profix		Completed
Reg. # LSC				Reg. # LSC				Reg. # LSC		
		Correc	ction			Correction				Correction
ID D		Comp	leted	10.0 %		Completed		10.0.5		Completed
						-				
Reg. # LSC				Reg.# LSC				Reg. # LSC		
		Correc				Correction				Correction
ID Prefix		Comp	leted	ID Prefix		Completed		ID Prefix		Completed
Reg. #				- ·		-		Reg. #		
LSC								LSC		
		Correc	ction			Correction				Correction
ID Drofiv		Comp	leted	ID Drofiv		Completed		ID Drafit		Completed
				D "		-				
Reg. # LSC				Reg.# LSC				Reg. # LSC		
Reviewed I	Ву Re	viewed By		Date:	Signature of Sur	veyor:			Date	:
State Agen	cy P	PK/SNL		11/21/2011	03	8006			1	0/31/2011
Reviewed E	Зу Re	viewed By		Date:	Signature of Sur	veyor:			Date	
Followup t	o Survey Compl				Check for any Uncor					
	9/13/20	11			Uncorrected Defic	ciencies (CN	15-25	or) Sent to	the Facility? YES	NO

	State Form: Revisit Report									
(Y1)	Provider / Supplier / CLIA / Identification Number 00907	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/9/2011						
Name	e of Facility		Street Address, City, State, Zip Code							
ES	SENTIA HEALTH OAK CROSSING		1040 LINCOLN AVENUE DETROIT LAKES, MN 56501							

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y	' 5)	Date
ID Prefix		Correction Completed 11/09/2011	ID Prefix		Correction Completed 11/09/2011		ID Prefix	21015		Correction Completed 11/09/2011
	MN Rule 4658.0400 Sub			MN Rule 4658.0525 Sub				MN Rule 4658.0		
		Correction Completed 11/09/2011 op.	ID Prefix Reg. # LSC	21415 MN Rule 4658.0815 Sub	Correction Completed 11/09/2011					
.			Reg. #				Dog #			
ID Prefix Reg. # LSC			Reg. #		Correction Completed					Correction Completed
Reg. #										
Reviewed E	By Reviewed	Ву	Date:	Signature of Sur	veyor:			I	Date:	
State Agen Reviewed E	110/511.		11/21/201 Date:	1 1283 Signature of Sur				I	11/0 Date :	09/2011
Followup to Survey Completed on: 9/15/2011			Check for any Uncor Uncorrected Defic				the Facility?	YES	NO	

PRINTED: 11/21/2011 FORM APPROVED

(X6) DATE

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDIN		(X3) DATE SURVEY COMPLETED	
	00907			B. WING _		11/09/2011	I
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ESSENT	IA HEALTH OAK CRO	OSSING		COLN AVEN LAKES, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDERSON THE APPROPRIES OF	JLD BE COMP	PLETE
{2 000}	Initial Comments			{2 000}			
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORE)ER				
	144A.10, this correct pursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Periodical Office of the Minnesota Periodical	hether a violation has compliance with all rule provided at the le number indicated ns several items, fail the items will be con Lack of compliance my item of multi-part ment of a fine even it uring the initial inspec- hearing on any asse n non-compliance with	issued ion, it is cited violation rdance rule of seen tag below. ure to sidered e upon rule will f the item ction was essments the these made to				
	the Department within 15 days of receipt of a notice of assessment for non-compliance.						
Minne	INITIAL COMMENT	18:			Minnesota Department of Health documenting the State Licensing Correction Orders using federal Tag numbers have been assigned Minnesota state statutes/rules for Homes.	software.	

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

STATE FORM 6899 0LNZ12 If continuation sheet 1 of 2

TITLE

PRINTED: 11/21/2011 FORM APPROVED

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		
		00907		B. WING _			9/2011
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	A HEALTH OAK CRO	SSING		COLN AVEN LAKES, MN	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
{2 000}	Continued From pa	ge 1		{2 000}	The assigned tag number appear far left column entitled "ID Prefix The state statute/rule out of comply the state statute/rule out of comply portion of the correction of the correction of the correction of the correction of the state after the statement, "This Rule is as evidence by." Following the state after the statement, "This Rule is as evidence by." Following the state after the statement, "This Rule is as evidence by." Following the state after the statement, "This Rule is as evidence by." Following the state after the statement, "This Rule is as evidence by." Following the state after the statement, "This Rule is as evidence by." Following the state after the statement, "This Rule is as evidence by." Following the state after the statement, "This Rule is as evidence by." Following the state after the statement, "This Rule is as evidence by." Following the state after the statement, "This Rule is as evidence by." Following the state after the statement, "This Rule is as evidence by." Following the state after the statement, "This Rule is as evidence by." Following the state after the statement, "This Rule is as evidence by." Following the statement of th	Tag." pliance is to of es the "To order. dings estatute on order of correction. ADING OF HOF STO Y. THIS E. TO TION FOR	
{21620}	MN Rule 4658.134			{21620}			10/24/11
	Drugs used in the n in accordance with	oursing home must be part 6800.6300.	e labeled				
	This MN Requirement by:	ent is not met as evi	denced				

6899

Minnesota Department of Health STATE FORM

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 0LNZ

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I	- TO BE COMP	PLETED BY T	THE STA	TE SURVI	EY AGENCY	Facility ID: 00	907
MEDICARE/MEDICAID PROVIDER (L1)		3. NAME AND AI (L3) ESSENTIA (L4) 1040 LINCO (L5) DETROIT I	HEALTH OAK OLN AVENUE			(L6) 56501	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recerti 3. Termination 4. CHOW 5. Validation 6. Compl	ification V
5. EFFECTIVE DATE CHANGE OF OV (L9)		7. PROVIDER/SU	05 HHA	09 ESRD	<u>02</u> 13 PTIP	(L7) 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint	
6. DATE OF SURVEY 09/1 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	L5/2011 (L34) — (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 IMR 12 RHC	14 CORF 15 ASC 16 HOSPI	CE	FISCAL YEAR ENDING DATE: 06/30	(L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	96 (L18) 96 (L17)	Complian1. X B. Not in Co		gram	2. 3. 4.	Approved Waivers Of Th Technical Personnel 24 Hour RN 7-Day RN (Rural SNF Life Safety Code B*	e Following Requirements:	
14. LTC CERTIFIED BED BREAKDOV 18 SNF 18/19 SNF 96 (L37) (L38)	19 SNF (L39)	ICF (L42)	IMR (L43)		15. FACILI	TTY MEETS (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMA See Attached Remarks 17. SURVEYOR SIGNATURE Teresa Platz, HFE NEII	rks (if applicabl	E SHOW LTC CANC	ELLATION DATE	(L19)		e survey agency and B. Leach, Prog	pram Specialist 10/19/2011	[(L20)
P	PART II - TO BE	COMPLETED	BY HCFA R		L OFFICE	OR SINGLE STA	ATE AGENCY	(E20)
DETERMINATION OF ELIGIBILITY	ΓΥ 'articipate	20. COM	MPLIANCE WITH IGHTS ACT:			Statement of Finan	cial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)	
22. ORIGINAL DATE OF PARTICIPATION 11/01/1976 (L24) 25. LTC EXTENSION DATE:	23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV A. Suspension	DATE	24. LTC AGREEN ENDING DAT (L25)		VOLUNTA 01-Merger, 02-Dissatisf		05-Fail to Meet Health/Sa	nt
(L27)	B. Rescind Sus	pension Date:	(L44) (L45)				00-Active	
28. TERMINATION DATE:	(L28)	. INTERMEDIARY/	CARRIER NO.	(L31)	30. REMAI	PB 11/03/11	0LNZ	
31. RO RECEIPT OF CMS-1539	(L32)	. DETERMINATION	OF APPROVAL D	DATE (L33)	DETERM	MINATION APPR	OVAL	
					PETER	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00907

C&T REMARKS - CMS 1539 FORM

CCN: 24-5212

At the time of the Standard Survey completed on September 15, 2011, the facility was not in substantial compliance with federal certification regulations. Please refer to CMS 2567 along with the facility's plan of correction for both health and life safety code. Post Certification Revisit to follow.

Please note that effective April 18, 2011, this nursing home had a name change to that shown above. The facility was previously known as St. Mary's Regional Health Center.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 5783

October 3, 2011

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

RE: Project Number S5212020

Dear Ms. Brinkman:

On September 15, 2011, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Maria King, Unit Supervisor Minnesota Department of Health 12 Civic Center, Plaza Suite #2105 Mankato, Minnesota 56001

Telephone: (507)344-2716 Fax: (507)344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 25, 2011, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 25, 2011 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 15, 2011 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 15, 2012 (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

Essentia Health Oak Crossing October 3, 2011 Page 5 regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Maria King, Unit Supervisor Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health 12 Civic Center, Plaza Suite #2105

Maria King

Mankato, Minnesota 56001

Telephone: (507)344-2716 Fax: (507)344-2723

Enclosure

cc: Licensing and Certification File

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

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SI COMPLE	
		245212	B. WI	IG		09/1	5/2011
	ROVIDER OR SUPPLIER	OSSING		10	TREET ADDRESS, CITY, STATE, ZIP CODE 1040 LINCOLN AVENUE DETROIT LAKES, MN 56501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	as your allegation of department's accept bottom of the first puber used as verifica. Upon receipt of an visit of your facility that substantial corhas been attained inverification.	Correction (POC) will serve of compliance upon the otance. Your signature at the page of the CMS-2567 form will tion of compliance. acceptable POC, an onsite may be conducted to validate inpliance with the regulations in accordance with your		272			THE CONTRACT OF THE CONTRACT O
\$\$=D	ASSESSMENTS The facility must co a comprehensive, a reproducible asses functional capacity. A facility must mak assessment of a reresident assessme by the State. The a least the following: Identification and dicustomary routine; Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-tensical functioning Continence;	enduct initially and periodically accurate, standardized sment of each resident's e a comprehensive sident's needs, using the nt instrument (RAI) specified assessment must include at emographic information; patterns; peing; and structural problems; and health conditions;	Flan of Concrin appoint many as	der eine der der eine der der eine eine eine eine	On 8-9-11, the tissue toleral assessment was fully complor R-15. The facility policy and prorequires a comprehensive states assessment, including the Braden's and tissue toleral test, along with the gatheric past medical history. Licensed staff trained of the facility's skin policy and procedure on 10/5/2011. Data gathering of assessment and history re-enforced to they are included in the Reprocess by the MDS coordinators.	cedure skin nce ng of ne ents assure	10 25 11
ABORATOR	/ DIRECTOR'S OR PROVI	 DER/SUPPLIER REPRESENTATJIYE'S SIGN	VATURE		TITLE		(X6) DATE

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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0LNZ11

Facility ID: 00907

If continuation sheet Page 1 of 18

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

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938-0391

OTATEMES	× 05 555101010	T TOTAL OF TAXABLE			· · · · · · · · · · · · · · · · · · ·	OMB NO	<u>0. 0938-0391</u>
AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A. BU		TPLE CONSTRUCTION	(X3) DATE COMPI	SURVEY
		245212	B. Wi	NG_		00/	15/0044
	PROVIDER OR SUPPLIER	SSING		1	REET ADDRESS, CITY, STATE, ZIP CODE 1040 LINCOLN AVENUE DETROIT LAKES, MN 56501	1 09/	15/2011
(X4) IÖ PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊΧ	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD RE	(X6) COMPLETION DATE
And provided the second	Medications; Special treatments a Discharge potential; Documentation of so the additional asses areas triggered by th Data Set (MDS); and Documentation of pa	Immary information regarding sment performed on the care ne completion of the Minimum d articipation in assessment. I is not met as evidenced and record review, the facility	F 2	272	The facility will complete skin assessments upon transferring a resident fro transitional care to a long care unit, in addition to the required assessments as pathe MDS schedule. DON will audit care plans assessments of newly admiresidents to assure comprehensive skin assess are complete. DON will report outcomes audit to the facility's OA for	m term e art of and itted ments	10/25/11 0/13 0/13 0/13 0/13 0/13 0/13 0/13 0
	sample review with a Findings include: Resident 15 (R15) lacassessment. R15 was diagnosed vocausing extremity were decreased sensation, and muscle weaknessorata Set (MDS) dated cognitively intact with ecall. The MDS also extensive assistance inctivities of daily living mitations to both lower	pressure ulcer. cked a comprehensive skin with a neurological disorder akness/paralysis with peripheral vascular disease s. The admission Minimum d 6/6/11, identified R15 was mild deficits in memory indicated that R15 required from staff with mobility and d (ADLs), had functional er extremities, had no ulcers) however was at risk			next 12 months.		

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

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	Turn.			OMR M	<i>).</i> 0938-0391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	- 1	ILDIN(PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		· 245212	B. Wi	NG		ng	15/2011
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1001	10/2011
ESSENT	TA HEALTH OAK CRO	SSING		10	40 LINCOLN AVENUE	•	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	15		ETROIT LAKES, MN 56501		
PRÉFIX TAG	LEACH DEFICIENCY	MUST BE PRECEDED BY FULL CC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD RE	COMPLETION DATE
F 272	for development of I pressure reducing d bed, with no pressur chair. The PU Care dated 6/2/11, indicat including: immobility nutritional status as ulcers to the left foot PU on the coccyx was factor on this CAA.	PU. The MDS indicated a evice was utilized for R15's re reducing device utilized in a Area Assessment (CAA) ed R15 had risk factors incontinence and poor well as current vascular. The resident's history of a as not identified as a risk dursing notes dated 5/30/11	F2	272			# 78
	on her coccyx with name areas. A Braden scale (a too assessment had bee The Braden score inc	car tissue from a healed PU o current redness or open old for predicting PU risk) in completed on 5/30/11. Sicated R15 was at low risk		THE PROPERTY OF THE PROPERTY O			
	sensory impairment, the resident's tissue t pressure, identified a Assessment" had be resident's risk while h	The facility's assessment of olerance to prolonged in a "Tissue Tolerance on conducted related to the ving down. That		The state of the s			11
	could tolerate lying for could tolerate lying for cover her bony proming dated 5/30/11, had be risks while seated. The resident's risks while sear tissue on the coowound, however no timelated to how long Reposition without redner 20 7/23/11, nursing necessitions.	seated indicated R15 had cyx from an old healed meframe was identified 15 could tolerate a sitting ss to bony prominence's.		demonstrative demonstrative and the second of the second o			
<u>;</u> 1	ound to have a stage	2 PU, (Partial thickness ing as a shallow open ulcer					

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

PRINTED: 10/03/2011 FORM APPROVED OMB NO 0938-0391

STATE	MENT OF DEFICIENCIES	& WEDICAID SERVICES				OMB N	O. 0938-039
AND PL	AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I A. BU		TIPLE CONSTRUCTION ING	(X3) DATE	SURVEY PLETED
		245212	B. WI	ING		8	
NAME	OF PROVIDER OR SUPPLIER			٦,		09	/15/2011
ESSE	ENTIA HEALTH OAK CRO	SSING		1	REET ADDRESS, CITY, STATE, ZIP CODE 1040 LINCOLN AVENUE DETROIT LAKES, MN 56501		
(X4) PREF TAC	IX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix.	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTH CROSS-REFERENCED TO THE APPRIDEFICIENCY)	III D RE	(X5) COMPLETION DATE
F 31	Duttock/hip area me 2.3 cm with a 3 cm; pressure ulcer subsistage 4 PU by 8/18/ On 9/15/11, at 9:51 stated their assessm was incomplete. RN comprehensively assessments. At 12: stated when since R lack of feeling and se as well as her history been assessed upon immediate intervention At 12:29 p.m. on 9/18 (DON) verified R15 la assessment. 483.25(c) TREATME PREVENT/HEAL PR Based on the compre resident, the facility m who enters the facility does not develop pres	cound bed), to the lower asuring 6 cm (centimeters) x x 2 cm area of necrosis. The equently deteriorated to a 11. a.m. registered nurse (RN)-A nent of R15's tissue tolerance I-A stated they should have sessed the resident by ng and lying tissue tolerance 12 p.m. on 9/15/11, RN-A 15 was at risk, due to her ensation to her lower body, of PU, she should have admission to implement ons to prevent PU. 5/11, the director of nursing acked a comprehensive skin NT/SVCS TO ESSURE SORES hensive assessment of a nust ensure that a resident without pressure sores source sores unless the	F 31	272	During survey DON and Surveyor audited R15's documentation and care plan, a	and	10/25/11
	they were unavoidable pressure sores received services to promote here prevent new sores from this REQUIREMENT by:	ndition demonstrates that e; and a resident having es necessary treatment and ealing, prevent infection and			all interventions were in place, remaining in place while on hospice care and passed peacefully on 9/25/11. At the time of death, R15's wounds were clean and the cause of de was consistent with symptoms congestive heart failure.	ath	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0LNZ11

Facility ID: 00907

If continuation sheet Page 4 of 18

OCT 1 2 2011

7,5355

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

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938-0391

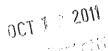
STATEMEN	NT OF DEFICIENCIES	(X1) PROMERICAND ISSUE				OMB NO	<u>). 0938-0391</u>
AND PLAN	PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A. BU		TIPLE CONSTRUCTION ING	(X3) DATE S COMPL	SURVEY
		245212	B. WI	NG_		004	15/0044
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 09/	15/2011
ESSENT	TIA HEALTH OAK CRO	SSING		ļ ·	1040 LINCOLN AVENUE		
22.010	CUBANADY				DETROIT LAKES, MN 56501		
(X4) ID PREFIX TAG	LEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	HI D RE	(X5) COMPLETION DATE
	and policy review, the appropriate assessminterventions to previous pressure ulcers for sample who had curfacility's failure to ad resulted in actual had development. Finding R15 had developed tissue loss with expositional manner to prevent the ulcers (PUs). R15 was diagnosed to causing extremity we decreased sensation and muscle weakness Data Set (MDS) date cognitively intact with recall. The MDS identification assistance from staff of daily living (ADLs.) R15 had functional linextremities, had no cut development of PU. To pressure reducing decreased sensation and muscle weakness and functional linextremities, had no cut development of PU. To pressure reducing decreased sensure reducin	ne facility failed to provide ment, monitoring and yent the development of of 1 resident (R15) in the grent pressure ulcers. The equately assess and monitor rm for R15, pressure ulcer gs include: a Stage 4 (full thickness used bone, tendon or muscle, ent) Pressure Ulcer (PU) on facility failed to monitor, and interventions in a timely use development of pressure with a neurological disorder takeness/paralysis with, peripheral vascular disease used to her history of PII to the CAA lacked indication ted to her history of PII to the cast and its to per lacked indication ted to her history of PII to the cast and its to per lacked indication ted to her history of PII to the cast and its to per lacked indication ted to her history of PII to the cast and its to per lacked indication ted to her history of PII to the cast and its to per lacked indication ted to her history of PII to the cast and its to per lacked indication ted to her history of PII to the cast and its to per lacked indication ted to her history of PII to the cast and its to per lacked indication ted to her history of PII to the cast and its to per lacked indication ted to her history of PII to the cast and its to per lacked indication ted to her history of PII to the cast and its to provide the cast and its top to provide the cast and its to provide the cast and its top to provide the cast an	F	314		272) ents of the dents on of as called was aff a be he ag	10/25/11
1	tips coccyx and inte	rvention to prevent the			competency test on 10/5/2011	1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0LNZ11

Facility ID: 00907

If continuation sheet Page 5 of 18



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

PRINTED: 10/03/2011 FORM APPROVED

STATEMEN	NT OF DEFICIENCIES	WAY DECLARATE OF TAXABLE				OMB NO	0.0938-039
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A. BU		FIPLE CONSTRUCTION NG	(X3) DATE : COMPL	SURVEY
		245212	B. WI	NG_			
ESSENT (X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREF		REET ADDRESS, CITY, STATE, ZIP CODE 1040 LINCOLN AVENUE DETROIT LAKES, MN 56501 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO	CTION	(X5)
F 314	Continued From page development of a Pi The Braden scale (a completed on 5/30/1 risk for developing a R15 had no sensory loss of sensation to her neurological completed on scale had been completed by the facility's lying "The facility's lying and the facility lying another lying and the facility lying and the facility lying and the	ge 5 U. It tool for predicting PU risk) It, indicated R15 was at low PU. The Braden indicated impairment despite R15's the lower extremities due to dition. No further Braden pleted. issue Tolerance 5/30/11, indicated R15 had a accyx and could tolerate lying edness over her bony cility's sitting "Tissue ent" dated 5/30/11, indicated on coccyx from an old over no timeframe was ow long R15 could tolerate a at redness to a bony e dated 6/2/11, lacked any to R15's PU risk including vices to her bed, electric itioning program. On 9/6/11, been revised to direct staff to of changes in skin condition, elieve pressure every hour, for pressure relief and in to prevent pressure on ishion while in electric ers on 8/28/11, directed	PREF TAG		CROSS-REFERENCED TO THE APP DEFICIENCY)	n s as sin lity's cation fective ns, the nal	COMPLETION DATE A) 25 1)

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0LNZ11 Facility ID: 00907

If continuation sheet Page 6 of 18

OCT 3 3 2011

Wilmerote Port Citi

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0038-0301

AND PLAN OF CORRECTION AND CONTRIBUTED A BULDING 245212 NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING CX4) ID CX5) ID CX4) ID	STATEME	NT OF DEFICIENCIES	WAL PROVIDE COLLARS		-		OMB N	O. 0938-0391
RAME OF PROWIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING CAGID SUMMARY STATEMENT OF DEFICIENCIES 1940 LINCOLN AVENUE DETROIT LAKES, MN 56501	AND PLAI	NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			(X3) DATE	SURVEY
SUMMARY STATELEBY OF DEFICIENCES (EACH DEFICIENCY MIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYMO INFORMATION) F 314 Continued From page 6 On 9/15/11, at 7:10 a.m. R15 was observed during her morning bath and wound care with assistance of nursing assistant (I/A)-C. NA-C was observed to provide assist with all mobility and ADL's for R15. R15 was noted to have an air mattress to her bad and a roho cushion to her electric wheelchair. At 7:70 a.m. licensed practical nurse (LPN)-E was observed to be irregularly shaped with a large crater which exposed muscle, with clean and healthy tissue present and no slough or eschar (necrosis) present. A review of the clinical record indicated: On 5/30/11, R15 was admitted to the transitional care unit for rehabilitation. Nursing notes indicated R15 has car tissue from a healed PU on her coccyx with no current redness or open areas. R15 was noted to require assistance from staff due to weakness and her inability to stand independently. On 6/7/11, nursing notes indicated R15 was found to have a small bilster on the right buttock. The blister was identified as intact and the documentation indicated R15 was to remain off her right side. No further assessment of R15's skin was noted at that time.			245212	B. WI	NG			H E IOO 4 4
(x ₀) Defermined to the transitional care unit for rehabilitation. Nursing notes indicated R15 had scar tissue from a healed PU on her coccyx with no current redness or open areas. R15 was noted to the transitional care entit for unit for the had some that time. Explain the transition of the remaining notes indicated R15 was found to have a small bilister on the right buttock. The bilister was identified as intact and the documentation indicated R15 was noted at that time.			essing		s	1040 LINCOLN AVENUE	[09	/15/2011
On 9/15/11, at 7:/10 a.m. R15 was observed during her morning bath and wound care with assistance of nursing assistant (NA)-C. NA-C was observed to provide assist with all mobility and ADL's for R15. R15 was noted to have an air mattress to her bed and a roho cushion to her electric wheelchair. At 7:57 a.m. licensed practical nurse (LPN)-E was observed to dress R15's wounds. The left buttock/hip wound was noted to be a stage 4 PU, measuring approximately 9 cm (centimeters) x 5 cm with 4 cm in depth. The wound was observed to be irregularly shaped with a large crater which exposed muscle, with clean and healthy tissue present and no slough or eschar (necrosis) present. A review of the clinical record indicated: On 5/30/11, R15 was admitted to the transitional care unit for rehabilitation. Nursing notes indicated R15 had scar tissue from a healed PU on her coccyx with no current redness or open areas. R15 was noted to require assistance from staff due to weakness and her inability to stand independently. On 6/7/11, nursing notes indicated R15 was found to have a small bilster on the right buttock. The bilster was identified as intact and the documentation indicated R15 was to remain off her right side. No further assessment of R15's skin was noted at that time.	PREFIX	LEACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	III D BE	(X5) COMPLETION DATE
On 6/14/11, nursing notes indicated R15 had been moved to another unit for long term placement to the facility due continued Issues with mobility and the required assistance from		On 9/15/11, at 7:10 during her morning I assistance of nursin was observed to pro and ADL's for R15. I mattress to her bed electric wheelchair. / practical nurse (LPN R15's wounds. The I noted to be a stage approximately 9 cm cm in depth. The woi irregularly shaped wi exposed muscle, with present and no sloug present. A review of the clinical On 5/30/11, R15 was care unit for rehabilitatindicated R15 had so on her coccyx with no areas. R15 was noted staff due to weakness independently. On 6/7/11, nursing no found to have a small The blister was identified documentation indicated her right side. No furth skin was noted at that On 6/14/11, nursing no been moved to another placement to the facility.	a.m. R15 was observed bath and wound care with g assistant (NA)-C. NA-C wide assist with all mobility R15 was noted to have an air and a roho cushion to her At 7:57 a.m. licensed)-E was observed to dress eft buttock/hip wound was 4 PU, measuring (centimeters) x 5 cm with 4 und was observed to be th a large crater which h clean and healthy tissue th or eschar (necrosis) all record indicated: admitted to the transitional ation. Nursing notes ar tissue from a healed PU or current redness or open at to require assistance from and her inability to stand the inability to stand the set indicated R15 was blister on the right buttock. Fied as intact and the ted R15 was to remain off the assessment of R15's time. Outsindicated R15 had be unit for long term by due continued issues	F	3314			

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938 0301

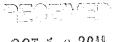
STATEM	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X3) I	At It I	TIPLE CONSTRUCTION		O. 0938-0391
AND PU	AN OF CORRECTION	IDENTIFICATION NUMBER:	A. BU			(X3) DATE COMP	SURVEY LETED
		245212	B. Wi	NG _			
	OF PROVIDER OR SUPPLIER NTIA HEALTH OAK CRO	PSSING	, ! ,	1	REET ADDRESS, CITY, STATE, ZIP CODE	1 09/	15/2011
(X4) II PREFI TAG	X (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	HIDRE	(X5) COMPLETION DATE
F 31	Continued From particles staff. Record review did n	ot include any documentation	F3	314			ef +8
	when the nursing no developed a stage 2 area measuring 6 cr cm area of necrosis.	pressure ulcer until 7/23/11, ites indicated R15 had PU to the lower buttock/hip n x 2.3 cm with a 3 cm x 2					70,11
	placed on R15's left hour repositioning so	notes indicated a thin o protect wounds) had been buttock/hip and an every shedule had been initiated. sen informed of the PU time.					351 351
	therapist (OT)-A, indi wheelchair with no cu R15 had an open are cushion for pressure it. The OT's notes ind	cated R15 had an electric ishion. The OT documented a on her bottom and had a relief but had not been using licated it had been aff use the cushion to the id to have R15 off her					
	wheelchair and neither resident. The OT indiction a daily assessment pressure relief and repositioning schedule aware of. At that time, turning and positioning	ed R15 did not have any established that she was the OT had developed a		. Date		To a substitution of the s	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0LNZ11

Facility ID: 00907

If continuation sheet Page 8 of 18



OCT 1 3 2011

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	NT OF DEFICIENCIES	(X1) ODOVIDEDICIDENTEDICINA				OMB N	<u>O. 0938-0391</u>
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I A. BU		TIPLE CONSTRUCTION NG	(X3) DATE	SURVEY PLETED
NAME OF	PROVIDER OR SUPPLIER	245212	B. WI	NG_		09	/15/2011
	TIA HEALTH OAK CRO	SSING		1 1	REET ADDRESS, CITY, STATE, ZIP CODE 1040 LINCOLN AVENUE DETPORT LAKES, MAN 5070	-1	. 70.2017
(X4) ID PREFIX TAG	I ICAGH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	MILD BE	(X5) COMPLETION DATE
	in the resident's roor resident should be resident should be recommended in the new ound flow sheets; It tolerance assessment 8/9/11. At that time, It redness over bony pressure. R15 was prepositioning schedul hour. Review of the revealed that R15 was schedule, often refus was provided with ed and benefits of not for schedule. Intervention implementation included and multiple interdisciples in electric where positioning schedul and multiple interdisciples of schedule. On 8/9/11, the facility' Documentation' week R15's wound was a state of the schar. On 8/10/11, physician apply an Allevyn dress he wound. On 8/16/11, the facility occumentation' week R15's wound had dete	m to reference how the epositioned. g of the wound was ursing notes and the weekly nowever, no new "tissue nt" had been completed until R15 was found to have rominences after 1 hour of laced on a 1 hour le despite redness after 1 esident's nursing notes as resistant to a repositioning ing to be repositioned. R15 ucation regarding the risk llowing a repositioning is identified for led: pressure relieving elchair, an air mattress, a e, wound dressing changes iplinary referrals. s "Wound Care thy flow sheets indicated lage 2 PU, measuring 6 cm in 50% slough and 50% of orders were received to sing should be applied to	F	314			7 6 201 7 9 201 7 201
i		1		1		1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0LNZ11

Facility ID: 00907

If continuation sheet Page 9 of 18

OCT 1 3 2011

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938-0391

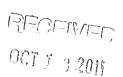
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	Tax			OMB NO	<u>0. 0938-0391</u>
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		AULTI. ILDIN	PLE CONSTRUCTION G	(X3) DATE COMPI	SURVEY LETED
		245212	B. WI	NG			4
NAME OF	PROVIDER OR SUPPLIER			\$TD	SET ADDRESS OFFICE ATTACK	09/	15/2011
ESSENT	TIA HEALTH OAK CRO	DSSING		10	EET ADDRESS, CITY, STATE, ZIP CODE 040 LINCOLN AVENUE ETROIT LAKES, MN 56501		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	lD.				
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
F 314	On 8/18/11, nursing wound debridement the left buttock/hip visualities following the debridations of the company of the compan	notes indicated R15 had a (removal of necrotic skin) of yound. Wound measurements ement indicated R15 had e undermining tissue	F:	314			ef 10
	health, Nursing notes indica	continued failure in overall ted on 8/20/11, an odor had					
	anterior aspects of the	į.		and the same of th			1 4
	K15's wound was an	ity's "Wound Care kly flow sheets indicated unstageable PU, measuring meter with 100% eschar.					j .
Addresses and the state of the	On 8/29/11, R15 aga wound debrided.	in had the left buttock/hip					
	progress of necrosis her compromised nul felt R15 could becom	n-A documented R15's was advanced, and due to ritional status, physician-A e septic and die from the ecommended R15 be kept ble.		num., stridikonum., in. manjela ili ili manjela		The second secon	
L F k	≺าธร PU was a stag∈ oss. Subcutaneous fa	sty flow sheets indicated 3 (Full thickness tissue at may be visible but no alle exposed) measuring 6			· •		
				the broughter.		reg .	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0LNZ11

Facility ID: 00907

If continuation sheet Page 10 of 18



PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938-0391

	STATEME	NT OF DEFICIENCIES	WILDICAID SERVICES				OMB N	O. 0938-0391
	AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	MULT()	PLE CONSTRUCTION G	(X3) DATE	
			245212	B. W	NG _			
	NAME OF	PROVIDER OR SUPPLIER			1000		09/	/15/2011
	ESSEN	TIA HEALTH OAK CRO	SSING		10	EET AODRESS, CITY, STATE, ZIP CODE 040 LINCOLN AVENUE		
ľ	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	1		ETROIT LAKES, MN 56501	_,	
	PRÉFIX TAG	I CAUT DEFIGIENCY	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	Hin oc	(X5) COMPLETION DATE
	F 314	on 9/8/11, physician be allowed to have a schedule while sleep measure due to the Nursing assistant (N. p.m. on 9/14/11, she repositioning schedule recently they had been every 2 hours if sleep	notes indicated R15's wound the eschar had been orders indicated R15 would a 2 hour repositioning bing as a comfort care resident's exhaustion. A)-C was interviewed at 2:27 stated R15 was on a 1 hour le however, she added that en directed to reposition R15 bing. NA-C also stated R15 wheelchair and an air	F	314			1 (04) Veo
		OT-A was interviewed OT-A stated she had for a cushion in her e development of a PU cushion for her electric her shortly after her a liked it and did not wa was not until R15 development of the cushion was found for OT-A verified that after finding the right cushion implemented a Roho was essentially a paraneurological condition been educated related following a repositioning Registered nurse (RN)	on for R15, they had cushion. She stated R15 plegic due to her OT-A also stated R15 had to risk and benefits of not ng schedule.				And the state of t	1.7%
	t	olerance assessment	A stated R15's "tissue ' was incomplete upon have included assessment				THE SECTION SECTION SECTIONS	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0LNZ11

Facility ID: 00907

If continuation sheet Page 11 of 18



PRINTED: 10/03/2011 FORM APPROVED OMB NO 0938-0391

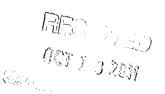
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	()(0)	** ** ***		<u>OMB N</u>	<u>O. 0938-0391</u>
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	- 1	NULTIF	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		245212	B. W	NG			
NAME OF	PROVIDER OR SUPPLIER			СТО	EET ADDRESS SITE OF THE	09.	/15/2011
ESSEN	TIA HEALTH OAK CRO	PSSING		10	EET ADDRESS, CITY, STATE, ZIP CODE 40 LINCOLN AVENUE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	Ţ	Di	ETROIT LAKES, MN 56501		**
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ON SHOULD BE CO LE APPROPRIATE	
	of the resident's sitti RN-A also stated the assessment" had no manner after the deverified R15's skin hassessed. She state walk and had been of She added she had previous PU prior to RN-A stated she had previous PU prior to RN-A stated she had the wound could have had developed eschiphysician had been of the PU and the faci implementing a new result. During additional interp.m. on 9/15/11, RN at risk of PU, a more assessment should hadded R15's lack of flower body as well as have been addressed stated no preventativitisks were found on the after admission. RN-PU had been discove to OT to have a cuship wheelchair. RN-A stated that time they had a control been using it and stated that on 7/28/11 requested. RN-A veriforessure reduction cu	ing and lying tissue tolerance. e "tissue tolerance of been completed in a timely velopment of the PU. RN-A and not been comprehensively of R15 had not been able to chair bound since admission. been aware R15 had a admission to the facility. If questioned staff about how we been undiscovered until it ar. RN-A stated R15's upset about the development cility had discussed PU prevention program as a erview with RN-A at 12:12 -A stated when a resident is comprehensive skin have been completed. RN-A feeling and sensation to her is her history of PU should di upon admission. RN-A e interventions related to PU he plan of care developed A verified that once R15's red, she had been referred in placed in her electric ted the OT had told her at ushion for R15, but R15 had did not want to use it. RN-A , a new cushion had been ied R15 had not utilized a	F	314			700
				j		i	

FORM CMS-2667(02-99) Previous Versions Obsolete

Event ID: 0LNZ11

Facility ID: 00907

If continuation sheet Page 12 of 18



PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938-0301

	STATEM	ENT OF DEFICIENCIES	WA PROJECTION SERVICES				OMB N	IO. 0938-039	. L
ĺ	AND PLA	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I A. BU		TIPLE CONSTRUCTION NG	(X3) DATE	SURVEY PLETED	2_
I			245212	B. WI	NG_				
ĺ	NAME O	F PROVIDER OR SUPPLIER			ет	DEET ADDRESS COMMANDE	09	/15/2011	
I	ESSE	ITIA HEALTH OAK CRO	ossing .		1	REET ADDRESS, CITY, STATE, ZIP CODE 1040 LINCOLN AVENUE			
ŀ	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	1		DETROIT LAKES, MN 56501			
	PREFIX TAG	C TEAGN DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	HIDDE	COMPLETION DATE	 I
	F 314	At 12:29 p.m. the did verified R15 lacked assessment to prevent to prevent the facility policy "Programment and Prevent the complete upon accomplete upon acco	rector of nursing (DON) a comprehensive skin ent the development of a PU. ressure Sore Assessment, ention" dated May 2005, Risk Assessment Scale would dmission, quarterly and with a status. The policy states sident' total risk score, each tial cause should be ." The "Tissue Tolerance be done for both lying and admission and with a Daily inspection by the NA n by the LPN will be done to fects to the skin are noted	F	314			74.0 74.0 73.93	,
	SS = E	STORE/PREPARE/S The facility must - (1) Procure food from considered satisfactor authorities; and (2) Store, prepare, dis under sanitary condition. This REQUIREMENT by: Based on observation failed to follow food sa	sources approved or ry by Federal, State or local stribute and serve food ons is not met as evidenced and interview, the facility nitation procedures on 2 of ed the possibility of food	F 37	7	The facility's Dietitian and will educate all Homemaker working in the neighborhook itchens through role play, I on situations and discussion sanitation policy and proced was also re-enforced during training which occurred on October 6, 2011.	's d nands . The ure	16/25/11	
							j		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0LNZ11

Facility ID: 00907

If continuation sheet Page 13 of 18



PRINTED: 10/03/2011 FORM APPROVED

If continuation sheet Page 14 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE		(X3) DATE	M APPRO O. 0938-0 SURVEY LETED
NAME OF PROVIDER OR SUPPLIER	245212	B. WING			
(X4) ID SUMMARY STA PREFIX (EACH DEFICIENCY TAG REGULATORY OR LS	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	TREET ADDRESS, CITY, STATE, ZIP CODE 1040 LINCOLN AVENUE DETROIT LAKES, MN 66501 PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION	15/2011 COMPLET DATE
Homemaker (HM)-D gloves while dishing was observed to dish resident, then to retu something down with dish another resident to pick up a sandwich to place a bag of chip handing the resident's for service to a reside handwashing or glove p.m. HM-D was obseresident's plate, return sheet of paper on the plate, dishes up food vanother plate to a resident's resident's handwashing or glove p.m. HM-D was obseresident's plate, return sheet of paper on the plate, dishes up food vanother plate to a resident's plate to a resident's resident's plate to a resident's plate to a resident's resident's plate to a resident to the service area and HM-D was interviewed. She confirmed she had nor washed her hands. On 9/12/11 at 6:20 p.m. Cedar Ridge Kitchenet fruit cups were observed cupboard. The fruit cup moisture/water sitting in Homemaker-A stated the noon meal and must they had been put away. On 9/15/11 at 10:20 am clear plastic glasses we on Harbor Springs. Neir	of the evening meal on the at 5:35 p.m. on 9/12/11, was observed to wear food for residents. HM-D in and serve a plate for a rin to the service area, write a pencil, and to proceed to its meal. She was observed in for a resident's plate, and its on the plate prior to its meal to a nursing assistant ent. There was no exchange observed. At 6:14 enved to dish another in to serving area, write on a serving cart, grabs a new with tongs, and deliver dent. HM-D then returned differenced the removed her gloves. If at 6:36 p.m. on 9/21/11, do not changed her gloves when she should have. In the sanitation tour of the te was completed. Fifteen ent to be stacked in a ps were observed to have in between the cups. The cups had been used for the tot have been dry when the cups had been dry when the cups ha	í	New employee orientation provided by the Dietitian winclude sanitation training. training is provided 1 day pmonth and all new employes scheduled to attend as part their new employee oriental All new employees working the Neighborhood attend the training, including nurses, nursing assistants, homemal neighborhood coordinators, neighborhood support staff. The dietitian will complete monthly audits in the neighborhood kitchens that winclude sanitation observation Any identified deficient practical will receive immediate coachi and correction by the dietitian. Audits will be reported in facility's QA. For the next 12 months.	vill This per pes are of tion. g in is cers, and	10/25/
MS-2567(02-99) Previous Versions Obsole				#	3

OCT 7 12011

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938-0391

A BUILDING CORRECTION COIL TO B. WING B. WING COIL TO B. WING		STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1,000			OMB N	<u>0. 0938-039</u>
PROVIDER OR SUPPLIER ESSENTIA HEALTH OAK CROSSING SUMMARY STATEMENT OF DEFICIENCES (X4) ID SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 371 Continued From page 14 Interview with the Dietary Manager on 9/15/11 at 11:30 am, stated the facility does allot of training for hand sanitation when serving food. The Dietary Manager also confirmed that she would not expect homemakers to put wet dishes in cupboards. SS=E LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of recipit and disposition of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Ahrse Presenters and the storage of controlled drugs listed in Schedule II of the Comprehensive Drug Ahrse Presenters and the storage of controlled drugs listed in Schedule II of the Comprehensive Drug Ahrse Presenter and the storage of controlled drugs listed in Schedule II of the Comprehensive Drug Ahrse Presenters and the storage of controlled drugs listed in Schedule II of the Comprehensive Drug Ahrse Presenters and the storage of controlled drugs listed in Schedule II of the Comprehensive Drug Ahrse Presenters and the sto		AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:				(X3) DATE	
ESSENTIA HEALTH OAK CROSSING (X4) ID PREFIX TAGE (X4) ID PREFIX TAGE SUMMARY STATEMENT OF DESICIENCIES (EACH DERICIENCY WIST BE PRECEDED BY PILL). TAGE F 371 Continued From page 14 Interview with the Dietary Manager on 9/15/11 at 11:30 am, stated the facility does alot of training for hand sanitation when serving food. The Dietary Manager also confirmed that she would not expect homemakers to put wet dishes in cupboards. F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconcilization; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in looked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abruse Presentions.				245212					<u>_</u>
CAMP ID SUMMAY STATEMENT OF DEFICIENCIES DETROIT LAKES, NM 56501		NAME OF	PROVIDER OR SUPPLIER			т—		09/	15/2011
FACT TAG REGULATORY OF LIGHT PRECEDED BY FULL RE		ESSENT	TIA HEALTH OAK CRO	DSSING		1	040 LINCOLN AVENUE		<u> </u>
F 371 Continued From page 14 Interview with the Dietary Manager on 9/15/11 at 11:30 am, stated the facility does alot of training for hand sanitation when serving food. The Dietary Manager also confirmed that she would not expect homemakers to put wet dishes in cupboards. F 431 A83.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Purp Abuse Prevention and accordance of controlled drugs listed in Schedule II of the Comprehensive Purp Abuse Prevention and a cordance with sast assured that	l		SUMMARY STA	TEMENT OF DEFICIENCIES	1 10				
Interview with the Dietary Manager on 9/15/11 at 11:30 am, stated the facility does alot of training for hand sanitation when serving food. The Dietary Manager also confirmed that she would not expect homemakers to put wet dishes in cupboards. F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Ahuse Preventice pred	-		: LUNCH DEFILIENTY	MUST BE DDEACHED by Eng.	PREF		CROSS-REFERENCED TO THE APPR	MIID DE	COMPLETION DATE
for hand sanitation when serving food. The Dietary Manager also confirmed that she would not expect homemakers to put wet dishes in cupboards. F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detait to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and accessing that they are accessing the survey, by 9/15/2011. The medication labels for R-97, R-11, R55, and R154 were corrected during the survey, by 9/15/2011. The facility will conduct a 100% audit of all pharmaceuticals to assure labels are current and correct per the order by 10/25/2011. RN's and LPN's were educated on the current policy and procedure on 10/5/2011. The DON met with the facility's pharmacy vendor on 10/12/2011. It was determined no changes were need to the policy and procedure and it was assured that		F 371	Continued From page	ge 14	F3	371			61.15
abuse, except when the facility uses single unit		SS=E	for hand sanitation variety Manager als not expect homemal cupboards. 483.60(b), (d), (e) DELABEL/STORE DRU The facility must empa licensed pharmacis of records of receipt controlled drugs in su accurate reconciliation records are in order a controlled drugs is mare conciled. Drugs and biologicals abeled in accordance professional principles appropriate accessory instructions, and the expelicable. In accordance with Standilly must store all docked compartments on trols, and permit or ave access to the key the facility must provide manently affixed controlled drugs listed comprehensive Drug Approprial Act of 1976 and pontrol Act of 1976 and pon	confirmed that she would kers to put wet dishes in RUG RECORDS, IGS & BIOLOGICALS Poloy or obtain the services of st who establishes a system and disposition of all afficient detail to enable an an account of all aintained and periodically If used in the facility must be a with currently accepted and cautionary expiration date when the analysis and biologicals in under proper temperature of the separately locked, impartments for storage of in Schedule II of the Abuse Prevention and the detail of the regregation of the separately locked, in Schedule II of the Abuse Prevention and the detail of the regregation of the separately locked, in Schedule II of the Abuse Prevention and the detail of the regregation of the separately locked, and the separately locked, and the separately locked, and the separately locked of the separately locked, and the separately locked of the separately locked, and the separately locked of the separately l	F 4	1 3	R-11, R55, and R154 were corrected during the survey 9/15/2011. The facility will conduct a audit of all pharmaceuticals assure labels are current and correct per the order by 10/25/2011. RN's and LPN's were educa on the current policy and procedure on 10/5/2011. The DON met with the facil pharmacy vendor on 10/12/2 It was determined no change were need to the policy and	ted ity's 2011.	10/25/1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0LNZ11

Facility ID: 00907

If continuation sheet Page 15 of 18

ner : 300il

PRINTED: 10/03/2011 FORM APPROVED

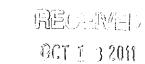
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	T _(Va) t			OMB N	O. 0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU		TIPLE CONSTRUCTION ING	(X3) DATE	
		. 245212	B. WII	NG_		1	
	PRÖVIDER OR SUPPLIER TIA HEALTH OAK CRO	DSSING .		·	REET ADDRESS, CITY, STATE, ZIP CODE 1040 LINCOLN AVENUE	09/	15/2011
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	أحبيا		DETROIT LAKES, MN 56501		**
PRÉFIX TAG	I LENGT VERILIENLY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	HIDDE	(X5) COMPLETION DATE
F 431	package drug distrit	ge 15 Dution systems in which the inimal and a missing dose can	F4	31	the pharmacy is properly processing the direction cha	nges.	10/25/11
	Based on observation review and interview medication labels we with physician orders and R154) residents medication pass. Firm The facility failed to form the facility failed to form the current physician of the pharmacon 9/12/11, at 5:00 p. Nurse (LPN)-D was of FlexPen for R97. The he staff to give 10 un The LPN was observen sulin for the resident changed and the resident staff to give 10 un the LPN was observen sulin for the resident changed and the resident staff to give 10 un the resident changed and the resident staff to give 10 un the resident changed and the resident staff to give 10 un the resident changed and the resident changed the change th	ollow their own polices to by sician orders by medication labels. In Licensed Practical beeved to obtain a Novolog pharmacy label directed by its of insulin before supper. Bed to prepare 7 units of the stated the order had been was to receive 7 units of the stated the order had been was to receive 7 units of the stated the order had been was to receive 7 units of the stated the order had been was to receive 7 units			The facility's Health Unit Coordinator (HUC) will randomly audit medication I to assure a "direction change label has been initiated and properly completed. The results of the audits will reported in facility's QA for months.	in ho	3 2011 3 324 3 324 3 324
g ir ir ci u O di m	Administration Recordative 7 units of insulin. Review of the adicated on 11/20/10, hanged the evening Marits to 7 units. In 9/13/11, at 9:55 a.r. sh up Psyllium Husk g (milligrams) for R1:	he Medication I (MAR) directed the staff to The LPN administered the current physician's orders the primary physician had Novolog insulin from 10 n. LPN-B was observed to (a fiber medication) 1000 1. The pharmacy label minister the medication at		Commence on commence of the co	· ·		

FORM

Event ID: 0LNZ11

Facility ID: 00907

If continuation sheet Page 16 of 18



Milmerola Lord of Brotto

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938 0301

1	STATEME	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	T _(Vn)			OMB N	O. 0938-0391
	AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	
-			245212	B. Wi	NG_			*. *
	NAME OF	PROVIDER OR SUPPLIER	*		ST	REET ADDRESS, CITY, STATE, ZIP CODE	09/	15/2011
	ESSEN	ITIA HEALTH OAK CRO	PSSING		1	040 LINCOLN AVENUE		. •
ŀ	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			DETROIT LAKES, MN 56501		
_	PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ION SHOULD BE CO	
	F 431	noon. Review of the medication was to be medications. LPN-E had been changed so not know why the phechanged. Review of order directed the standard cation before broken changed on 6/3. On 9/15/11, at 8:30 at 15.	e MAR indicated the e given with the morning stated the medication time everal years ago. She did earmacy label had not been if the current physician's aff to administer the eakfast. The order had last 80/08.	FZ	131			16 12.
		mg for R55. The phastaff to give one pill edizziness. Review of to give the medication verified the pharmacy match. Review of the indicated on 5/5/10, to	medication for dizziness) 25 medication for dizziness and directed the staff of twice a day. LPN-C medication land the MAR did not directed and the MAR did not directed the courrent physician's orders are physician had changed deded to a scheduled twice		, r y			
		msn up Celexa (an an mg for R154. The phastaff to give one 10 mg also a hand written no which read "2 tabs." L know who had written Review of the MAR dirmg of the medication.	m. LPN-A was observed to tidepressant medication) 20 armacy label directed the g tablet daily. There was te on the pharmacy label .PN-A stated she did not on the pharmacy label. rected the staff to give 20 Review of the current cated the medication had 0 mg to 20 mg on 7/7/11.		Amended to the second s			T Marie
	r	nedication orders were	egistered nurse (RN)-A at RN-A stated that when e changed, the nurse was abel which would alert staff		The second section of the second section secti		part and management of the management of the second	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0LNZ11

Facility ID: 00907

If continuation sheet Page 17 of 18

OCT 1 3 5011

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938-0391

I	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				OMB N	<u>0. 0938-0</u> 391
	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE	
ŀ	NAME OF	PROVIDER OR SUPPLIER	245212	B. WI	NG		09/	15/2011
		TIA HEALTH OAK CRO	DSSING			TREET ADDRESS, CITY, STATE, ZIP CODE 1040 LINGOLN AVENUE	1 001	10/2011
	(X4) ID PREFIX TAG	: (ENOR DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OF CORRECTION CTION SHOULD BE O THE APPROPRIATE	
		to the order change review the physician new label had been RN-A stated she had members were not labels for the medic label was needed. Review of the facility Policies dated 1/201 change" label will be until new med/label on 9/14/11, at 9:45 at (DON) verified the network the curre labels matched. The policy had not been for 9/15/11, at 10:54 of all the above described in the discrepancies between the control of the medication order ensure that the curre labels matched. The policy had not been for 9/15/11, at 10:54 of all the above described in the discrepancies between the discrepancies between the discrepancies and the discrepancies and the discrepancies are reviewed to the staff members and the discrepancies and the discrepancies are reviewed to the staff members are reviewe	The nurse was then to n's order and make sure a ordered for the medication. It do not been aware that staff utilizing the order change ation containers when a new of the medication and the placed on medication label is sent from pharmacy." a.m. the Director of Nursing ursing staff should be using the change labels and should ent orders and the pharmacy and pool to the pharmacy and the pharmacy and pool to the pharmacy and	F	431	•		2011 2010 2010 2010 2010 2010 2010 2010
			And the state of t		en en se sense en		and design the second s	

PATRICK SHEEHAN SUPERVISOR STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

TITLE

(X8) DATE

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

Facility ID: 00907

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 02 - EXISTING BUILDING 02	(X3) DATE SURVEY COMPLETED
		245212	B, WING		09/13/2011
	ROVIDER OR SUPPLIER	OSSING	10	EET ADDRESS, CITY, STATE, ZIP CODE 040 LINCOLN AVENUE ETROIT LAKES, MN 56501	
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
K 000	ST PAUL, MN 55. Email: pat.sheeha <mailto:pat.sheeha 1.="" 2-story="" 2.="" 3.="" 651-="" <mailto:pat.sheeha="" a="" actual,="" and="" building="" co="" correct="" defi="" deficiency="" description="" fax="" following="" for="" inf="" mary's="" mu="" name="" number="" of="" or="" page="" plan="" prevent="" regional="" reoccur="" responsible="" she="" she<="" st="" td="" the="" to="" with=""><td>an@state.mn.us an@state.mn.us> 215-0525 CRRECTION FOR EACH ST INCLUDE ALL OF THE CORMATION: f what has been, or will be, done ciency. croposed, completion date. for title of the person prection and monitoring to preciously all Health Center C & NC is a part of the deficiency and the original constructed in 1968, is 2-story and basement and was not the original building. In the original control of the original control of the original conce addition is Type V (111)</td><td>K 000</td><td></td><td>.C11 MED 1391</td></mailto:pat.sheeha>	an@state.mn.us an@state.mn.us> 215-0525 CRRECTION FOR EACH ST INCLUDE ALL OF THE CORMATION: f what has been, or will be, done ciency. croposed, completion date. for title of the person prection and monitoring to preciously all Health Center C & NC is a part of the deficiency and the original constructed in 1968, is 2-story and basement and was not the original building. In the original control of the original control of the original conce addition is Type V (111)	K 000		.C11 MED 1391
	the hospital addit 1-story without a building, without a 2-hour fire barrier and was determing construction. The	ories without a basement and ion is Type II (111) construction, basement. In 2008 a 2-story a basement, separated with two rs south of the entrance addition ned to be Type II (111) buildings are divided into 12 per floor) by 2- hour and 30 rs.			73:

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LDING	E CONSTRUCTION 02 - EXISTING BUILDING 02	(X3) DATE SI COMPLE	
	ROVIDER OR SUPPLIE!	•		104	ET ADDRESS, CITY, STATE, ZIP CODE 10 LINCOLN AVENUE TROIT LAKES, MN 58501	0071	
(X4) ID PREFIX TAG	(FACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	Due to the remote construction type Type II (000) required have a complete. The project is to The Administration of Sp. 2 2008 building accordance with Installation of Sp. 2 systems. The facility has a pull station near in the corridor sycommon areas in the corridor sycommon ar	deling of the main building, the has been down graded to a uiring the existing building be automatic fire sprinkler system. be complete by January 2010. on/ Entrance addition and the of (02) main building and the g are fully sprinkler protected in NFPA 13 Standard for the rinkler Systems 1999 edition with a fire alarm system with manual each exit door, smoke detection stem properly spaced and all accordance with NFPA 72 "The arm Code" (1999 edition). The grooms have smoke detection ed and connected to the fire he fire alarm system is monitored a department notification. In the grooms have smoke detection or that are on the fire alarm system is the Minnesota State Fire ion). The capacity of 96 beds and had a the time of the survey. Surveyed as two buildings, 02-uilding (1968 building and the tion / Entrance additions) as an Care and 03 South Building (2008).	K	000			
	7.() IVIL I HI DU	none or an original st.					hoot Page 3 of

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		E CONSTRUCTION 02 - EXISTING BUILDING 02	COMPLE	
		245212	B, WIN	G		09/1	3/2011
	ROVIDER OR SUPPLIER A HEALTH OAK CR	OSSING		104	T ADDRESS, CITY, STATE, ZIP CODE D LINCOLN AVENUE TROIT LAKES, MN 56501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 011 SS=F	If the building has nonconforming but barrier having at leasting constructed addition. Communications and are	a common wall with a ilding, the common wall is a fire east a two-hour fire resistance of materials as required for the nicating openings occur only in protected by approved fors. 19.1.1.4.1, 19.1.1.4.2	K)11	The 1½ hour fire rated do the 2 nd floor kitchen and thour fire rated door to the building will be repaired 10/25/2011. The Director of Maintena be responsible to ensure correction of the door late	he 1 ½ south by nce will	(0 25 11 0 0 11 0 11 0 11 0 11 0 11 0 11
	Observations rev are not in accorda Safety Code" (200 This deficient prac of the residents, s	is not met as evidenced by: ealed that two fire rated doors ince with NFPA 101 "The Life 00 edition) section 18.1.1.4.1. ctice could negatively affect all traff and visitors in the event of a e and smoke to pass from one er.			Monthly audits of all fire in the facility will be com and will be reviewed by the facility's QA during the months.	doors pleted ne	
;		tour on September 13, 2011, n and 3:30 pm, observations		numeros estados de la constante de la constant			3 1 . 7 . 5
	1) The 1 1/2- hour floor kitchen did n	r fire rated door near the 2nd ot latch, and					dan di Amerika Vannan indodesia antara di Amerika da Amerika da Amerika da Amerika da Amerika da Amerika da Am
K 050	building did not la The Administrator Maintenance (CG the inspection and	r fire rated door to the south tch. (CB) and the Director of overified these findings during dat the exit conference, safety CODE STANDARD	K	050			
K 050 SS=C		at unexpected times under	11				

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARI	E & MEDICAID SERVICES				ONID NO.	0930-0351
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - EXISTING BUILDING 02			(X3) DATE SURVEY COMPLETED	
		245212	B. WII	۷G _	THE OWNER WAS ASSESSED TO THE OWNER WAS ASSESSED.	09/13	/2011
	ROVIDER OR SUPPHER A HEALTH OAK CR	ossing		1	REET ADDRESS, CITY, STATE, ZIP CODE 1040 LINCOLN AVENUE DETROIT LAKES, MN 56501		
(X4) ID PREFIX TAG	(ÉACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	ŧΧ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
K 050	varying conditions The staff is familia that drills are part Responsibility for assigned only to c qualified to exercic conducted believe announcement ma alarms. 19.71.2 This STANDARD A review of fire destaff revealed that conducted fire exi 101 "The Life Safe section 19.7.1.2. I could allow confus response, which is residents, visitors Findings include: A review of fire dr for 20010-2011 at the facility tour on approximately 11: exit drills have no under varying con the four day shift between 9:27 am four evening shift pm and 3:05 pm. The Administrator Maintenance (CG	at least quarterly on each shift. If with procedures and is aware of established routine. planning and conducting drills is ompetent persons who are se leadership. Where drills are en 9 PM and 6 AM a coded ay be used instead of audible	K	050	Starting with the October 2 fire drill, the facility will c monthly fire drills at varied under varying conditions. per 12 month period will between each 2 hours incre6-8 am, 8-10 am, 10 am — 12 pm — 2 pm, 2 pm — 4 ppm, 6-8 pm, 8-10 pm, 10 12 am. This will capture stresidents with all types of variation. The Director of Maintena be responsible to monitor correction plan and will rethe facility's QA committed the next 12 months.	onduct d times 1 drill be held ement, 12 pm, om, 4-6 pm — staff and chiseport to	10 2 5 1 1 2 6 1 1 2 6 1 1 1 1 1 1 1 1 1 1 1 1
	SST/02-00) Provious /areir	ons Obsolete Event ID: 0LNZ21			Facility ID: 00907	ontinuation she	ot Dogo 5 of

PAGE

PRINTED: 10/03/2011 FORM APPROVED

DEPARTMENT			
CENTERS FOR	MEDICARE	& MEDICAID	SERVICES

		& MEDICAID SERVICES		T5212019	OMB NO.	0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A, BUIL	DITIPLE CONSTRUCTION DING 03 - 2008 SOUTH	(X3) DATE \$1 COMPLE	
		245212	B, WIN	G	09/1	3/2011
	ROVIDER OR SUPPLIER	OSSING		STREET ADDRESS, CITY, STATE, ZIP 1040 LINCOLN AVENUE DETROIT LAKES, MN 56501		
(X4) ID PREFIX	(EACH DEFICIÉNC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T	ION SHOULD BE	(XE) COMPLETION DATE

IM-CO-PORT VIII	IA REALTH OAK SKOODIKS			
(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)	(XE) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		
	FIRE SAFETY			
	03 South Bullding		ark	
	THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.		ACK 10-17-11	110s 6 03v- 10g -1
	UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	:		- · · · · · · · · · · · · · · · · · · ·
	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey St Mary's Regional Health Center C & NC 03 South Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.			\$11,08; 1
	PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:			
	PATRICK SHLEHAN SUPERVISOP STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

TITLE

(X6) DATE

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

PRINTED: 10/03/2011 FORM APPROVED: OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - 2008 SOUTH			(X3) DATE SURVEY COMPLETED	
	ACCO ARROST FEDERAL PROPERTY AND ACCOUNT A	245212	B. Wil	1	- A. L. Michigan	09/1	3/2011
	ROVIDER OR SUPPLIER A HEALTH OAK CR			10	EET ADDRESS, CITY, STATE, ZIP CODE 140 LINCOLN AVENUE ETROIT LAKES, MN 56501		·
(X4) ID PREFIX TAG	reach deficiend	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	XIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD SE	(X5) COMPLETION DATE
K 000	ST PAUL, MN 552 Email: pat.sheeha Fax Number 6512 THE PLAN OF CO DEFICIENCY MU FOLLOWING INF 1. A description of to correct the defication of the correct and the correct and the correct and the constructed south addition to the hobuilding. The entrection of the construction, 2-step without a building, without a building, without a building, without a building, without a 2-hour fire barrier was constructed in (111) construction of the particulation of the particul	In 215-0525 CRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: If what has been, or will be, done ciency. Corposed, completion date. Cor title of the person correction and monitoring to rence of the deficiency at Health Center C & NC is a lith a partial basement. The citructed at 3 different times. The citructed at 3 different times. The color was constructed in 1968, is lith a small basement and was of Type II (000) construction. In cration / Entrance addition was a of the original building and an spital north of the original ance addition is Type V (111) cories without a basement and ion is Type II (111) construction, basement. In 2008 a 2-story a basement, separated with two is south of the entrance addition and was determined to be Type ion. The buildings are divided nes (6 per floor) by 2- hour and	K	000			150 - 174
			•				

PRINTED: 10/03/2011 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: 03 - 2008 SOUTH AND PLAN OF CORRECTION A, BUILDING B. WING. 09/13/2011 245212 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1040 LINCOLN AVENUE ESSENTIA HEALTH OAK CROSSING DETROIT LAKES, MN 56501 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG K 000 Continued From page 2 K 000 automatic fire sprinkler system in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition with 2 systems. The facility has a fire alarm system with manual pull station near each exit door, smoke detection in the corridor system properly spaced and all common areas in accordance with NFPA 72 "The 3611 National Fire Alarm Code" (1999 edition), The 177 水紐切 resident sleeping rooms have smoke detection 1391 that are hard wired and connected to the fire alarm system. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). Starting with the October 2011 fire drill, the facility will conduct The facility has a capacity of 96 beds and had a monthly fire drills at varied times census of 85 at the time of the survey. under varying conditions. 1 drill The facility was surveyed as two buildings, 02per 12 month period will be held Main Existing Building (1968 building and the between each 2 hours increment, 1999 Administration / Entrance additions) as an 6-8 am, 8-10 am, 10 am -12 pm, Existing Health Care and 03 South Building (2008) building) as New Health Care. 12 pm - 2 pm, 2 pm - 4 pm, 4-6pm, 6-8 pm, 8-10 pm, 10 pm -The requirement at 42 CFR, Subpart 483.70(a) is 12 am. This will capture staff and NOT MET in building 03 as evidenced by: residents with all types of K 050 NFPA 101 LIFE SAFETY CODE STANDARD K 050 variation. SS=C Fire drills are held at unexpected times under

varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine.

Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded

The Director of Maintenance will be responsible to monitor this correction plan and will report to the facility's QA committee for the next 12 months.

If continuation sheet Page 3 of 4

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938-0391

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM A	0938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPI	E CONSTRUCTION	(X3) DATE SU COMPLET	IRVEY
STATEMENT AND PLAN OI	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	03 - 2008 SOUTH		
		245212	B. WI	NG		09/13	3/2011
	ROVIDER OR SUPPLIER	,		10	ET ADDRESS, CITY, STATE, ZIP CODE 40 LINCOLN AVENUE		VE 11.
ESSENTI	A HEALTH OAK CR	OSSING			PROVIDER'S PLAN OF CORRECT	TION	(X5)
(X4) ID PREFIX TAG	(きょうし ひきだいごろん)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	FIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	COMPLÉTION DATE
K 050	Continued From p	age 3	K	050			3 (3) 3.
	announcement ma alarms. 18.7.1.2	ay be used instead of audible					
		, .		1			
	A review of fire d	is not met as evidenced by: rill records and an interview with					
A CONTRACTOR OF THE CONTRACTOR	staff revealed that conducted fire extended 101 "The Life Safesection 19.7.1.2.	t the facility staff have not it drills in accordance with NFPA ety Code" 2000 edition (LSC) Not conducting fire exit drills					
	could allow confu	sion and delay in the staff would negatively impact all and staff in a fire emergency.	The same of the sa				4 4
- Torrange	for 20010-2011 a	rill records for St Marys Regional and an interview with staff prior to a September 13, 2011, at					
	approximately 11 exit drills have no under varying co	:45 am, revealed that the fire of been held at unexpected times inditions as indicated by three of					
	the four day shift between 9:27 an	drills have been conducted and 9:56 am and three of the trills were held between 3:00	and the second				
	Maintenance (Co	or (CB) and the Director of 3) verified these findings during and at the exit conference.					, date of the state of the stat
	HICHIOPOUNT W	•• •• •• •• •• •• •• •• •• •• •• •• ••					
	P. Committee of the control of the c		Ì				



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 5783

October 3, 2011

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5212020

Dear Ms. Brinkman:

The above facility was surveyed on September 12, 2011 through September 15, 2011 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, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 <u>only a suggestion</u> 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

Essentia Health Oak Crossing October 3, 2011 Page 2 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.

When all orders are corrected, the order form should be signed and returned to this office at 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 me.

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

Please feel free to call me with any questions.

Sincerely,

Maria King, Unit Supervisor

Maria King

Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health 12 Civic Center, Plaza Suite #2105

Mankato, Minnesota 56001

Telephone: (507)344-2716 Fax: (507)344-2723

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

Minnesota Department of Health

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU 00907		(X2) MULTI A. BUILDIN B. WING _		(X3) DATE S COMPL	
	ROVIDER OR SUPPLIER		1040 LIN	DRESS, CITY, S COLN AVEN LAKES, MN		03/	13/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCII Y MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 000	NH LICENSING In accordance with 144A.10, this correpursuant to a surve found that the deficiency of the Minnesota Deputermination of wear corrected requires requirements of the number and MN Ruwhen a rule contains comply with any of lack of compliance re-inspection with a result in the assess that was violated discorrected. You may request a that may result from orders provided that the Department with notice of assessment in the assessment in the assessment in the department of the Department with notice of assessment in the Department with	hether a violation had compliance with all erule provided at the ule number indicated in several items, faithe items will be corolling. Lack of compliance any item of multi-particularly the initial inspersion on any assembly the properties of a written request is thin 15 days of receipent for non-compliance was the compliance was the	section in issued ition, it is is cited in violation ordance y rule of se been the tag de below. Iure to insidered the upon the rule will if the item the tion was the sesments ith these is made to obt of a ce. 1, ited the ing orders ingleted, hese innesota	2 000			
Minnesota D	epartment of Health						

. TITLE (X6) DATE

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

Minnesota Department of Health

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00907		B. WING _		09/1	5/2011
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH OAK CRO	SSING		COLN AVEN LAKES, MN			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Continued From pa	ge 1		2 000			
		ng and Certification F za, Suite #2105 Man					
2 540	MN Rule 4658.0400 Resident Assessme	O Subp. 1 & 2 Compr ent	ehensive	2 540			
	conduct a compreh resident's needs, w capability to perform significant impairmenursing assessmen Minnesota Statutes 15, may be used as resident assessmen comprehensive resused to develop, recomprehensive plant 4658.0405. Subp. 2. Informational comprehensive resinclude at least the A. medically demedical history; B. medical static. physical and D. sensory and E. nutritional starts.	ion; ential; n potential; tus; v; and	of each esident's and eacity. A ng to abdivision ensive esust be resident's in part ust at prior eatus; ets; ets; ets;				
	This MN Requireme	ent is not met as evi	denced				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE S COMPL		
		00907		B. WING _		09/1	5/2011
NAME OF P	ROVIDER OR SUPPLIER	00001	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	00/1	0/2011
ESSENT	IA HEALTH OAK CRO	OSSING		NCOLN AVENUE IT LAKES, MN 56501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
2 540	by: Based on interview and record review, the facility failed to complete a comprehensive skin assessment on 1 of 1 resident (R15) in the sample review with a pressure ulcer. Findings include:		2 540				
	Resident 15 (R15) lacked a comprehensive skin assessment.						
	causing extremity wedecreased sensation and muscle weaking Data Set (MDS) darecognitively intact with recall. The MDS alsextensive assistance activities of daily livil limitations to both locurrent PU (pressure for development of pressure reducing of bed, with no pressure chair. The PU Caredated 6/2/11, indicating including: immobility nutritional status as ulcers to the left for PU on the coccyx we factor on this CAA. indicated R15 had son her coccyx with areas.	d with a neurological yeakness/paralysis wan, peripheral vasculatess. The admission Nated 6/6/11, identified the mild deficits in measo indicated that R15 per from staff with moling (ADLs), had functower extremities, had re ulcers) however was utilized for the MDS indicated R15 had risk factories and parallel as current vasculated R15 had risk factories and parallel as current vasculated R15 had risk factories and parallel as current vasculated R15 had risk factories and parallel as current vasculated R15 had risk factories and parallel as current vasculated R15 had risk factories and parallel as current vasculated R15 had risk factories and parallel as current vasculated R15 had risk factories and parallel as current vasculated R15 had risk factories and parallel R15 had ris	with ar disease Minimum R15 was mory required bility and tional I no as at risk ted a pr R15's tilized in a CAA) tors coor cular tory of a a risk 5/30/11, caled PU pr open				
	assessment had be The Braden score i for developing PU,	ool for predicting PU een completed on 5/3 ndicated R15 was at and indicated R15 hat. The facility's asses	80/11. low risk ad no				

6899

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDIN		(X3) DATE S COMPL	
		00907		B. WING _		09/1	5/2011
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH OAK CRO	OSSING		COLN AVEN LAKES, MN			
(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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 540	40 Continued From page 3			2 540			
	pressure, identified Assessment" had be resident's risk while assessment was do indicated R15 had could tolerate lying over her bony promodated 5/30/11, had risks while seated. resident's risks whiscar tissue on the cowound, however not related to how long position without recomposition without recomposition without resident's present to have a state loss of dermis present with a red or pink with buttock/hip area med 2.3 cm with a 3 cm	ated 5/30/11. The asscar tissue on her confor 2 hours without rehinence's. Another assessment of the assessment of the seated indicated Foccyx from an old head timeframe was identified by the conformation of the seated indicated Foccyx from an old head timeframe was identified by the conformation of the lower of the	sessment accyx and edness assessment ated to the at 15 had ealed atified a sitting ence's. 5 was exhess open ulcer wer meters) x osis. The				
	stated their assess was incomplete. R comprehensively a conducting both sit assessments. At 12 stated when since lack of feeling and as well as her histobeen assessed upo immediate interven	a.m. registered nurs ment of R15's tissue N-A stated they show seessed the resident ting and lying tissue to 2:12 p.m. on 9/15/11 R15 was at risk, due sensation to her lower bry of PU, she should on admission to imple tions to prevent PU.	tolerance uld have by tolerance , RN-A to her er body, have ement				
		15/11, the director of lacked a compreher					

6899

(X3) DATE SURVEY

Minnesota Department of Health

STATEMENT OF DEFICIENCIES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00907		B. WING _		09/1	15/2011
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
				COLN AVEN LAKES, MN			
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 540	Continued From pa	ge 4		2 540			
	Nursing or designe policies and proced comprehensive res they comply with the develop a monitoring. Time Period for Co	ident assessments t e regulations, retrair	evise o ensure ı staff, and				
2 900	days MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers		ressure	2 900			
	comprehensive res of nursing services	sores. Based on the ident assessment, the must coordinate the ursing care plan whi	ne director				
	A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and						
	receives necessar	tho has pressure sory treatment and serverevent infection, and reloping.	ices to				
	by: Based on observate and policy review, to appropriate assess interventions to prepressure ulcers for	ent is not met as ever ion, interview, record he facility failed to proment, monitoring and vent the development of 1 resident (R15 arrent pressure ulcer	review rovide d nt of) in the				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 5 of 23 0LNZ11

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTII A. BUILDING B. WING	PLE CONSTRUCTION G	(X3) DATE S	ETED
		00907	0		TATE 7/2 000E	09/1	15/2011
	PROVIDER OR SUPPLIER	DSSING	1040 LING	COLN AVEN	SS, CITY, STATE, ZIP CODE N AVENUE KES, MN 56501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 900	facility's failure to a resulted in actual hadevelopment. Finding R15 had developed tissue loss with expeschar may be preleft buttock/hip. The assess and implement manner to prevent ulcers (PUs). R15 was diagnosed causing extremity with decreased sensation and muscle weakned Data Set (MDS) da cognitively intact with recall. The MDS ideassistance from state of daily living (ADLs R15 had functional extremities, had not development of PU pressure reducing to bed, but no pressure for R15's chair. The (CAA) dated 6/2/11 such as immobility, nutritional status as ulcers to her left for of PU risk factors of R15's coccyx and indevelopment of a Functional status as ulcers to her left for of PU risk factors of R15's coccyx and indevelopment of a Functional status as ulcers to her left for of PU risk factors of R15's coccyx and indevelopment of a Functional status as ulcers to her left for of PU risk factors of R15's coccyx and indevelopment of a Functional status as ulcers to her left for of PU risk factors of R15's coccyx and indevelopment of a Functional status as ulcers to her left for of PU risk factors of R15's coccyx and indevelopment of a Functional status as ulcers to her left for of PU risk factors of R15's coccyx and indevelopment of a Functional status as ulcers to her left for of PU risk factors of R15's coccyx and indevelopment of a Functional status as ulcers to her left for of PU risk factors of R15's coccyx and indevelopment of a Functional status as ulcers to her left for of PU risk factors of R15's coccyx and indevelopment of a Functional status as ulcers to her left for of PU risk factors of R15's coccyx and indevelopment of a Functional status as ulcers to her left for of PU risk factors of R15's coccyx and indevelopment of a Functional status as ulcers to her left for of PU risk factors of R15's coccyx and indevelopment of R15's coc	dequately assess an arm for R15, pressurings include: If a Stage 4 (full thick bosed bone, tendon content interventions in a stage of the development of pressure under the development of pressure under the development of press. The admission of the development of the development of the development of press. The admission of the development of the development of the defect in metal the mild deficits in metal the mild deficit in metal the mild deficits in metal the mild deficit in mild deficit in metal the mild deficit in mild deficit in metal the mild deficit in metal the mild deficit in mil	ness or muscle. (PU) on nitor, a timely pressure disorder with ar disease Winimum R15 was amory extensive activities indicated wer at risk for a pr R15's as utilized essment risk factor por cular indication of PU to at the PU risk) as at low dicated e R15's	2 900			

6899

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTII A. BUILDING B. WING	PLE CONSTRUCTION G	(X3) DATE S COMPL	
		00907				09/1	15/2011
	TIA HEALTH OAK CROSSING STREET ADDRESS, CITY, STATE, ZIP CODE 1040 LINCOLN AVENUE DETROIT LAKES, MN 56501						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
2 900	The facility's lying "Assessment" dated scar tissue on her of for 2 hours without prominences. The Tolerance Assessing R15 had scar tissue healed wound, how indicated related to sitting position with prominence. The initial plan of conterventions related pressure relieving wheelchair or a repute plan of care has inform the physicial reposition on side the utilize an air mattre utilize an air mattre utilize a Roho (cust bony prominences) wheelchair. Current physician of staff to pack R15's wash out the woun On 9/15/11, at 7:10 during her morning assistance of nursi was observed to promote and ADL's for R15. mattress to her bed electric wheelchair practical nurse (LP)	rindition. No further Empleted. Tissue Tolerance of 5/30/11, indicated Fooccyx and could tole redness over her botacility's sitting "Tissuent" dated 5/30/11, e on coccyx from an ever no timeframe ver how long R15 could out redness to a bondare dated 6/2/11, lact d to R15's PU risk in devices to her bed, expositioning program. In the devices to her bed, expositioning program. In of changes in sking or relieve pressure exposition to prevent pressure cushion while in elected or deres on 8/28/11, directed or deres or 8/28/11, directed or 8/28/11, direc	R15 had a arrate lying ny ue indicated old vas tolerate a y ked any cluding lectric On 9/6/11, ect staff to condition, very hour, f and sure on ctric rected uze and rved e with NA-C mobility ave an air to her ed o dress	2 900			

6899

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE S COMPL	
		00907		B. WING _		09/1	5/2011
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH OAK CRO	OSSING		COLN AVEN LAKES, MN			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 7		2 900			
	cm in depth. The w irregularly shaped v exposed muscle, w	4 PU, measuring (centimeters) x 5 cm ound was observed to with a large crater wh ith clean and healthy ugh or eschar (necros	to be ich tissue				
	A review of the clini	ical record indicated:					
	On 5/30/11, R15 was admitted to the transitional care unit for rehabilitation. Nursing notes indicated R15 had scar tissue from a healed PU on her coccyx with no current redness or open areas. R15 was noted to require assistance from staff due to weakness and her inability to stand independently.						
	On 6/7/11, nursing notes indicated R15 was found to have a small blister on the right buttock. The blister was identified as intact and the documentation indicated R15 was to remain off her right side. No further assessment of R15's skin was noted at that time.						
	On 6/14/11, nursing notes indicated R15 had been moved to another unit for long term placement to the facility due continued issues with mobility and the required assistance from staff.						
	of the presence of a when the nursing no developed a stage :	not include any docur a pressure ulcer until otes indicated R15 h 2 PU to the lower but m x 2.3 cm with a 3 of	7/23/11, ad ttock/hip				
		g notes indicated a th to protect wounds) h					

6899

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE		(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION G	(X3) DATE S COMPL	ETED
	DD0//DED 05 2::55::5	00907	OTDEET AS		TATE ZID CODE	09/1	15/2011
	PROVIDER OR SUPPLIER	DSSING	1040 LING	COLN AVENU LAKES, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	placed on R15's lefthour repositioning is The physician had development at that On 7/28/11, the factories of the rapist (OT)-A, in wheelchair with no R15 had an open a cushion for pressurit. The OT's notes is recommended that electric wheelchair bottom every 2 hour On 8/8/11, the OT of OT-A had trialed 2 wheelchair and neither resident. The OT in from a daily assess pressure relief and documentation indite repositioning schedaware of. At that tirt turning and position education with staff in the resident's root resident should be Continued monitori documented in the wound flow sheets; tolerance assessm 8/9/11. At that time redness over bony pressure. R15 was repositioning sched hour. Review of the	it buttock/hip and an schedule had been in been informed of the st time. Sility's "Nursing Care igned by Occupation idicated R15 had an cushion. The OT do irea on her bottom a re relief but had not lendicated it had been staff use the cushio and to have R15 off irs. Indicated R15 would be in the cushion for R15's eletter had been tolerandicated R15 would be incated R15 did not had been tolerandicated R15 did not had been	Partner al electric cumented nd had a been using in to the her licated ectric ted by the benefit of ave any she was eloped a aucted es posted the she weekly issue leted until have hour of after 1 notes	2 900			

6899

Minnesota Department of Health

	PROVIDER/SUPPLIEI		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE S COMPLI	
	00907		B. WING _		09/1	5/2011
NAME OF PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	STATE, ZIP CODE	00/ -	0,2011
ESSENTIA HEALTH OAK CROSSIN	NG		COLN AVEN LAKES, MN	-		
(X4) ID SUMMARY STATEMEI PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	T BE PRECEDED BY	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 900 Continued From page 9 schedule, often refusing was provided with educa and benefits of not follow schedule. Interventions i implementation included device in electric wheeled repositioning schedule, wand multiple interdisciplin. On 8/9/11, the facility's "Documentation" weekly R15's wound was a stag x 5 cm in diameter with eschar. On 8/10/11, physician or apply an Allevyn dressing the wound. On 8/16/11, the facility's Documentation" weekly R15's wound had deterior unstageable PU, measured diameter. On 8/18/11, nursing note wound debridement (rend the left buttock/hip wound following the debridement issue damage to the unrevealing a stage 4 PU. On 8/22/11, R15 was add services due to her continued the left buttod during R15's 8/22/11, undermining was serviced to her continued the left buttod during R15's 8/22/11, undermining was serviced to her continued the left buttod during R15's 8/22/11, undermining was serviced to her continued the left buttod during R15's 8/22/11, undermining was serviced to her continued to her continued the left buttod during R15's 8/22/11, undermining was serviced to her continued the left buttod during R15's 8/22/11, undermining was serviced to her continued the left buttod during R15's 8/22/11, undermining was serviced to her continued to h	y to be reposition ation regarding the wing a reposition identified for d: pressure relies chair, an air matte wound dressing inary referrals. "Wound Care flow sheets indicated PU, measure 50% slough and reders were received should be apposed by the wound Care flow sheets indicated and was auring 4 cm x 4 cm. The estindicated R15 moval of necroticated and was auring 4 cm x 4 cm. The indicated R15 moval of necroticated and was auring 4 cm x 4 cm. The indicated R15 moval of necroticated and was auring 4 cm x 4 cm. The indicated R15 moval of necroticated and was auring 4 cm x 4 cm. The indicated R15 moval of necroticated and was auring 4 cm x 4 cm. The indicated R15 moval of necroticated R15 moval of necrot	he risk hing ving ving ress, a changes cated ring 6 cm 50% of ved to died to cated how an in in so had a coskin) of surements a had experienced by the coordinate of the coord	2 900			

6899

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SI COMPLE	
		00907		B. WING _		09/1	5/2011
NAME OF F	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
ESSENT	IA HEALTH OAK CRO	DSSING		OLN AVEN LAKES, MN			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 10		2 900			
	On 8/23/11, the facility's "Wound Care Documentation" weekly flow sheets indicated R15's wound was an unstageable PU, measuring 5 cm x 5.5 cm in diameter with 100% eschar.						
	wound debrided.	gain had the left butto	оск/пір				
	On 8/29/11, Physician-A documented R15's progress of necrosis was advanced, and due to her compromised nutritional status, physician-A felt R15 could become septic and die from the wound. Physician-A recommended R15 be kept as comfortable possible.						
	On 8/30/11, the facility's "Wound Care Documentation" weekly flow sheets indicated R15's PU was a stage 3 (Full thickness tissue loss. Subcutaneous fat may be visible but no bone, tendon or muscle exposed) measuring 6 cm x 5 cm with 3.1 cm in depth.						
		notes indicated R15 I the eschar had bee					
	On 9/8/11, physician orders indicated R15 would be allowed to have a 2 hour repositioning schedule while sleeping as a comfort care measure due to the resident's exhaustion.						
	p.m. on 9/14/11, sh repositioning sched recently they had be every 2 hours if slee	NA)-C was interviewed be stated R15 was on lule however, she ad een directed to repos eping. NA-C also sta er wheelchair and an l.	a 1 hour ded that sition R15 ted R15				

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPL	
		00907		B. WING _		09/1	15/2011
	ROVIDER OR SUPPLIER	OSSING	1040 LING	DRESS, CITY, S COLN AVEN LAKES, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	OT-A was interview OT-A stated she had for a cushion in her development of a Fushion for her electher shortly after her liked it and did not was not until R15 dushion was found OT-A verified that a finding the right custimplemented a Rohwas essentially a preurological condition been educated related following a reposition. Registered nurse (Fa.m. on 9/15/11. Reposition to the resident's sitt RN-A also stated the assessment had not manner after the deverified R15's skin assessed. She stated walk and had been she added she had previous PU prior to RN-A stated she had had developed escophysician had been of the PU and the faimplementing a new result.	ved at 9:30 a.m. on 9 ad been asked to associate electric wheelchair PU. She stated R15 hotric wheelchair prover admission but R15 want to use it. OT-A eveloped a PU that a for her electric wheel after multiple attempts shion for R15, they had cushion. She stated araplegic due to her included to risk and benefited to risk and	sess R15 due to the had a ided for had not added it a new elchair. ts at ad ed R15 d R15 had fits of not ed at 9:51 ssue upon ssessment tolerance. n a timely J. RN-A ehensively n able to dmission. ad a acility. about how ed until it 5's velopment I gram as a	2 900			

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPL	
		00907		B. WING _		09/1	5/2011
	PROVIDER OR SUPPLIER	DSSING	1040 LING	COLN AVENI LAKES, MN	CITY, STATE, ZIP CODE VENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	at risk of PU, a moral assessment should added R15's lack of lower body as well have been address stated no preventarisks were found or after admission. RNPU had been discoto OT to have a customate wheelchair. RN-A stated that on 7/28/requested. RN-A verified RN-A verified RN-A verified R15 lacked assessment to preventation wheelchair since transfer and Preventation and Preventation and Preventation of the province of the risk factor and poter reviewed individual Assessment" should sitting positions upon and weekly inspect ensure no adverse.	re comprehensive skill have been completed feeling and sensations as her history of PU ed upon admission. Live interventions related the plan of care devended, she had been shion placed in her estated the OT had took a cushion for R15, but did not want to us first an ew cushion herified R15 had not us cushion to her electronsferring to her unit in a comprehensive slevent the development of the plant of th	ed. RN-A on to her should RN-A ated to PU veloped e R15's referred electric d her at at R15 had e it. RN-A ad been tillized a ric on ON) kin t of a PU. ssment, 2005, cale would and with a states ore, each e rance ving and th a ore noted. Director of evise as	2 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		00907		B. WING _		09/1	5/2011
NAME OF P	ROVIDER OR SUPPLIER	00007	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	03/1	3/2011
ESSENT	IA HEALTH OAK CRO	OSSING		COLN AVEN LAKES, MN			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 13		2 900			
	care for residents at risk or with pressure ulcers; educate staff on pressure ulcers protocols, and develop a monitoring system to ensure compliance.						
	Time Period for Codays	rrection: Twenty-one	e (21)				
21015		MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi					
	Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.						
	This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to follow food sanitation procedures on 2 of 3 units, which minimized the possibility of food borne illness. Findings included: During observation of the evening meal on the Harbor Springs unit at 5:35 p.m. on 9/12/11, Homemaker (HM)-D was observed to wear gloves while dishing food for residents. HM-D was observed to dish and serve a plate for a resident, then to return to the service area, write something down with a pencil, and to proceed to dish another resident's meal. She was observed to pick up a sandwich for a resident's plate, and to place a bag of chips on the plate prior to handing the resident's meal to a nursing assistant for service to a resident. There was no handwashing or glove change observed. At 6:14 p.m. HM-D was observed to dish another resident's plate, return to serving area, write on a						

Minnesota Department of Health

STATE FORM 6899 0LNZ11 If continuation sheet 14 of 23

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPLI	
		00907		B. WING _		09/1	5/2011
NAME OF F	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
				COLN AVEN LAKES, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21015	plate, dishes up for another plate to a rot to the service area. HM-D was interview She confirmed she nor washed her har. On 9/12/11 at 6:20 Cedar Ridge Kitche fruit cups were obscupboard. The fruit moisture/water sittin Homemaker-A state the noon meal and they had been put a clear plastic glasse on Harbor Springs. confirmed findings practice. Interview with the D 11:30 am, stated the for hand sanitation Dietary Manager also not expect homema cupboards. Suggested Method Administrator and the revise food service ensure that food is sanitary manner. Since service monitor the service and the service monitor the service and the service monitor the service and the service and the service monitor the service and the service monitor the service and the service and the service monitor the service and the servi	od with tongs, and de esident. HM-D then and removed her gloved at 6:36 p.m. on 9 had not changed hends when she should p.m. the sanitation to enette was completed erved to be stacked to cups were observed in between the cued the cups had bee must not have been	returned oves. 2/21/11. r gloves I have. our of the d. Fifteen in a d to have ps. n used for dry when 10 wet cupboard dinator-E, thormal /15/11 at f training The e would es in view and ures to a a as ger could cobasis.	21015			

6899

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDIN		(X3) DATE S COMPL	
		00907		B. WING _		09/1	5/2011
NAME OF F	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH OAK CRO	OSSING		COLN AVEN LAKES, MN			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21400	Continued From pa	ge 15		21400			
21400	MN Rule 4658.0810 Tuberculosis Progra			21400			
	Subpart 1. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Informational Bulletin 09-02 Tuberculosis Prevention and Control Guidelines:Nursing Homes, Minnesota Rule 4658.0810 Subpart 1 Resident Tuberculosis Program is waived. Conditions of Waver:						
	- All residents must receive baseline TB screening within 72 hours of admission or within 3 months prior to admission. TB Screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms, and a two-step TST or a single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON ® TB Gold or TB Gold In Tube, T-SPOT ®.TB). Routine serial TB screening of residents may be done at the discretion of the infection control team. - All reports and copies of resident tuberculin skin tests (TSTs), results from IGRAs for M. tuberculosis, medical evaluations, and chest						
	radiograph results r resident's medical recommendations f recommended follo	must be maintained i record. Consult curr for the diagnosis of T w-up of residents wh of active TB disease	n the ent CDC B for o display				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUMBER OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION (X1) PROVIDER/SUPPLIE IDENTIFICAT			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		00907		B. WING _		09/1	5/2011	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ESSENT	IA HEALTH OAK CRO	SSING		COLN AVEN LAKES, MN				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)		
21400	Continued From page	ge 16		21400				
	This MN Requirement is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to complete required Tuberculosis (TB) baseline symptom screening for 5 of 5 residents (R15, R103, R22, R112, R127) newly admitted to the facility. In addition, the facility failed to ensure all resident had documentation of the required tuberculin skin testing (TST) for 1 of 5 residents (R15) reviewed who required TST. Findings include: R15 was admitted on 5/30/11, and the record indicated R15 did not receive the recommended baseline TB symptom screening within 72 hours of admission. In addition, R15 had an initial TST administered but lacked assessment if the test was negative and lacked a 2nd step TST. R103 was admitted on 12/22/10, and the record indicated R103 did not receive the recommended baseline TB symptom screening within 72 hours of admission.							
	R22 was admitted on 7/27/11, and the record indicated R22 did not receive the recommended baseline TB symptom screening within 72 hours of admission.							
	R112 was admitted on 9/18/09, and the record indicated R15 did not receive the recommended baseline TB symptom screening within 72 hours of admission.							
	indicated R127 did	on 12/21/10, and the not receive the recor om screening within 7	nmended					

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NU			(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		(X3) DATE SURVEY COMPLETED		
		00907		B. WING _		09/1	5/2011
ESSENTIA HEALTH OAK OPOSSING 1040 LING			DDRESS, CITY, STATE, ZIP CODE ICOLN AVENUE I LAKES, MN 56501				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21400	Continued From page 17 On 9/15/11, at 11:05 a.m. registered nurse (RN) -B and RN-C stated they do not complete a symptomology screening for residents. At 2:15 p.m. RN-A stated R15 did not have her 1st step TST read nor was a 2nd step administered. Suggested Method for Correction: The Administrator or designee could review the facility system to ensure newly admitted residents receive the tuberculin test and are screened for risk factors and symptoms of tuberculosis, as required by State rule. They could revise the system as needed and educate staff. In addition, they could develop a system to monitor and review the delivery of mantoux tests and screenings, and adjust the system as needed. Time Period for Correction: Twenty-one (21) days		21400				
21415	and as defined in M Health Informationa Rule 4658.0815 St Tuberculosis Progr Conditions of Waix - All paid and unpai "CDC Guidelines") screening. This scr assessment of any two-step tuberculin interferon gamma r	am to Minnesota Rule 4 flinnesota Departme al Bulletin 09-02, Mi ubpart 2 Employee am is waived.	d in the ne TB a written ns, and a ingle of the	21415			

6899

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPL		
		00907		B. WING _		09/1	15/2011	
ESSENTIA HEALTH OAK CROSSING 1040 LINC				COLN AVENUE LAKES, MN 56501				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21415	TB Gold - In Tube, - All paid and unpai "CDC Guidelines") screening based or low risk - not neede potential ongoing tr Minnesota Departm and Control Progra - HCWs with abnor must receive follow according to curren the diagnosis of TB - All reports or copi M. tuberculosis, me radiograph results r HCW 's employee f - All HCWs exhibit consistent with TB i physician within 72 return to work until non-infectious.	T-SPOT ® .TB). d HCWs (as defined must receive serial 7 in the facility 's risk level; (2) medium risk - ansmission - consulting the facility is the facility	rB vel: (1) yearly; (3) the Prevention esults on tions for th dichest in the ms y a s must not	21415				
	by: Based on interview file review, the facili Tuberculosis (TB) s	, policy review and p ity failed to documen symptom screening u s (LPN-F and NA-F)	ersonnel It baseline Ipon hire					

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPL IDENTIFICATION N 00907			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET AD 1040 LIN			DDRESS, CITY, STATE, ZIP CODE ICOLN AVENUE T LAKES, MN 56501				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21415	In addition, the faci documentation of the testing (TST) or time employees (LPN-F Findings include: Review of employeenew hire start date written symptom so LPN-F did not have administered. Review of employeenew hire start date written symptom so NA-F did not have a which was after the frame On 9/15/11, at 11:3 registered nurse-A required to have a added a 2nd step T1-3 weeks after the The facility policy T5/29/09, indicated a testing completed Suggested Method Administrator or desystem to ensure in tuberculin test and and symptoms of to state rule. Revise feducate staff. Mon mantoux tests and system as needed.	lity failed to provide the required tuberculinely testing for 2 of 5 and NA-F), reviewed the files revealed LPN was 7/28/11, did not be reening for TB. In act the 2nd step TST the files revealed NA-F was 6/2/11, did not be reening for TB. In act the 2nd step TST under the 3 weeks after the files of Correction: The signee could review ewly hired staff receivance are screened for risk uberculosis, as requiting the system as needed ittor and review the discreenings, and adjustice the screenings, and adjustice the screenings and adjustice the screenings and adjustice the screenings and adjustice the screenings, and adjustice the screenings.	d. F, whose have a ddition, whose have a ddition, till 7/19/11, week time arol sare She histered in ting" dated step TST rest step. the facility ive the a factors red by d and belivery of ust the	21415			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		00907		B. WING _		09/1	5/2011
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENTIA HEALTH OAK CROSSING				OLN AVEN LAKES, MN			
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	(X5) COMPLETE DATE	
21415	Continued From page 20			21415			
	days						
21620	MN Rule 4658.1345	Labeling of Drugs		21620			
		ursing home must be part 6800.6300.	e labeled				
	by: Based on observation review and interview medication labels with physician order and R154) residents medication pass. For The facility failed to ensure the current particle of the pharm of 12/11, at 5:00 Nurse (LPN)-D was FlexPen for R97. The staff to give 10 to The LPN was observed insulin for the residench anged and the residench anged anged anged and the residench anged and the residench anged anged and the residench anged and	in accordance with part 6800.6300. This MN Requirement is not met as evidenced					
	dish up Psyllium Hu mg (milligrams) for	a.m. LPN-B was obsisk (a fiber medication R11. The pharmacy administer the medi	n) 1000 label				

Minnesota Department of Health

STATE FORM 6899 0LNZ11 If continuation sheet 21 of 23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPL IDENTIFICATION N			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED		
		00907		B. WING		09/1	15/2011
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
			COLN AVENI LAKES, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21620	noon. Review of the medication was to be medications. LPN-had been changed not know why the public changed. Review order directed the semedication before been changed on 60 on 9/15/11, at 8:30 dish up Meclizine (amg for R55. The public staff to give one pill dizziness. Review to give the medicative verified the pharma match. Review of the indicated on 5/5/10 the order from "as a day medication. On 9/15/11, at 9:00 dish up Celexa (animg for R154. The staff to give one 10 also a hand written which read "2 tabs. know who had	e MAR indicated the per given with the more B stated the medical several years ago. Sharmacy label had not the current physicated to administer the preakfast. The order	rning tion time She did to been cian's that last served to iness) 25 ed the needed for the staff N-C R did not 's orders changed led twice served to ication) 20 cted the the ere was cy label did not label. give 20 urrent tion had n 7/7/11. RN)-A at when urse was d alert staff en to	21620			

6899

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00907		B. WING _		09/1	5/2011
NAME OF P	ROVIDER OR SUPPLIER	00001	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	00/1	0/2011
ESSENT	IA HEALTH OAK CRO	SSING		OLN AVEN LAKES, MN			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	(X5) COMPLETE DATE	
21620	Continued From pa	ge 22		21620			
	new label had been ordered for the medication. RN-A stated she had not been aware that staff members were not utilizing the order change labels for the medication containers when a new label was needed.						
	Review of the facility's Medication Administration Policies dated 1/2010, included: "14. A "dose change" label will be placed on medication label until new med/label is sent from pharmacy."						
	On 9/14/11, at 9:45 a.m. the Director of Nursing (DON) verified the nursing staff should be using the medication order change labels and should ensure that the current orders and the pharmacy labels matched. The DON verified the facility's policy had not been followed.						
	On 9/15/11, at 10:54 a.m. RN-A verified the dates of all the above described order changes, and stated the staff members should have identified the discrepancies between the orders and the pharmacy labels and requested new labels for the medications as directed by the facility's policy.						
	Suggested Method of Correction: The Director of Nursing or designee could develop and implement policies and procedures to ensure medications are labeled appropriately. The Director of Nursing or designee could monitor the licensed staff for adherence to the policies and procedures.						
	Time Period for Coldays	rrection: Twenty-one	e (21)				

6899