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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0LNZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00907

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245212**

2. STATE VENDOR OR MEDICAID NO. (L2) **623840800**

3. NAME AND ADDRESS OF FACILITY (L3) **ESSENTIA HEALTH OAK CROSSING**
(L4) **1040 LINCOLN AVENUE**
(L5) **DETROIT LAKES, MN** (L6) **56501**

4. TYPE OF ACTION: **2** (L8)

1. Initial	2. Recertification
3. Termination	4. CHOW
5. Validation	6. Complaint
7. On-Site Visit	9. Other
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/08/2011** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY ~~02~~ (L7)

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

FISCAL YEAR ENDING DATE: (L35) **06/30**

11. .LTC PERIOD OF CERTIFICATION

From (a) :

To (b) :

12. Total Facility Beds **96** (L18)

13. Total Certified Beds **96** (L17)

10. THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:

___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	96			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date : Candy Bourassa, HFE NEII 12/21/2011 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Colleen B. Leach, Program Specialist 01/19/2012 (L20)

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

19. DETERMINATION OF ELIGIBILITY (L21)

__X__ 1. Facility is Eligible to Participate

____ 2. Facility is not Eligible

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **11/01/1976** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

Posted 1/17/2012 ML.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **11/03/2011** (L33)

DETERMINATION APPROVAL

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.

MINNESOTA MDH DEPARTMENT OF HEALTH

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 Leach

Colleen B. Leach, Program Specialist
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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245212	A. Building B. Wing	12/8/2011

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	12/07/2011	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PK/cbl	12/21/2011	29436	12/08/2011
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/15/2011

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0LNZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00907

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245212**
2.STATE VENDOR OR MEDICAID NO.
(L2) **623840800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH OAK CROSSING**
(L4) **1040 LINCOLN AVENUE**
(L5) **DETROIT LAKES, MN** (L6) **56501**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/09/2011** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **96** (L18)

13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	96			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Edith Hasskamp, HFE NEII 11/21/2011 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 1/09/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1976
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 1/17/2012 ML.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/03/2011
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

Enclosure

cc: Licensing and Certification File 5212r111.rtf

Department of Health and Human Services
Centers for Medicare & Medicaid Services

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245212	A. Building B. Wing	11/9/2011

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
ID Prefix F0272 Reg. # 483.20(b)(1) LSC	Correction Completed 11/09/2011	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 11/09/2011	ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 11/09/2011
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PK/SNL	11/21/2011	12831	11/09/2011
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/15/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING _____ B. WING _____	R 11/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH OAK CROSSING	1040 LINCOLN AVENUE DETROIT LAKES, MN 56501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		
{F 431} SS=D	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 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 be readily detected.	{F 431}	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.	11/9/11 12/7/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christy Pankratz — TITLE — (X6) DATE: 12/2/2011

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING _____ B. WING _____	R 11/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH OAK CROSSING	1040 LINCOLN AVENUE DETROIT LAKES, MN 56501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and documentation review, the facility failed to ensure pharmacy prescription labels were current and consistent with physician orders for 1 of 4 residents (R300) whose medications were reviewed for correct labels. Findings include: At 9:15 a.m. on 11/09/11, Licensed Practical Nurse (LPN)-A indicated she gave Novolog insulin 10 units before breakfast via FlexPen for R300. The pharmacy label on the insulin FlexPen directed staff to give 7 units of insulin before breakfast. LPN-A stated the order had changed and the resident was to receive 10 units of insulin before breakfast. LPN-A indicated she did not know why the pharmacy label had not been changed, however, the "direction change" label had been put on the insulin FlexPen. Review of the physician's orders with LPN-A confirmed on 05/06/11, the primary physician had changed the morning Novolog insulin FlexPen from 7 units to 10 units (6 months ago). Review of R300's August, September, October and November's, Medication Administration Record (MAR) directed the staff to give 10 units of Novolog insulin and recorded 10 units were administered each morning before breakfast. Review of the facility's labeling education note to LPN-A, dated 10/16/11, indicated staff should make sure that all new orders are sent to pharmacy regardless if you need the medication or not. Staff were to make a notation to the	{F 431}	Results of the 100% audit were evaluated, summarized, and used to identify issues with the facility's medication policy and procedure. The policy and procedure was revised and approved on 12/2/2011. As part of the revised policy and procedure, a new process has been initiated around medication check-in as medications are received from a pharmacy. A (purple) binder has been placed in each of the 4 nursing stations. As a new order is transcribed or a medication is re-ordered/refilled, a copy of the documentation will be made and placed in the purple binder. When the medications arrive from the pharmacy, the nurse will check them in, assuring the label, order, and medication administration record all match, and then sign the documentation to indicate the medication was received and the label is correct.	12/7/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING _____ B. WING _____	R 11/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH OAK CROSSING	1040 LINCOLN AVENUE DETROIT LAKES, MN 56501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 2 pharmacy letting them know if they need the medication or just the label changed. This was to ensure that the next time the medication was ordered the correct direction would be on the label. LPN-A signed that all pharmaceuticals on her unit had the correct labels on them on 10/28/11. Review of the Prescription Edit/Label form faxed from the pharmacy on 11/9/2011, indicated the pharmacy had not received a physician order change for the Novolog FlexPen 7 units at breakfast as of 11/09/11. LPN-A confirmed at 10:15 a.m. on 11/09/11, that she had signed a note dated 10/28/11 that all pharmaceuticals had the correct label on the bottle/package. LPN-A indicated that she wasn't sure if she had informed the pharmacy that the morning Novolog FlexPen insulin label needed to be changed. At approximately 10:45 a.m. on 11/09/11, the Director of Nursing (DON) confirmed the Novolog FlexPen morning insulin label should have been changed. She confirms the insulin order was changed on 5/6/2011. She indicated the pharmacy does not get a copy of the computer generated printed quarterly medication orders, they only get the original physician's order or change in the physician's order. She further confirmed the Monthly Nurses Meeting notes dated October 2011, included education to the nurses that the pharmacy would be notified of every order change.	{F 431}	The facility (DON, Nurse Manager, RN Clinical Coordinators and MDS Coordinators) will educate 100% of regularly scheduled RNs and LPNs on the revised medication policy and procedure, beginning 12/2/2011, to be completed by 12/7/2011. PRN nurses will receive a copy of the revised policy and procedure via mail and before their next scheduled shift, will receive a follow-up discussion with the Nurse Manager or DON. The Nurse Managers and RN Clinical Coordinators will audit the purple binders at least 2 times per week for the next 90 days, and then audit 1 time/month for the next 9 months. The results of the audits will be reviewed quarterly by the facility's Quality Assurance Committee.	12/7/2011

Department of Health and Human Services
Centers for Medicare & Medicaid Services

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245212	A. Building B. Wing 02 - EXISTING BUILDING 02	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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0011	10/25/2011	ID Prefix Reg. # NFPA 101 LSC K0050	10/25/2011	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PK/SNL	11/21/2011	03006	10/31/2011
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/13/2011

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245212	A. Building B. Wing **03 - 2008 SOUTH**	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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0050	**10/25/2011**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PK/SNL	11/21/2011	03006	10/31/2011
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/13/2011

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00907	A. Building B. Wing	11/9/2011

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 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	(Y5) Date
ID Prefix **20540** Reg. # **MN Rule 4658.0400 Subp.** LSC	Correction Completed **11/09/2011**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **11/09/2011**	ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp.** LSC	Correction Completed **11/09/2011**
ID Prefix **21400** Reg. # **MN Rule 4658.0810 Subp.** LSC	Correction Completed **11/09/2011**	ID Prefix **21415** Reg. # **MN Rule 4658.0815 Subp.** LSC	Correction Completed **11/09/2011**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PK/SNL	11/21/2011	12831	11/09/2011
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/15/2011				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00907	A. BUILDING _____ B. WING _____	R 11/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH OAK CROSSING	**1040 LINCOLN AVENUE DETROIT LAKES, MN 56501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS:	{2 000}	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00907	A. BUILDING _____ B. WING _____	R 11/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH OAK CROSSING	1040 LINCOLN AVENUE DETROIT LAKES, MN 56501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Continued From page 1	{2 000}	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	
{21620}	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by:	{21620}		10/24/11

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0LNZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00907

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245212**
2.STATE VENDOR OR MEDICAID NO.
(L2) **623840800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH OAK CROSSING**
(L4) **1040 LINCOLN AVENUE**
(L5) **DETROIT LAKES, MN** (L6) **56501**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/15/2011** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **96** (L18)

13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	96			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Platz, HFE NEII 10/18/2011 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 10/19/2011 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1976
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
DB 11/03/11 0LNZ

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

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
Mankato, Minnesota 56001

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING _____ B. WING _____	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH OAK CROSSING	1040 LINCOLN AVENUE DETROIT LAKES, MN 56501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility Plan of Correction (POC) will serve as your allegation of compliance upon the department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an onsite visit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit;	F 272	Plan of Correction Approved MHPS 10/18/11 On 8-9-11, the tissue tolerance assessment was fully completed for R-15. The facility policy and procedure requires a comprehensive skin assessment, including the Braden's and tissue tolerance test, along with the gathering of past medical history. Licensed staff trained of the facility's skin policy and procedure on 10/5/2011. Data gathering of assessments and history re-enforced to assure they are included in the RAI process by the MDS coordinators.	10/25/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christy Brinkman	Admin	10/15/11

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

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F 272	Continued From page 1 Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced 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: Resident 15 (R15) lacked a comprehensive skin assessment. R15 was diagnosed with a neurological disorder causing extremity weakness/paralysis with decreased sensation, peripheral vascular disease and muscle weakness. The admission Minimum Data Set (MDS) dated 6/6/11, identified R15 was cognitively intact with mild deficits in memory recall. The MDS also indicated that R15 required extensive assistance from staff with mobility and activities of daily living (ADLs), had functional limitations to both lower extremities, had no current PU (pressure ulcers) however was at risk	F 272	The facility will complete all skin assessments upon transferring a resident from transitional care to a long term care unit, in addition to the required assessments as part of the MDS schedule. DON will audit care plans and assessments of newly admitted residents to assure comprehensive skin assessments are complete. DON will report outcomes of the audit to the facility's QA for the next 12 months.	10/25/11

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F 272	Continued From page 2 for development of PU. The MDS indicated a pressure reducing device was utilized for R15's bed, with no pressure reducing device utilized in a chair. The PU Care Area Assessment (CAA) dated 6/2/11, indicated R15 had risk factors including: immobility, incontinence and poor nutritional status as well as current vascular ulcers to the left foot. The resident's history of a PU on the coccyx was not identified as a risk factor on this CAA. Nursing notes dated 5/30/11, indicated R15 had scar tissue from a healed PU on her coccyx with no current redness or open areas. A Braden scale (a tool for predicting PU risk) assessment had been completed on 5/30/11. The Braden score indicated R15 was at low risk for developing PU, and indicated R15 had no sensory impairment. The facility's assessment of the resident's tissue tolerance to prolonged pressure, identified as a "Tissue Tolerance Assessment" had been conducted related to the resident's risk while lying down. That assessment was dated 5/30/11. The assessment indicated R15 had scar tissue on her coccyx and could tolerate lying for 2 hours without redness over her bony prominence's. Another assessment dated 5/30/11, had been conducted related to risks while seated. The assessment of the resident's risks while seated indicated R15 had scar tissue on the coccyx from an old healed wound, however no timeframe was identified related to how long R15 could tolerate a sitting position without redness to bony prominence's. On 7/23/11, nursing notes indicated R15 was found to have a stage 2 PU, (Partial thickness loss of dermis presenting as a shallow open ulcer	F 272		

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F 272	Continued From page 3 with a red or pink wound bed), to the lower buttock/hip area measuring 6 cm (centimeters) x 2.3 cm with a 3 cm x 2 cm area of necrosis. The pressure ulcer subsequently deteriorated to a stage 4 PU by 8/18/11. On 9/15/11, at 9:51 a.m. registered nurse (RN)-A stated their assessment of R15's tissue tolerance was incomplete. RN-A stated they should have comprehensively assessed the resident by conducting both sitting and lying tissue tolerance assessments. At 12:12 p.m. on 9/15/11, RN-A stated when since R15 was at risk, due to her lack of feeling and sensation to her lower body, as well as her history of PU, she should have been assessed upon admission to implement immediate interventions to prevent PU. At 12:29 p.m. on 9/15/11, the director of nursing (DON) verified R15 lacked a comprehensive skin assessment.	F 272		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review	F 314	During survey DON and Surveyor audited R15's documentation and care plan, 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 death was consistent with symptoms of congestive heart failure.	10/25/11

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F 314	Continued From page 4 and policy review, the facility failed to provide appropriate assessment, monitoring and interventions to prevent the development of pressure ulcers for 1 of 1 resident (R15) in the sample who had current pressure ulcers. The facility's failure to adequately assess and monitor resulted in actual harm for R15, pressure ulcer development. Findings include: R15 had developed a Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle. Eschar may be present) Pressure Ulcer (PU) on left buttock/hip. The facility failed to monitor, assess and implement interventions in a timely manner to prevent the development of pressure ulcers (PUs). R15 was diagnosed with a neurological disorder causing extremity weakness/paralysis with decreased sensation, peripheral vascular disease and muscle weakness. The admission Minimum Data Set (MDS) dated 6/6/11, identified R15 was cognitively intact with mild deficits in memory recall. The MDS identified R15 required extensive assistance from staff with mobility and activities of daily living (ADLs.) The MDS further indicated R15 had functional limitations to both lower extremities, had no current PU and was at risk for development of PU. The MDS indicated a pressure reducing device was utilized for R15's bed, but no pressure reducing device was utilized for R15's chair. The PU Care Area Assessment (CAA) dated 6/2/11, indicated R15 had risk factor such as immobility, incontinence and poor nutritional status as well as current vascular ulcers to her left foot. The CAA lacked indication of PU risk factors related to her history of PU to R15's coccyx and intervention to prevent the	F 314	Please see the above correction plan for skin assessment (F272) which assures that all residents will receive proper skin assessment. It is the policy of the facility to issue a pressure relieving device to any residents who is admitted that uses a wheelchair; this will be documented as an intervention on the care plan. To assure timely identification of skin concerns, the facility has initiated the Interact II tool called "Stop and Watch" for shift reporting of any changes in resident condition, including skin changes. The facility's skin policy and procedure was revised to include this tool. This tool was reviewed with staff during staff meetings in September and in October 2011. The tool will be reinforced with staff during the facility's weekly care planning meetings. All RNs and LPNs reviewed the facility's skin policy and procedure and completed a competency test on 10/5/2011.	10/25/11

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F 314	Continued From page 5 development of a PU. The Braden scale (a tool for predicting PU risk) completed on 5/30/11, indicated R15 was at low risk for developing a PU. The Braden indicated R15 had no sensory impairment despite R15's loss of sensation to the lower extremities due to her neurological condition. No further Braden scale had been completed. The facility's lying "Tissue Tolerance Assessment" dated 5/30/11, indicated R15 had a scar tissue on her coccyx and could tolerate lying for 2 hours without redness over her bony prominences. The facility's sitting "Tissue Tolerance Assessment" dated 5/30/11, indicated R15 had scar tissue on coccyx from an old healed wound, however no timeframe was indicated related to how long R15 could tolerate a sitting position without redness to a bony prominence. The initial plan of care dated 6/2/11, lacked any interventions related to R15's PU risk including pressure relieving devices to her bed, electric wheelchair or a repositioning program. On 9/6/11, the plan of care had been revised to direct staff to inform the physician of changes in skin condition, reposition on side to relieve pressure every hour, utilize an air mattress for pressure relief and utilize a Roho (cushion to prevent pressure on bony prominences) cushion while in electric wheelchair. Current physician orders on 8/28/11, directed staff to pack R15's wound with plain gauze and wash out the wound twice daily.	F 314	Staff received education on preventative skin measures as outlined in the facility's skin policy and procedure in September and October 2011. In order to improve the facility's interdisciplinary communication and to assure timely and effective intervention of skin concerns, the facility has added a Nurse Practitioner and Occupational Therapist to the wound team, effective 10/4/2011. The facility's QA will review any incidents of pressure ulcers over the next 12 months.	10/25/11

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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 (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 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	F 314		

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F 314	Continued From page 7 staff. Record review did not include any documentation of the presence of a pressure ulcer until 7/23/11, when the nursing notes indicated R15 had developed a stage 2 PU to the lower buttock/hip area measuring 6 cm x 2.3 cm with a 3 cm x 2 cm area of necrosis. On 7/24/11, nursing notes indicated a thin duoderm (dressing to protect wounds) had been placed on R15's left buttock/hip and an every hour repositioning schedule had been initiated. The physician had been informed of the PU development at that time. On 7/28/11, the facility's "Nursing Care Partner Screening Form" signed by Occupational therapist (OT)-A, indicated R15 had an electric wheelchair with no cushion. The OT documented R15 had an open area on her bottom and had a cushion for pressure relief but had not been using it. The OT's notes indicated it had been recommended that staff use the cushion to the electric wheelchair and to have R15 off her bottom every 2 hours. On 8/8/11, the OT plan of treatment indicated OT-A had trialed 2 cushion for R15's electric wheelchair and neither had been tolerated by the resident. The OT indicated R15 would benefit from a daily assessment and schedule of pressure relief and repositioning. The documentation indicated R15 did not have any repositioning schedule established that she was aware of. At that time, the OT had developed a turning and positioning schedule, conducted education with staff and provided pictures posted	F 314		

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F 314	Continued From page 8 in the resident's room to reference how the resident should be repositioned. Continued monitoring of the wound was documented in the nursing notes and the weekly wound flow sheets; however, no new "tissue tolerance assessment" had been completed until 8/9/11. At that time, R15 was found to have redness over bony prominences after 1 hour of pressure. R15 was placed on a 1 hour repositioning schedule despite redness after 1 hour. Review of the resident's nursing notes revealed that R15 was resistant to a repositioning schedule, often refusing to be repositioned. R15 was provided with education regarding the risk and benefits of not following a repositioning schedule. Interventions identified for implementation included: pressure relieving device in electric wheelchair, an air mattress, a repositioning schedule, wound dressing changes and multiple interdisciplinary referrals. On 8/9/11, the facility's "Wound Care Documentation" weekly flow sheets indicated R15's wound was a stage 2 PU, measuring 6 cm x 5 cm in diameter with 50% slough and 50% of eschar. On 8/10/11, physician orders were received to apply an Allevyn dressing should be applied to the wound. On 8/16/11, the facility's "Wound Care Documentation" weekly flow sheets indicated R15's wound had deteriorated and was now an unstageable PU, measuring 4 cm x 4 cm in diameter.	F 314		

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F 314	Continued From page 9 On 8/18/11, nursing notes indicated R15 had a wound debridement (removal of necrotic skin) of the left buttock/hip wound. Wound measurements following the debridement indicated R15 had tissue damage to the undermining tissue revealing a stage 4 PU. On 8/22/11, R15 was admitted to hospice services due to her continued failure in overall health. Nursing notes indicated on 8/20/11, an odor had been noted during R15's dressing change. On 8/22/11, undermining was noted to the distal and anterior aspects of the wound. 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. On 8/29/11, R15 again had the left buttock/hip wound debrided. 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.	F 314		

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	245212	A. BUILDING _____ B. WING _____	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH OAK CROSSING	1040 LINCOLN AVENUE DETROIT LAKES, MN 56501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 10 On 9/6/11, nursing notes indicated R15's wound was deeper after all the eschar had been removed. 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. Nursing assistant (NA)-C was interviewed at 2:27 p.m. on 9/14/11, she stated R15 was on a 1 hour repositioning schedule however, she added that recently they had been directed to reposition R15 every 2 hours if sleeping. NA-C also stated R15 had a cushion in her wheelchair and an air mattress in her bed. OT-A was interviewed at 9:30 a.m. on 9/15/11. OT-A stated she had been asked to assess R15 for a cushion in her electric wheelchair due to the development of a PU. She stated R15 had a cushion for her electric wheelchair provided for her shortly after her admission but R15 had not liked it and did not want to use it. OT-A added it was not until R15 developed a PU that a new cushion was found for her electric wheelchair. OT-A verified that after multiple attempts at finding the right cushion for R15, they had implemented a Roho cushion. She stated R15 was essentially a paraplegic due to her neurological condition. OT-A also stated R15 had been educated related to risk and benefits of not following a repositioning schedule. Registered nurse (RN)-A was interviewed at 9:51 a.m. on 9/15/11. RN-A stated R15's "tissue tolerance assessment" was incomplete upon admission and should have included assessment	F 314		

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F 314	Continued From page 11 of the resident's sitting and lying tissue tolerance. RN-A also stated the "tissue tolerance assessment" had not been completed in a timely manner after the development of the PU. RN-A verified R15's skin had not been comprehensively assessed. She stated R15 had not been able to walk and had been chair bound since admission. She added she had been aware R15 had a previous PU prior to admission to the facility. RN-A stated she had questioned staff about how the wound could have been undiscovered until it had developed eschar. RN-A stated R15's physician had been upset about the development of the PU and the facility had discussed implementing a new PU prevention program as a result. During additional interview with RN-A at 12:12 p.m. on 9/15/11, RN-A stated when a resident is at risk of PU, a more comprehensive skin assessment should have been completed. RN-A added R15's lack of feeling and sensation to her lower body as well as her history of PU should have been addressed upon admission. RN-A stated no preventative interventions related to PU risks were found on the plan of care developed after admission. RN-A verified that once R15's PU had been discovered, she had been referred to OT to have a cushion placed in her electric wheelchair. RN-A stated the OT had told her at that time they had a cushion for R15, but R15 had not been using it and did not want to use it. RN-A stated that on 7/28/11, a new cushion had been requested. RN-A verified R15 had not utilized a pressure reduction cushion to her electric wheelchair since transferring to her unit on 6/14/11.	F 314		

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F 314	Continued From page 12 At 12:29 p.m. the director of nursing (DON) verified R15 lacked a comprehensive skin assessment to prevent the development of a PU. The facility policy "Pressure Sore Assessment, Treatment and Prevention" dated May 2005, indicated a Braden Risk Assessment Scale would be complete upon admission, quarterly and with a significant change in status. The policy states "regardless of the resident' total risk score, each risk factor and potential cause should be reviewed individually." The "Tissue Tolerance Assessment" should be done for both lying and sitting positions upon admission and with a change in condition. Daily inspection by the NA and weekly inspection by the LPN will be done to ensure no adverse effects to the skin are noted.	F 314		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This 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:	F 371	The facility's Dietitian and DON will educate all Homemakers working in the neighborhood kitchens through role play, hands on situations and discussion. The sanitation policy and procedure was also re-enforced during this training which occurred on October 6, 2011.	10/25/11

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F 371	Continued From page 13 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 sheet of paper on the serving cart, grabs a new plate, dishes up food with tongs, and deliver another plate to a resident. HM-D then returned to the service area and removed her gloves. HM-D was interviewed at 6:36 p.m. on 9/21/11. She confirmed she had not changed her gloves nor washed her hands when she should have. On 9/12/11 at 6:20 p.m. the sanitation tour of the Cedar Ridge Kitchenette was completed. Fifteen fruit cups were observed to be stacked in a cupboard. The fruit cups were observed to have moisture/water sitting in between the cups. Homemaker-A stated the cups had been used for the noon meal and must not have been dry when they had been put away. On 9/15/11 at 10:20 am, observation of 10 wet clear plastic glasses were stored in the cupboard on Harbor Springs. Neighborhood Coordinator-E, confirmed findings and stated this is not normal practice.	F 371	New employee orientation provided by the Dietitian will include sanitation training. This training is provided 1 day per month and all new employees are scheduled to attend as part of their new employee orientation. All new employees working in the Neighborhood attend this training, including nurses, nursing assistants, homemakers, neighborhood coordinators, and neighborhood support staff. The dietitian will complete monthly audits in the neighborhood kitchens that will include sanitation observations. Any identified deficient practices will receive immediate coaching and correction by the dietitian. Audits will be reported in facility's QA. For the next 12 months.	10/25/11

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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 371		
F 431 SS=E	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 Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431	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	10/25/11

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F 431	Continued From page 15 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review and interview, the facility failed to ensure medication labels were current and consistent with physician orders for 4 of 10 (R97, R11, R55 and R154) residents observed during the medication pass. Findings include: The facility failed to follow their own polices to ensure the current physician orders matched the pharmacy medication labels. On 9/12/11, at 5:00 p.m. Licensed Practical Nurse (LPN)-D was observed to obtain a Novolog FlexPen for R97. The pharmacy label directed the staff to give 10 units of insulin before supper. The LPN was observed to prepare 7 units of insulin for the resident. She stated the order had changed and the resident was to receive 7 units of insulin. Review of the Medication Administration Record (MAR) directed the staff to give 7 units of insulin. The LPN administered the insulin. Review of the current physician's orders indicated on 11/20/10, the primary physician had changed the evening Novolog insulin from 10 units to 7 units. On 9/13/11, at 9:55 a.m. LPN-B was observed to dish up Psyllium Husk (a fiber medication) 1000 mg (milligrams) for R11. The pharmacy label directed the staff to administer the medication at	F 431	the pharmacy is properly processing the direction changes. The facility's Health Unit Coordinator (HUC) will randomly audit medication labels to assure a "direction change" label has been initiated and properly completed. The results of the audits will be reported in facility's QA for 12 months.	10/25/11

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F 431	Continued From page 16 noon. Review of the MAR indicated the medication was to be given with the morning medications. LPN-B stated the medication time had been changed several years ago. She did not know why the pharmacy label had not been changed. Review of the current physician's order directed the staff to administer the medication before breakfast. The order had last been changed on 6/30/08. On 9/15/11, at 8:30 a.m. LPN-C was observed to dish up Meclizine (a medication for dizziness) 25 mg for R55. The pharmacy label directed the staff to give one pill every 12 hours as needed for dizziness. Review of the MAR directed the staff to give the medication twice a day. LPN-C verified the pharmacy label and the MAR did not match. Review of the current physician's orders indicated on 5/5/10, the physician had changed the order from "as needed" to a scheduled twice a day medication. On 9/15/11, at 9:00 a.m. LPN-A was observed to dish up Celexa (an antidepressant medication) 20 mg for R154. The pharmacy label directed the staff to give one 10 mg tablet daily. There was also a hand written note on the pharmacy label which read "2 tabs." LPN-A stated she did not know who had written on the pharmacy label. Review of the MAR directed the staff to give 20 mg of the medication. Review of the current physician's orders indicated the medication had been increased from 10 mg to 20 mg on 7/7/11. During interview with registered nurse (RN)-A at 2:30 p.m. on 9/13/11, RN-A stated that when medication orders were changed, the nurse was to put a sticker on the label which would alert staff	F 431		

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F 431	Continued From page 17 to the order change. The nurse was then to review the physician's order and make sure a 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.	F 431		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

F521209

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	245212	A. BUILDING 02 - EXISTING BUILDING 02 B. WING _____	09/13/2011

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K 000	INITIAL COMMENTS FIRE SAFETY 02 Main Building 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. 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 02 Main 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: PATRICK SHEEHAN SUPERVISOR STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145	K 000	POC ok JS 10-17-11	

Dc. 10-25-11

EXIT: 9-15-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christy Bornhorst	Administrator	10/15/11

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

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K 000	Continued From page 1 ST PAUL, MN 55101-5145 Email: pat.sheehan@state.mn.us <mailto:pat.sheehan@state.mn.us> Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency St Mary's Regional Health Center C & NC is a 2-story building with a basement. The building was constructed at 3 different times. The original building (02) was constructed in 1968, is 2-story building with a small basement and was determined to be of Type II(000) construction due to the on going remodeling of this building. In 1999 an Administration / Entrance addition was constructed south of the original building and an addition to the hospital north of the original building. The entrance addition is Type V (111) construction, 2-stories without a basement and the hospital addition is Type II (111) construction, 1-story without a basement. In 2008 a 2-story building, without a basement, separated with two 2-hour fire barriers south of the entrance addition and was determined to be Type II (111) construction. The buildings are divided into 12 smoke zones (6 per floor) by 2- hour and 30 minute fire barriers.	K 000		

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K 000	Continued From page 2 Due to the remodeling of the main building, the construction type has been down graded to a Type II (000) requiring the existing building be have a complete automatic fire sprinkler system. The project is to be complete by January 2010. The Administration/ Entrance addition and the south east wings of (02) main building and the (03) 2008 building are fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition with 2 systems. The facility has a fire alarm system with manual pull station near each exit door, smoke detection in the corridor system properly spaced and all common areas in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). The resident sleeping rooms have smoke detection 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). The facility has a capacity of 96 beds and had a census of 71 at the time of the survey. The facility was surveyed as two buildings, 02-Main Existing Building (1968 building and the 1999 Administration / Entrance additions) as an Existing Health Care and 03 South Building (2008 building) as New Health Care. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET in Building 02 as evidenced by:	K 000		

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

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K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Observations revealed that two fire rated doors are not in accordance with NFPA 101 "The Life Safety Code" (2000 edition) section 18.1.1.4.1. This deficient practice could negatively affect all of the residents, staff and visitors in the event of a fire by allowing fire and smoke to pass from one building to the other. Findings include: During the facility tour on September 13, 2011, between 12:00 pm and 3:30 pm, observations revealed that: 1) The 1 1/2- hour fire rated door near the 2nd floor kitchen did not latch, and 2) The 1 1/2- hour fire rated door to the south building did not latch. The Administrator (CB) and the Director of Maintenance (CG) verified these findings during the inspection and at the exit conference.	K 011	The 1 ½ hour fire rated door near the 2nd floor kitchen and the 1 ½ hour fire rated door to the south building will be repaired by 10/25/2011. The Director of Maintenance will be responsible to ensure correction of the door latching. Monthly audits of all fire doors in the facility will be completed and will be reviewed by the facility's QA during the next 12 months.	10/25/11
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under	K 050		

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING 02 - EXISTING BUILDING 02 B. WING _____	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH OAK CROSSING	1040 LINCOLN AVENUE DETROIT LAKES, MN 56501

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K 050	Continued From page 4 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 announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: A review of fire drill records and an interview with staff revealed that the facility staff have not conducted fire exit drills in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.1.2. Not conducting fire exit drills could allow confusion and delay in the staff response, which would negatively impact all residents, visitors and staff in a fire emergency. Findings include: A review of fire drill records for St Marys Regional for 20010-2011 and an interview with staff prior to the facility tour on September 13, 2011, at approximately 11:45 am, revealed that the fire exit drills have not been held at unexpected times under varying conditions as indicated by three of the four day shift drills have been conducted between 9:27 am and 9:56 am and three of the four evening shift drills were held between 3:00 pm and 3:05 pm. The Administrator (CB) and the Director of Maintenance (CG) verified these findings during the inspection and at the exit conference.	K 050	Starting with the October 2011 fire drill, the facility will conduct monthly fire drills at varied times under varying conditions. 1 drill per 12 month period will be held between each 2 hours increment, 6-8 am, 8-10 am, 10 am – 12 pm, 12 pm – 2 pm, 2 pm – 4 pm, 4-6 pm, 6-8 pm, 8-10 pm, 10 pm – 12 am. This will capture staff and residents with all types of variation. 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.	10/25/11

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

FS212019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING 03 - 2008 SOUTH B. WING _____	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH OAK CROSSING	1040 LINCOLN AVENUE DETROIT LAKES, MN 56501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 03 South Building 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: PATRICK SHLEHAN SUPERVISOR STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145	K 000	POC ok FS 10-17-11	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christy Bo — TITLE: Administrator — (X6) DATE: 10/15/11

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245212	A. BUILDING 03 - 2008 SOUTH B. WING _____	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH OAK CROSSING	1040 LINCOLN AVENUE DETROIT LAKES, MN 56501

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K 000	Continued From page 1 ST PAUL, MN 55101-5145 Email: pat.sheehan@state.mn.us Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency St Mary's Regional Health Center C & NC is a 2-story building with a partial basement. The building was constructed at 3 different times. The original building (02) was constructed in 1968, is 2-story building with a small basement and was determined to be of Type II(000) construction. In 1999 an Administration / Entrance addition was constructed south of the original building and an addition to the hospital north of the original building. The entrance addition is Type V (111) construction, 2-stories without a basement and the hospital addition is Type II (111) construction, 1-story without a basement. In 2008 a 2-story building, without a basement, separated with two 2-hour fire barriers south of the entrance addition was constructed and was determined to be Type II (111) construction. The buildings are divided into 12 smoke zones (6 per floor) by 2- hour and 30 minute fire barriers. The facility is completely protected with an	K 000		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	245212	A. BUILDING 03 - 2008 SOUTH B. WING _____	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH OAK CROSSING	1040 LINCOLN AVENUE DETROIT LAKES, MN 56501

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K 000	Continued From page 2 automatic fire sprinkler system in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition with 2 systems. The facility has a fire alarm system with manual pull station near each exit door, smoke detection in the corridor system properly spaced and all common areas in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). The resident sleeping rooms have smoke detection 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). The facility has a capacity of 96 beds and had a census of 85 at the time of the survey. The facility was surveyed as two buildings, 02-Main Existing Building (1968 building and the 1999 Administration / Entrance additions) as an Existing Health Care and 03 South Building (2008 building) as New Health Care. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET in building 03 as evidenced by:	K 000		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 050	Starting with the October 2011 fire drill, the facility will conduct monthly fire drills at varied times under varying conditions. 1 drill per 12 month period will be held between each 2 hours increment, 6-8 am, 8-10 am, 10 am – 12 pm, 12 pm – 2 pm, 2 pm – 4 pm, 4-6 pm, 6-8 pm, 8-10 pm, 10 pm – 12 am. This will capture staff and residents with all types of variation. 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.	10/25/11

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K 050	Continued From page 3 announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: A review of fire drill records and an interview with staff revealed that the facility staff have not conducted fire exit drills in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.1.2. Not conducting fire exit drills could allow confusion and delay in the staff response, which would negatively impact all residents, visitors and staff in a fire emergency. Findings include: A review of fire drill records for St Marys Regional for 20010-2011 and an interview with staff prior to the facility tour on September 13, 2011, at approximately 11:45 am, revealed that the fire exit drills have not been held at unexpected times under varying conditions as indicated by three of the four day shift drills have been conducted between 9:27 am and 9:56 am and three of the four evening shift drills were held between 3:00 pm and 3:05 pm. The Administrator (CB) and the Director of Maintenance (CG) verified these findings during the inspection and at the exit conference.	K 050		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

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
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00907	A. BUILDING _____ B. WING _____	Co. 09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH OAK CROSSING	**1040 LINCOLN AVENUE DETROIT LAKES, MN 56501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On September 12, 13, 14, and 15, 2011, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00907	A. BUILDING _____ B. WING _____	09/15/2011

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2 000	Continued From page 1 Monitoring, Licensing and Certification Program, 12 Civic Center Plaza, Suite #2105 Mankato, MN 56001.	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced	2 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 540	Continued From page 2 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: Resident 15 (R15) lacked a comprehensive skin assessment. R15 was diagnosed with a neurological disorder causing extremity weakness/paralysis with decreased sensation, peripheral vascular disease and muscle weakness. The admission Minimum Data Set (MDS) dated 6/6/11, identified R15 was cognitively intact with mild deficits in memory recall. The MDS also indicated that R15 required extensive assistance from staff with mobility and activities of daily living (ADLs), had functional limitations to both lower extremities, had no current PU (pressure ulcers) however was at risk for development of PU. The MDS indicated a pressure reducing device was utilized for R15's bed, with no pressure reducing device utilized in a chair. The PU Care Area Assessment (CAA) dated 6/2/11, indicated R15 had risk factors including: immobility, incontinence and poor nutritional status as well as current vascular ulcers to the left foot. The resident's history of a PU on the coccyx was not identified as a risk factor on this CAA. Nursing notes dated 5/30/11, indicated R15 had scar tissue from a healed PU on her coccyx with no current redness or open areas. A Braden scale (a tool for predicting PU risk) assessment had been completed on 5/30/11. The Braden score indicated R15 was at low risk for developing PU, and indicated R15 had no sensory impairment. The facility's assessment of	2 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 540	Continued From page 3 the resident's tissue tolerance to prolonged pressure, identified as a "Tissue Tolerance Assessment" had been conducted related to the resident's risk while lying down. That assessment was dated 5/30/11. The assessment indicated R15 had scar tissue on her coccyx and could tolerate lying for 2 hours without redness over her bony prominence's. Another assessment dated 5/30/11, had been conducted related to risks while seated. The assessment of the resident's risks while seated indicated R15 had scar tissue on the coccyx from an old healed wound, however no timeframe was identified related to how long R15 could tolerate a sitting position without redness to bony prominence's. On 7/23/11, nursing notes indicated R15 was found to have a stage 2 PU, (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed), to the lower buttock/hip area measuring 6 cm (centimeters) x 2.3 cm with a 3 cm x 2 cm area of necrosis. The pressure ulcer subsequently deteriorated to a stage 4 PU by 8/18/11. On 9/15/11, at 9:51 a.m. registered nurse (RN)-A stated their assessment of R15's tissue tolerance was incomplete. RN-A stated they should have comprehensively assessed the resident by conducting both sitting and lying tissue tolerance assessments. At 12:12 p.m. on 9/15/11, RN-A stated when since R15 was at risk, due to her lack of feeling and sensation to her lower body, as well as her history of PU, she should have been assessed upon admission to implement immediate interventions to prevent PU. At 12:29 p.m. on 9/15/11, the director of nursing (DON) verified R15 lacked a comprehensive skin assessment.	2 540		

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2 540	Continued From page 4 Suggested Method of Correction: The Director of Nursing or designee could review and revise policies and procedures pertaining to comprehensive resident assessments to ensure they comply with the regulations, retrain staff, and develop a monitoring procedure. Time Period for Correction: Twenty-one (21) days	2 540		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: 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 B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, record review and policy review, the facility failed to provide appropriate assessment, monitoring and interventions to prevent the development of pressure ulcers for 1 of 1 resident (R15) in the sample who had current pressure ulcers. The	2 900		

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

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2 900	Continued From page 5 facility's failure to adequately assess and monitor resulted in actual harm for R15, pressure ulcer development. Findings include: R15 had developed a Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle. Eschar may be present) Pressure Ulcer (PU) on left buttock/hip. The facility failed to monitor, assess and implement interventions in a timely manner to prevent the development of pressure ulcers (PUs). R15 was diagnosed with a neurological disorder causing extremity weakness/paralysis with decreased sensation, peripheral vascular disease and muscle weakness. The admission Minimum Data Set (MDS) dated 6/6/11, identified R15 was cognitively intact with mild deficits in memory recall. The MDS identified R15 required extensive assistance from staff with mobility and activities of daily living (ADLs.) The MDS further indicated R15 had functional limitations to both lower extremities, had no current PU and was at risk for development of PU. The MDS indicated a pressure reducing device was utilized for R15's bed, but no pressure reducing device was utilized for R15's chair. The PU Care Area Assessment (CAA) dated 6/2/11, indicated R15 had risk factor such as immobility, incontinence and poor nutritional status as well as current vascular ulcers to her left foot. The CAA lacked indication of PU risk factors related to her history of PU to R15's coccyx and intervention to prevent the development of a PU. The Braden scale (a tool for predicting PU risk) completed on 5/30/11, indicated R15 was at low risk for developing a PU. The Braden indicated R15 had no sensory impairment despite R15's loss of sensation to the lower extremities due to	2 900		

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2 900	Continued From page 6 her neurological condition. No further Braden scale had been completed. The facility's lying "Tissue Tolerance Assessment" dated 5/30/11, indicated R15 had a scar tissue on her coccyx and could tolerate lying for 2 hours without redness over her bony prominences. The facility's sitting "Tissue Tolerance Assessment" dated 5/30/11, indicated R15 had scar tissue on coccyx from an old healed wound, however no timeframe was indicated related to how long R15 could tolerate a sitting position without redness to a bony prominence. The initial plan of care dated 6/2/11, lacked any interventions related to R15's PU risk including pressure relieving devices to her bed, electric wheelchair or a repositioning program. On 9/6/11, the plan of care had been revised to direct staff to inform the physician of changes in skin condition, reposition on side to relieve pressure every hour, utilize an air mattress for pressure relief and utilize a Roho (cushion to prevent pressure on bony prominences) cushion while in electric wheelchair. Current physician orders on 8/28/11, directed staff to pack R15's wound with plain gauze and wash out the wound twice daily. 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	2 900		

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2 900	Continued From page 7 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 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. Record review did not include any documentation of the presence of a pressure ulcer until 7/23/11, when the nursing notes indicated R15 had developed a stage 2 PU to the lower buttock/hip area measuring 6 cm x 2.3 cm with a 3 cm x 2 cm area of necrosis. On 7/24/11, nursing notes indicated a thin duoderm (dressing to protect wounds) had been	2 900		

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2 900	Continued From page 8 placed on R15's left buttock/hip and an every hour repositioning schedule had been initiated. The physician had been informed of the PU development at that time. On 7/28/11, the facility's "Nursing Care Partner Screening Form" signed by Occupational therapist (OT)-A, indicated R15 had an electric wheelchair with no cushion. The OT documented R15 had an open area on her bottom and had a cushion for pressure relief but had not been using it. The OT's notes indicated it had been recommended that staff use the cushion to the electric wheelchair and to have R15 off her bottom every 2 hours. On 8/8/11, the OT plan of treatment indicated OT-A had trialed 2 cushion for R15's electric wheelchair and neither had been tolerated by the resident. The OT indicated R15 would benefit from a daily assessment and schedule of pressure relief and repositioning. The documentation indicated R15 did not have any repositioning schedule established that she was aware of. At that time, the OT had developed a turning and positioning schedule, conducted education with staff and provided pictures posted in the resident's room to reference how the resident should be repositioned. Continued monitoring of the wound was documented in the nursing notes and the weekly wound flow sheets; however, no new "tissue tolerance assessment" had been completed until 8/9/11. At that time, R15 was found to have redness over bony prominences after 1 hour of pressure. R15 was placed on a 1 hour repositioning schedule despite redness after 1 hour. Review of the resident's nursing notes revealed that R15 was resistant to a repositioning	2 900		

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2 900	Continued From page 9 schedule, often refusing to be repositioned. R15 was provided with education regarding the risk and benefits of not following a repositioning schedule. Interventions identified for implementation included: pressure relieving device in electric wheelchair, an air mattress, a repositioning schedule, wound dressing changes and multiple interdisciplinary referrals. On 8/9/11, the facility's "Wound Care Documentation" weekly flow sheets indicated R15's wound was a stage 2 PU, measuring 6 cm x 5 cm in diameter with 50% slough and 50% of eschar. On 8/10/11, physician orders were received to apply an Allevyn dressing should be applied to the wound. On 8/16/11, the facility's "Wound Care Documentation" weekly flow sheets indicated R15's wound had deteriorated and was now an unstageable PU, measuring 4 cm x 4 cm in diameter. On 8/18/11, nursing notes indicated R15 had a wound debridement (removal of necrotic skin) of the left buttock/hip wound. Wound measurements following the debridement indicated R15 had tissue damage to the undermining tissue revealing a stage 4 PU. On 8/22/11, R15 was admitted to hospice services due to her continued failure in overall health. Nursing notes indicated on 8/20/11, an odor had been noted during R15's dressing change. On 8/22/11, undermining was noted to the distal and anterior aspects of the wound.	2 900		

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2 900	Continued From page 10 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. On 8/29/11, R15 again had the left buttock/hip wound debrided. 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. On 9/6/11, nursing notes indicated R15's wound was deeper after all the eschar had been removed. 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. Nursing assistant (NA)-C was interviewed at 2:27 p.m. on 9/14/11, she stated R15 was on a 1 hour repositioning schedule however, she added that recently they had been directed to reposition R15 every 2 hours if sleeping. NA-C also stated R15 had a cushion in her wheelchair and an air mattress in her bed.	2 900		

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2 900	Continued From page 11 OT-A was interviewed at 9:30 a.m. on 9/15/11. OT-A stated she had been asked to assess R15 for a cushion in her electric wheelchair due to the development of a PU. She stated R15 had a cushion for her electric wheelchair provided for her shortly after her admission but R15 had not liked it and did not want to use it. OT-A added it was not until R15 developed a PU that a new cushion was found for her electric wheelchair. OT-A verified that after multiple attempts at finding the right cushion for R15, they had implemented a Roho cushion. She stated R15 was essentially a paraplegic due to her neurological condition. OT-A also stated R15 had been educated related to risk and benefits of not following a repositioning schedule. Registered nurse (RN)-A was interviewed at 9:51 a.m. on 9/15/11. RN-A stated R15's "tissue tolerance assessment" was incomplete upon admission and should have included assessment of the resident's sitting and lying tissue tolerance. RN-A also stated the "tissue tolerance assessment" had not been completed in a timely manner after the development of the PU. RN-A verified R15's skin had not been comprehensively assessed. She stated R15 had not been able to walk and had been chair bound since admission. She added she had been aware R15 had a previous PU prior to admission to the facility. RN-A stated she had questioned staff about how the wound could have been undiscovered until it had developed eschar. RN-A stated R15's physician had been upset about the development of the PU and the facility had discussed implementing a new PU prevention program as a result. During additional interview with RN-A at 12:12 p.m. on 9/15/11, RN-A stated when a resident is	2 900		

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2 900	Continued From page 12 at risk of PU, a more comprehensive skin assessment should have been completed. RN-A added R15's lack of feeling and sensation to her lower body as well as her history of PU should have been addressed upon admission. RN-A stated no preventative interventions related to PU risks were found on the plan of care developed after admission. RN-A verified that once R15's PU had been discovered, she had been referred to OT to have a cushion placed in her electric wheelchair. RN-A stated the OT had told her at that time they had a cushion for R15, but R15 had not been using it and did not want to use it. RN-A stated that on 7/28/11, a new cushion had been requested. RN-A verified R15 had not utilized a pressure reduction cushion to her electric wheelchair since transferring to her unit on 6/14/11. At 12:29 p.m. the director of nursing (DON) verified R15 lacked a comprehensive skin assessment to prevent the development of a PU. The facility policy "Pressure Sore Assessment, Treatment and Prevention" dated May 2005, indicated a Braden Risk Assessment Scale would be complete upon admission, quarterly and with a significant change in status. The policy states "regardless of the resident' total risk score, each risk factor and potential cause should be reviewed individually." The "Tissue Tolerance Assessment" should be done for both lying and sitting positions upon admission and with a change in condition. Daily inspection by the NA and weekly inspection by the LPN will be done to ensure no adverse effects to the skin are noted. Suggested Method of Correction: The Director of Nursing or designee could review and revise as needed the policies and procedures regarding	2 900		

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2 900	Continued From page 13 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 Correction: Twenty-one (21) days	2 900		
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 sheet of paper on the serving cart, grabs a new	21015		

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21015	Continued From page 14 plate, dishes up food with tongs, and deliver another plate to a resident. HM-D then returned to the service area and removed her gloves. HM-D was interviewed at 6:36 p.m. on 9/21/11. She confirmed she had not changed her gloves nor washed her hands when she should have. On 9/12/11 at 6:20 p.m. the sanitation tour of the Cedar Ridge Kitchenette was completed. Fifteen fruit cups were observed to be stacked in a cupboard. The fruit cups were observed to have moisture/water sitting in between the cups. Homemaker-A stated the cups had been used for the noon meal and must not have been dry when they had been put away. On 9/15/11 at 10:20 am, observation of 10 wet clear plastic glasses were stored in the cupboard on Harbor Springs. Neighborhood Coordinator-E, confirmed findings and stated this is not normal practice. 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. Suggested Method of Correction: The Administrator and the Dietician could review and revise food service policies and procedures to ensure that food is stored and served in a sanitary manner. Staff could be trained as necessary. The Certified Dietary Manager could monitor the service of food on a periodic basis. Time Period for Correction: Fourteen (14) days.	21015		

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21400	Continued From page 15	21400		
21400	MN Rule 4658.0810 Subp. 1 Resident Tuberculosis Program 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 must be maintained in the resident's medical record. Consult current CDC recommendations for the diagnosis of TB for recommended follow-up of residents who display signs or symptoms of active TB disease.	21400		

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21400	Continued From page 16 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. R127 was admitted on 12/21/10, and the record indicated R127 did not receive the recommended baseline TB symptom screening within 72 hours of admission.	21400		

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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	MN Rule 4658.0815 Subp. 2 Employee Tuberculosis Program Subp. 2. Pursuant to Minnesota Rule 4658 0040 and as defined in Minnesota Department of Health Informational Bulletin 09-02, Minnesota Rule 4658.0815 Subpart 2 Employee Tuberculosis Program is waived. Conditions of Waiver: - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive baseline TB screening. This screening must include a written assessment of any current TB symptoms, and a two-step tuberculin skin test (TST) or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or	21415		

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21415	Continued From page 18 TB Gold - In Tube, T-SPOT ® .TB). - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive serial TB screening based on the facility 's risk level: (1) low risk - not needed; (2) medium risk - yearly; (3) potential ongoing transmission - consult the Minnesota Department of Health's TB Prevention and Control Program at 651-201-5414. · HCWs with abnormal TB screening results must receive follow-up medical evaluation according to current CDC recommendations for the diagnosis of TB. See www.cdc.gov/tb · All reports or copies of HCW TSTs, IGRAs for M. tuberculosis, medical evaluation, and chest radiograph results must be maintained in the HCW 's employee file. · All HCWs exhibiting signs or symptoms consistent with TB must be evaluated by a physician within 72 hours. These HCWs must not return to work until determined to be non-infectious. This MN Requirement is not met as evidenced by: Based on interview, policy review and personnel file review, the facility failed to document baseline Tuberculosis (TB) symptom screening upon hire for 2 of 5 employees (LPN-F and NA-F) reviewed.	21415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00907	A. BUILDING _____ B. WING _____	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH OAK CROSSING	1040 LINCOLN AVENUE DETROIT LAKES, MN 56501

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21415	Continued From page 19 In addition, the facility failed to provide documentation of the required tuberculin skin testing (TST) or timely testing for 2 of 5 employees (LPN-F and NA-F), reviewed. Findings include: Review of employee files revealed LPN-F , whose new hire start date was 7/28/11, did not have a written symptom screening for TB. In addition, LPN-F did not have the 2nd step TST administered. Review of employee files revealed NA-F, whose new hire start date was 6/2/11, did not have a written symptom screening for TB. In addition, NA-F did not have the 2nd step TST until 7/19/11, which was after the recommended 1-3 week time frame On 9/15/11, at 11:31 a.m. infection control registered nurse-A stated all employees are required to have a symptom screening. She added a 2nd step TST should be administered in 1-3 weeks after the first step. The facility policy "Tuberculin Skin Testing" dated 5/29/09, indicated staff will have a 2nd step TST testing completed 1-3 weeks after the first step. Suggested Method of Correction: The Administrator or designee could review the facility system to ensure newly hired staff receive the tuberculin test and are screened for risk factors and symptoms of tuberculosis, as required by state rule. Revise the system as needed and educate staff. Monitor and review the delivery of mantoux tests and screenings, and adjust the system as needed. Time Period for Correction: Twenty one (21)	21415		

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21415	Continued From page 20 days	21415		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, record review, policy review and interview, the facility failed to ensure medication labels were current and consistent with physician orders for 4 of 10 (R97, R11, R55 and R154) residents observed during the medication pass. Findings include: The facility failed to follow their own polices to ensure the current physician orders matched the pharmacy medication labels. On 9/12/11, at 5:00 p.m. Licensed Practical Nurse (LPN)-D was observed to obtain a Novolog FlexPen for R97. The pharmacy label directed the staff to give 10 units of insulin before supper. The LPN was observed to prepare 7 units of insulin for the resident. She stated the order had changed and the resident was to receive 7 units of insulin. Review of the Medication Administration Record (MAR) directed the staff to give 7 units of insulin. The LPN administered the insulin. Review of the current physician's orders indicated on 11/20/10, the primary physician had changed the evening Novolog insulin from 10 units to 7 units. On 9/13/11, at 9:55 a.m. LPN-B was observed to dish up Psyllium Husk (a fiber medication) 1000 mg (milligrams) for R11. The pharmacy label directed the staff to administer the medication at	21620		

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21620	Continued From page 21 noon. Review of the MAR indicated the medication was to be given with the morning medications. LPN-B stated the medication time had been changed several years ago. She did not know why the pharmacy label had not been changed. Review of the current physician's order directed the staff to administer the medication before breakfast. The order had last been changed on 6/30/08. On 9/15/11, at 8:30 a.m. LPN-C was observed to dish up Meclizine (a medication for dizziness) 25 mg for R55. The pharmacy label directed the staff to give one pill every 12 hours as needed for dizziness. Review of the MAR directed the staff to give the medication twice a day. LPN-C verified the pharmacy label and the MAR did not match. Review of the current physician's orders indicated on 5/5/10, the physician had changed the order from "as needed" to a scheduled twice a day medication. On 9/15/11, at 9:00 a.m. LPN-A was observed to dish up Celexa (an antidepressant medication) 20 mg for R154. The pharmacy label directed the staff to give one 10 mg tablet daily. There was also a hand written note on the pharmacy label which read "2 tabs." LPN-A stated she did not know who had written on the pharmacy label. Review of the MAR directed the staff to give 20 mg of the medication. Review of the current physician's orders indicated the medication had been increased from 10 mg to 20 mg on 7/7/11. During interview with registered nurse (RN)-A at 2:30 p.m. on 9/13/11, RN-A stated that when medication orders were changed, the nurse was to put a sticker on the label which would alert staff to the order change. The nurse was then to review the physician's order and make sure a	21620		

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21620	Continued From page 22 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 Correction: Twenty-one (21) days	21620		