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	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essentia Health Oak Crossing	1040 Lincoln Avenue Detroit Lakes, MN 56501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on interview and document review, the facility failed to ensure advanced directives for emergency care and treatment were accurately reflected in all areas of the resident's medical record to ensure residents wishes would be implemented correctly in an emergency for 3 of 25 residents (R10, R60, R68) reviewed for advanced directives. Findings Include: R10 R10's admission Minimum Data Set (MDS) dated [DATE], identified R10 was cognitively intact and had diagnoses which included: heart failure, diabetes mellitus, and respiratory failure. Review of R10's electronic medical record (EMR) identified the following: -R10's dashboard Profile (banner viewed on computer screen) identified Advance Directive: do not resuscitate (DNR). -R10's Physician Order Report identified Advance Directive: Full Code, order date [DATE]. -R10's scanned in Provider Orders For Life-Sustaining Treatment (POLST) signed [DATE], identified Attempt Resuscitation/Cardiopulmonary resuscitation (CPR). Review of R10's paper chart identified the following: -R10's POLST signed [DATE], identified Do Not Attempt Resuscitation/DNR (Allow Natural Death). R60 R60's Prospective Payment System (PPS) MDS dated [DATE], identified R60 was cognitively intact and had diagnoses which included: heart failure, displaced transverse fracture of shaft of left femur (thigh bone), and respiratory failure. Review of R60's EMR identified the following: (continued on next page)

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.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-R60's dashboard Profile identified Advance Directive: Full Code. -R60's Physician Order Report identified Advance Directive: Full Code, order date [DATE]. -R60's scanned in POLST signed [DATE], identified Do Not Attempt Resuscitation/DNR (Allow Natural Death), with attachment date of [DATE]. -R60's scanned in POLST signed [DATE], identified Attempt Resuscitation/CPR, with attachment date of [DATE]. Review of R60's paper chart identified the following: -R60's POLST signed [DATE], identified Attempt Resuscitation/CPR. R68 R68's significant change MDS dated [DATE], identified R68 was cognitively intact and had diagnoses which included: diabetes mellitus, chronic kidney disease and amputation. Review of R68's EMR identified the following: -R68's dashboard Profile identified Advance Directive: DNR. -R68's Physician Order Report identified Advance Directive: Full Code, order date [DATE]. -R68 had lacked a scanned POLST in EMR Review of R68's paper chart identified the following: -R68's POLST signed [DATE], identified Do Not Attempt Resuscitation/DNR (Allow Natural Death). During an interview on [DATE] at 9:05 a.m. R68 indicated he wanted CPR if needed. R68 stated he was pretty confused when he first arrived at the facility, and indicated he thought he had told the facility staff he wished to have CPR if needed, however could not remember who he had spoken to. During an interview on [DATE] at 9:09 a.m., R10 stated she did not want CPR, and registered nurse (RN)-A had discussed this with her. During an interview on [DATE] at 11:25 a.m., RN-C indicated her usual practice was to locate a resident's code status on the EMR banner, which identified the advanced directives, or in the paper chart in the nurses station. During an interview on [DATE] at 11:25 a.m., RN-H indicated her usual practice to locate a resident's code status was on the EMR banner, face sheet, or the paper chart POLST, or the POLST scanned into the computer, which ever was quicker. RN-H stated if it said Full Code, she would initiate CPR and call for help, and if it said DNR, she would contact the family and provider. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:43 a.m., registered nurse (RN)-B stated her usual practice to locate a resident's code status was to look on the computer and indicated the dashboard profile. RN-B stated the usual practice was to ask the residents and/or family members to fill out a POLST on admission. RN-B indicated if a resident was transferred, they would give an oral report of the resident's code status, and send a copy of their POLST. During an interview on [DATE] at 11:14 a.m. RN-A confirmed the above findings. RN-A stated R10's scanned POLST identified Full Code, and that could be a problem, because someone could initiate CPR which did not follow R10's wishes for DNR. RN-A verified R60's latest scanned EMR POLST , which was scanned into EMR on [DATE], identified DNR, which was not her most recent POLST, and did not match her EMR banner or orders for Full Code. RN-confirmed R68's EMR banner identified DNR, but R68's physician orders identified Full Code, then confirmed director of nursing (DON) had updated R68's orders on [DATE], to DNR. RN-A indicated if a resident's banner, orders, or POLST did not match, it could cause a resident to receive CPR if they were DNR, or a resident who's wishes were for CPR, to not receive it. During an interview on [DATE] at 12:10 p.m. DON confirmed the above findings. DON confirmed R10's most recent POLST was not scanned into her EMR and did not match her orders or banner, which could cause someone to assume it was R10's most recent POLST. DON confirmed R60's most recent scanned POLST for DNR was not current, and could cause someone to not follow R60's current wishes for CPR. DON confirmed R68's orders were for Full Code, and did not match R68's banner or POLST. DON confirmed she had updated R68's order to DNR on [DATE]. DON stated the facility's usual practice was to complete a POLST at the time of a resident's admission or change of status. Then the process was to put the POLST in their paper chart, add their code status to the EMR banner, obtain orders, and then scan the POLST into their EMR. The facility policy titled Advanced Care Planning (POLST) dated ,d+[DATE], identified upon admission, the nurse would identify if the resident had an advanced directive or not, and determine the resident's wishes to formulate an advanced directive. All advance directive document copies would be obtained and located in the medical record. A POLST would be completed upon admission, and reviewed upon readmission, quarterly and with significant changes and as needed. Changes would be documented on the face sheet. Upon completion of the POLST a copy would be placed in the front of the resident's paper chart, with a notation awaiting provider signature. Once the provider had reviewed and signed, a copy would be scanned into the EMR and the original would remain in the front of the paper chart. Once signed the code status would be recorded in the EMR on the face sheet under advanced directives, and the code status would appear on the resident banner.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49620 Based on observation, interview and document review, the facility failed to appropriately implement identified pressure relieving interventions to promote healing for 1 of 3 resident (R1) reviewed with current, recurring, stage three (3) pressure ulcer on R1's left heel. Stage 3 pressure ulcer; full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling. Slough; non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had moderate cognitive impairment and had diagnoses which included aphasia (a disorder that could affect how a person communicated. It may impact speech, as well as the way a person may write and understand both spoken and written language) following cerebral infarction (stroke), dementia, severe, with psychotic disturbance, chronic kidney disease, stage three, congestive heart failure, anemia (not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues.). Indicated R1 required limited assistance from one staff for bed mobility and extensive assistance of one staff for transfers and toileting. Identified R1 was at risk for pressure ulcers, had a current stage three pressure ulcer. Indicated pressure relieving interventions of pressure relieving devices for bed and chair and identified R1 received treatments to her stage three pressure ulcer. R1's significant change Care Area Assessment (CAA) dated 11/29/23, identified R1 required extensive assistance with dressing, transfers, bed mobility and grooming. Indicated R1 was alert, easily forgetful, required frequent cues and reminders. Identified R1 was at risk for pressure ulcer development and pressure ulcer care being provided to left heel included dressing change as ordered. R1's care plan dated 10/19/23, identified R1 had an unstageable deep tissue injury (purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue to the left heel). R1's care plan dated 6/17/24, identified wound to left heel was now a stage three pressure ulcer. R1's care plan directed facility staff to free float (remove weight from an area) R1's heels in bed and recliner and encourage R1 to wear post op shoe to left foot when up. R1's care plan directed facility staff to administer treatments as ordered and assist R1 to reposition every two hours. Review of R1's Braden Scale (tool used to determine risk for pressure ulcer development) dated 8/26/24, identified R1 was at low risk for developing pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's pressure ulcer event report dated 10/18/23, identified R1 was at risk for developing pressure ulcers with interventions in place of: turning and repositioning every two hours, free float heels with heel lift cushion and pressure relief boots on at all times. The pressure ulcer report further identified the following: -10/15/23, R1 had a suspected deep tissue injury to the left heel, purple area of intact skin, boggy to the touch. Thin blister over dark wound bed. -10/18/23, nurse practitioner (NP) identified an unstageable pressure ulcer to R1's left heel and ordered Mepilex dressing to R1's left heel, change the dressing every three days and as needed. -11/1/23, R1 had a large black area to the left heel and Mepilex dressing was applied. -11/15/23, R1 had a deep tissue injury to the left heel that measured 6 centimeters (cm) in length by 6cm in width with a thin blister over the area that had opened. Mepilex dressing was applied. -11/17/23, referral to podiatry for R1's left heel pressure ulcer. -11/20/23, orders from podiatry for R1: paint left heel with Betadine and cover with Mepilex border dressing. Change dressing every three days and as needed. Continue with prevalon boots for offloading. -11/22/23, R1 had an excoriated (damaged or to remove part of the surface of the skin) pressure ulcer to left heel and Mepilex was placed on heel. -12/8/23, R1's left heel unstageable pressure ulcer measured 1.4cm in length by 1.4cm in width. Wound base was dark purple/black necrotic tissue (Necrosis is the death of tissues of the body. Necrotic tissue forms when tissue is not getting enough blood as a result of circumstances like injury, infection, or chemical exposure. The resulting damage cannot be reversed). Betadine applied and Mepilex dressing placed on left heel. -12/22/23, R1's left heel unstageable pressure ulcer remained unchanged in measurement of 1.4cm in length and 1.4cm in width. Wound base remained dark purple/black necrotic tissue. Betadine applied and Mepilex dressing place on left heel. Review of R1's Wound Management Report revealed the following: -9/13/24, R1's left heel stage 3 pressure ulcer measured 0.5cm in length by 0.5cm in width. -9/21/24, R1's left heel stage 3 pressure ulcer measured 0.5cm in length by 0.5cm in width. -9/24/24, R1's left heel stage 3 pressure ulcer measured 0.5cm in length by 0.5cm in width. -10/4/24, R1's left heel stage 3 pressure ulcer measured 0.5cm in length by 0.5cm in width. Pressure ulcer covered entirely with slough. -10/10/24, R1's left heel stage 3 pressure ulcer measured 0.5cm in length by 0.5cm in width. Area in center of pressure ulcer was a yellow scab. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/15/24, R1's left heel stage 3 pressure ulcer measured 0.5cm in length by 0.5cm in width. Pressure ulcer covered with white scabbed area. -10/23/24, R1's left heel stage 3 pressure ulcer measured 1cm in length by 1cm in width. Necrotic tissue covered 25% of pressure ulcer. On 2/12/24, podiatry note identified the following orders: -Change dressing to R1's left heel to iodosorb for antimicrobial and exudate management. -R1's should offload left heel at all times. -R1 had declined to wear the prevalon boots, ok to wear post-op shoe to left foot. -Follow up with podiatry in one month. On 3/25/24, podiatry note identified the nursing home was unable to get iodosorb due to cost and continued with mepilex border dressing to R1's left heel. R1's left heel pressure ulcer measured 1.5cm in length by 1/7cm in width by 0.3cm in depth. The podiatry note further identified the following orders: -offloading of R1's left heel was most important to help heal. -Post op shoe only when up. -Keep left heel floated when R1 was in bed and when R1 was sitting in chair. -Follow up with podiatry in one month. On 4/22/24, podiatry note identified R1's left heel unstageable pressure ulcer measured 1.2cm in length by 1. 5cm in width by 0.3cm in depth. The podiatry note further identified the following orders: -R1 must continue to offload left heel and limit use of the post op shoe. -Continue with Mepilex dressing to R1's left heel every three days and as needed. -Follow up with podiatry in one month. On 5/20/24, podiatry note identified R1's left heel unstageable pressure ulcer measured 1cm in length by 1cm in width by 0.3cm in depth. The podiatry note further identified the following orders: -R1 to continue to offload left heel. -Continue with Mepilex dressing to R1's left heel every three days and as needed. -Follow up with podiatry in one month. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/24, podiatry note identified R1's left heel unstageable pressure ulcer measured 1cm in length by 1cm in width by 0.2cm in depth. The podiatry note further identified the following orders: -R1 to continue to offload left heel. -Continue with Mepilex dressing to R1's left heel every three days and as needed. -Follow up with podiatry in six weeks. On 8/1/24, podiatry note identified R1's left heel unstageable pressure ulcer measured 0.5cm in length by 0. 5cm in width by 0.2cm in depth. The podiatry note further identified the following orders: -R1 to continue to offload left heel. -Continue with Mepilex dressing to R1's left heel every three days and as needed. -Follow up with podiatry in one month. Review of R1's physician visit note dated 7/30/24, identified R1 had a pressure ulcer to the left heel that was being offloaded by facility nursing staff. The facility untitled, undated, care sheets identified R1's heels were to be free floated in bed and recliner-wear post op shoe when up. During an observation on 10/22/24 at 11:10 a.m., R1 was sitting in the recliner in R1's room with eyes closed, blanket on lap, feet flat on the floor with post op shoe on left foot and regular shoe on right foot. During an observation on 10/22/24 at 1:29 p.m., R1 was sitting in the recliner in R1's room looking at pictures, blanket on lap, feet flat on the floor with post op shoe on left foot and regular shoe on right foot. During an observation on 10/22/24 at 4:30 p.m., R1 was sitting in the recliner in R1's room looking at pictures, blanket on lap, feet flat on the floor with post op shoe on left foot and regular shoe on right foot. During an observation on 10/23/24 at 9:29 a.m., R1 was sitting in the recliner in R1's room looking at pictures, blanket on lap, feet flat on the floor with post op shoe on left foot and regular shoe on right foot. Registered nurse (RN)-F entered R1's room and provided pressure ulcer measurements and treatment. RN-F placed sock and post op shoe back onto R1's left foot and set R1's foot onto the floor. RN-F did not offer or attempt to offload R1's feet prior to leaving R1's room. During an observation on 10/23/24 at 11:18 a.m., R1 was sitting in the recliner in R1's room looking at pictures, blanket on lap, feet flat on the floor with post op shoe on left foot and regular shoe on right foot. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 11:51 a.m., nursing assistant (NA)-E verified R1 had a pressure ulcer to her left heel. NA-E stated R1 would complain about shoes being too tight and NA-E would remove the shoes and allow R1 to sit in recliner without shoes on. NA-E stated the care plan and care sheet identified that R1 was to wear the post op shoe for an intervention and there were no other interventions. NA-E reviewed facility care sheet with surveyor and agreed the care sheet identified R1 was to have heels free floated in bed and recliner. NA-E stated she was unaware of this intervention. During an interview on 10/23/24 at 12:47 p.m., RN-F verified R1 had a pressure ulcer to the left heel. RN-F confirmed current measurements of R1's left heel pressure ulcer completed earlier today. RN-F stated the facility policy was to update the RN Care Coordinator (RNCC) with changes to pressure ulcers. RN-F stated she did not feel the change in measurement was a concern as the pressure ulcer had been improving. RN-F stated interventions for R1 were to have a wedge under the heels while in bed so R1's heels were floating, to wear the post op shoe when up and put a pillow under R1's feet when R1 was not walking. During an interview on 10/23/24 at 12:55 p.m., RN-E the (RNCC) verified R1 had a stage 3 pressure ulcer to the left heel. RN-E stated the expectation of nursing was to measure pressure ulcers weekly and update the (RNCC) and doctor with any changes. RN-E verified nursing staff would follow the care plan interventions for R1 to promote healing/prevent worsening of pressure ulcer. RN-E confirmed R1 had a podiatry appointment on 8/1/24 with an order to follow up with podiatry in one month. RN-E was unable to verify why R1 lacked a follow up podiatry appointment. Follow up observation/interview at 1:47 p.m., RN-E entered R1's room. R1 was sitting in the recliner with feet flat on the floor with post op shoe on left foot and regular shoe on right foot. RN-E measured R1's left heel pressure ulcer: 1cm in length by 1.3cm in width. RN-E verified the pressure ulcer had 25% black necrotic tissue present and a hard yellow scab crusted area. RN-E stated a podiatry appointment for R1 would be made and RNCC would update the primary doctor. On 10/23/24 at 2:06 p.m., a voice message was left for R1's podiatrist by surveyor. During an interview on 10/23/24 at 2:10 p.m., R1's primary medical doctor (MD) confirmed R1 had a stage 3 pressure ulcer to the left heel managed by podiatry. MD stated the expectation that facility nursing staff update MD and podiatry with changes. MD confirmed the expectation that nursing staff would update when not following care plan interventions and podiatry orders of offloading R1's heels. MD verified it was important for nursing staff to update the MD and podiatrist on changes so treatment may be adjusted and prevent decline or infection. During an interview on 10/23/24 at 2:34 p.m., director of nursing (DON) verified R1 had a facility acquired stage 3 pressure ulcer. DON confirmed the expectation of nursing staff to update family and R1's providers of changes in order to make treatment changes and care plan updates. DON verified this was important to promote healing and prevent infection. A facility policy for pressure ulcers was requested, however was not provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48740 Based on observation, interview, and document review, the facility failed to identify the root cause of falls, implement appropriate interventions and follow care planned interventions for 2 of 3 residents (R 29, R127) who had multiple falls in the facility. Findings include: R29 R29's quarterly Minimum Data Set (MDS) assessment dated [DATE], identified R29 had diagnoses that included hypertension, Diabetes Mellitus, and dementia. Indicated R29 had mildly impaired cognition. Indicated R29 required maximal assistance with toileting, moderate assistance with dressing and hygiene, and assistance with transfers. R29 utilized a walker and a wheelchair. Identified R29 had fallen since admission with injury. R29's significant change Care Area Assessment (CAA) dated 2/29/24, identified R29 had delusional disorder, alcohol abuse, and a history of falling. Indicated R29 was at risk for falls due to her impaired mobility, cognition, psychotropic medication use, and incontinence. Resident required one assist with transfers. R29 had attempted self-transfer and has had falls in the past. Recent fall with hip and wrist fracture. Due to R29's cognition, R29 did not remember to wait for assistance. R29 required assistance with transfers and toileting. R29 had past falls with hip and wrist fractures. R29 was at risk for urinary incontinence due to impaired cognition and impaired mobility. R29 required one assist with toileting. Staff were to offer toileting every two hours and as needed. Fall interventions in place included; assuring room was free of clutter and obstacles, call light within reach, encouraged to use the call light to request assist with mobility, carpet to floor, frequently used items within reach, staff to staff with when in the bathroom, encouraging gripper socks when not wearing shoes, hourly rounding, and skid strips in front of the toilet. R29 required assistance with transfers and toileting. R29 had past falls with hip and wrist fractures. Review of R29's most recent care plan revised 10/22/24, revealed the following interventions: Offer and assist to the bathroom every two hours and as needed (PRN), Dycem (anti-slip material) underneath the TABS alarm pad and on the top of the alarm pad in the wheelchair to decrease sliding, blood pressure monitoring in the morning for five days and review with the provider, auto-lock brakes on wheelchair, bed, wheelchair, recliner TABS alarms to alert staff to her movements, gripper strips placed on the floor alongside bed and in front of the recliner, bathroom door alarm to alert staff when self-transferred into the bathroom, sign on bathroom door saying please use the walker as a reminder, call light within reach, encourage use of call light to request assistance with mobility, carpet to floor in room, check room before leaving to ensure call light, water, phone, TV remote, etc. is in reach, assure room was free of clutter and obstacles, do not leave alone in the bathroom, encourage resident to wear gripper socks when not wearing shoes, hourly rounding, skid strips to the bathroom in front of toilet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R29's care sheet, untitled, undated, identified R29 was to be toileted with assist of one staff with front front-wheeled walker every two hours and as needed (PRN). Indicated to not leave alone in the bathroom. Review of R29's fall incident reports dated 7/27/24, to 10/17/24, revealed the following: - Unwitnessed fall on 7/27/24 at 2:30 p.m., R29 fell in the bathroom while attempting to self-transfer. R29 was found kneeling in front of the toilet; resident on their elbows on the toilet with pants down. R29 was clean and dry. The call light and tab alarm had activated. R29 was unable to tell writer how she got there but communicated that her knees hurt. No footwear on at time of fall. Pain stopped after getting off the floor. Incision area redressed with no pain or drainage noted. The report lacked the time R29 had been toileted last. Interventions were to ensure R29 did not remove gripper socks and review the bathroom door alarm report to see if there were any consistent times the resident was toileting. The report lacked any new interventions added R29's care plan. - Witnessed fall on 8/12/24 at 9:26 a.m., R29 fell in the bathroom while self-transferring and refused staff assistance. The last time toileted was at 7:13 a.m., 13 minutes after the two hour toileting plan. R29 was incontinent of stool. R29's blood pressure (BP) was 87/50. Intervention was a new order from the nurse practitioner to hold Lisinopril (medication for high blood pressure) for two weeks and then follow up with the nurse practitioner. The report lacked revisions or changes made to the care plan related to the every two hour toileting plan. - Unwitnessed fall on 10/5/24 at 6:40 a.m., R29 was found lying on her left side with pants and brief pulled down. Incontinent of urine. TAB alarm on bed was going off. [NAME] off to the side of pt. Gripper socks on. The report identified R29 had last been toileted at 4:00 a.m. Stated she was going to use the bathroom. In addition, R29 stated she slipped all over. R29 complained of pain in lower back and left hip. BP 111/55 initially then 79/46 upon sitting in wheelchair. Pt unable to stand for standing BP. Required assist of three staff to get up off floor. Heart rate (HR) 50 initially then 52 in wheelchair. Sent to emergency room (ER) per provider Dr. [NAME]. - Unwitnessed fall on 10/17/24 at 6:00 p.m., R29 fell in the resident's room out of her wheelchair. The call light was on, gripper socks were on. Attempting to self-transfer. The last time toileted was at 3:00 p.m. Incontinent of urine and stool. Intervention placed for a Dycem to the wheelchair on top of the tab alarm and continue with every two-hour toileting and as-needed toileting. Review of R29's incident reports lacked new interventions to the care plan related to revising the toileting plan as needed to reduce the likelihood of further falls. Review of R29's progress notes dated 7/27/24, through 10/18/24, revealed the following: - 7/27/24 at 2:48 p.m., resident had an unwitnessed fall at 1430. Found kneeling in front of toilet with pants down. Complained of pain in knees but went away after getting off floor. Incision looked good. Some redness to bilateral knees. No pain. Stated she did not hit head. Neuros range of motion (ROM) and vital signs (VS) within normal limits (WNL). Currently resting in bed. (continued on next page)

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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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 8/1/24 at 11:20 a.m., interdisciplinary team (IDT) note identified R29 self-transferred to the bathroom and was not able to tell the staff why. Was continent at the time, was barefoot and may have slipped on the floor. Pintail intervention was to apply the gripper socks and to run the bathroom door alarm report. It was identified the alarm had been on for seven minutes which included the time staff assisted R29 off the floor. Staff would review the report to see if there was any consistent times with toileting. - 8/12/24 at 9:26 a.m., nurse called to R29's room as R29 refused gait belt/help from staff. R29 fell while transferring to toilet, staff present, did not hit head. No injuries noted, Blood pressure slightly low. Neuros (neurological vital signs) within normal limits. Strength within normal limits. Incontinent of bowel movement at the time of the fall. - 8/14/24 at 11:27 a.m., IDT note identified R29 refused staff assitance with applying the gait belt to her while transferring her. In addition, R29's BP was noted to be low. Initial intervention was for staff to monitor BP for five days and report results to provider. - 8/20/24 at 12:29 p.m., new orders obtained from provider to hold lisinopril (medication used to reduce BP), and review BP's in two weeks. - 10/5/24 at 7:17 a.m., staff heard R29 yelling into hallway at 6:40 a.m. Upon entering room, R29 was lying on the floor on left side with brief and pants around ankles. Pt was incontinent of urine. BP 111/55 while on floor then 79/46 when in wheelchair. Heart rate 50 on floor 52 in wheelchair. R29 complained of pain in left hip and lower back. R29 was wearing gripper socks. TAB alarm was going off for bed. Placement of walker suggests R29 used incorrectly. Called provider on call. New orders as follows: Send to ER for eval due to fall. R29 aware and went to ER. - 10/5/24 at 10:26 a.m., resident fall reviewed with direct care staff. Current interventions include carpet to room with gripper strips along bed and in front of recliner and toilet. Do not leave alone in bathroom, bathroom door alarm, wheelchair with auto lock breaks, tabs to bed, wheelchair and recliner, hourly rounding and sign in bathroom to please use walker. Current toileting was every two hours and as needed. Will pace a five-day bowel and bladder tracker to determine if she may benefit from a toileting plan. - 10/5/24 at 1:27 p.m., R29 admitted to Fargo due to L1 compression fracture. - 10/5/24 at 2:40 p.m., IDT note identified resident self-transferred in her room, most likely attempting to the bathroom as she was incontinent of urine. Brief and pants were down around her knees most likely causing the fall. Initial intervention was reviewed normal daily routine with direct care staff. Initiate bowel and bladder tracker to determine new toileting habits upon return from the hospital. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 10/8/24 at 6:25 p.m., resident returned from the hospital today following a Keyholes to her lumbar spine. R29 transfers with one assist and a walker. She moves slowly and is unsteady. R29 has orders for physical therapy, occupational therapy (PT/OT) to evaluate and treat. She has carpet on the floor in her room. She is currently wearing gripper socks. There are gripper strips on the floor in front of her recliner and one gripper strip by her bed. There are no gripper strips on the floor in front of her toilet. Maintenance request put in to have the gripper strips put down in front of the toilet and more gripper strips put by the bed. She has a history of self-transferring. She has TABS alarms on her bed, recliner and wheelchair. There is an alarm on her bathroom door to alert staff when she self-transfers to the bathroom. She has auto lock brakes on her wheelchair. She has a manual recliner which she did not sit in today. R29 wants to use the side rails on her bed because she says she likes to grab onto them. R29 has two call lights. One is a box on her rolling table and the other is a regular call light cord on her bed. She is able to activate them with cueing and encouragement. However, she does not remember to use them when she needs assistance. R29 on hourly rounding so staff can anticipate her needs. Staff remain with her when she is on the toilet. They offer toileting every two hours, but she will refuse to go at times. A bowel and bladder tracker was started due to her recent fall. She has a Roam Alert bracelet on her left wrist. R29 has been very confused and tearful since she returned. - 10/17/24 at 8:22 p.m., R29 was attempting to stand, and she slid from her wheelchair onto the floor. R29 had a scratch on her left side from the wheelchair. She is currently in her bed resting without any pain at this time. - 10/18/2024 11:47 a.m., Reviewed bowel and bladder tracker that was just completed. There was insufficient information to determine a toileting plan. Staff will continue to offer toileting every two hours and PRN. Review of R29's ER provider notes dated 10/8/24 , revealed the following: - Associated symptoms include abdominal pain. Fall at nursing home (NH)- moderate dementia and poor historian. Complained of back pain. Impression: Acute mild to moderate anterior wedge compression fracture of L1. No retropulsion (displacement of a vertebral fracture fragment into the spinal canal.) Review of R29's discharge summary on 10/8/24, revealed the following: - [AGE] year old female with dementia, hypertension cardiac disease, complaining of back pain after fall. During evaluation, patient confused. Not oriented. Did not remember falling. Did not remember having any back pain or abdominal pain. Did not remember any other symptoms. Patient admitted with status post fall with closed compression fracture of L1 vertebra. CT (computerized tomography): acute mild to moderate anterior wedge compression fracture of L1. No discrete acute thoracic fracture, however, evaluation is limited by osteopenia (reduced bone density). MRI (magnetic resonance imaging) lower spine shows acute mild anterior wedge compression fracture of L1. Neurosurgery recommended kyphoplasty. Status post kyphoplasty on 10/7/24. Patient hemodynamically stable for discharge. Continue with PT/OT. During an interview on 10/23/24 at 11:26 a.m., nursing assistant (NA)-D indicated R29 was every two-hour toilet and could not be left alone in the bathroom. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 11:04 a.m., NA-C indicated staff were supposed to offer the toilet every two hours. During an interview on 10/23/24 at 1:32 p.m., NA-A stated nursing assistants would communicate with the nurse when R29 refused to toilet. Nursing assistants documented when a resident had been toileted on a toileting sheet. Nursing assistants would bring the toileting sheets to the nurse's station and the registered nurse care coordinator (RNCC) would review the sheets. NA-A indicated R29 required every two hour repositioning and staff would offer toileting at that time. Staff were expected to walk by her room every hour to check on R29. If R29 was sleeping, staff would let her sleep, and would offer toileting when she was restless. During an interview on 10/23/24 at 1:16 a.m., licensed practical nurse (LPN)-A indicated R29 had had a fall with an injury on 10/5/24. The facility was expected to put a new intervention in place after each fall. LPN-A was unable to verify what the new intervention was put in place after the 10/5/24 fall. During an interview and document review on 10/23/24 at 8:38 a.m., registered nurse (RN)-E indicated the facility process was for the RNCC to put in a note in the electronic health record (EHR) after a resident fall occurred. RN-E stated R29 was on an every two-hour toileting plan and R29 would refuse at times. The facility did not have a process in place for nursing assistants to document when a resident refused toileting. RN-E indicated when R29 would self-transfer, there was a door alarm and alarms on the chair and bed to alert staff. Review of the facility incident reports with RN-E revealed the following: The fall on 7/27/24, staff noted the bathroom door alarm was sounding and R29 was found on the floor. RN-E was unable to verify when R29 had last been toileted. A bathroom alarm door report was completed after the fall on 7/27/24. No new interventions were put in place after RNCC reviewed the alarm door report and the every two hour toileting plan remained on the care plan. On 8/12/24, R29 fell while staff were assisting R29 to the bathroom at 9:26 a.m. R29 had last been toileted at 7:13 a.m. R29 was toileted 13 minutes after the two-hour toileting time. R29's blood pressure was noted to be low when R29 fell , the provider held R29's Lisinopril for two weeks and blood pressures were monitored. The Lisinopril was later discontinued by the provider. No new toileting interventions were placed on the care plan and the every two hour toileting plan remained in place On 10/5/24, R29 self-transferred to the bathroom and was found on the floor. R29 was found with brief down and was incontinent of urine. R29 had last been toileted at 4:00 a.m., 40 minutes past the every two hour toileting schedule that was in place. R29 was hospitalized with a compression fracture as a result of the fall that occurred. The interdisciplinary team (IDT) reviewed all the interventions to ensure they were still appropriate. RNCC put out a five-day bowel and bladder assessment to be completed after R29 returned from the hospital. After the review, RN-E stated R29 remained on the every two-hour toileting plan. RN-E stated the fall on 10/17/24, the bowel and bladder tracker had been reviewed and it was decided that the every two-hour toileting plan continued to be an appropriate intervention. In addition, a Dycem (a non-stick rubber-like material that could be used to stabilize surfaces) was placed in R29's wheelchair. 37905 R127 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R127's face sheet identified R127 was admitted to the facility on [DATE], and had diagnoses which included: dementia, delirium, history of falling and posterior displaced Type II dens fracture (cervical fracture). R127's John Hopkins Fall Risk Assessment Tool dated 10/16/24, identified R127 was high risk for falls and had a history of falls prior to admission. R127's Fall-Prevention Analysis Tool, dated 10/16/24 identified R127's trends of prior falls- were at assisted living, getting out of bed. R127 received new at risk medications including oxycodone (opioid), Trazodone (antidepressant), Zoloft (antidepressant), and Seroquel (antipsychotic). Interventions initiated at that time were hourly rounding, TABS, and wander guard. R127's care plan revised 10/23/24, identified R127 was at risk for falls related to impaired cognition, impaired mobility, altered balance, incontinence, and diagnoses of history of falls, weakness, seizures, and pain. R127's interventions included assure room was free of clutter and obstacles, call light within reach, carpet to floor in room, encourage resident to wear gripper socks when not wearing shoes, hourly rounding, skid strips to bathroom in front of toilet, and TAB alarm to bed and wheelchair to alert staff of R127's needs when not using call light, with additional interventions added 10/22/24 and 12/23/23. R127's care plan also identified R127 had mobility and activities of daily living (ADL) deficit with interventions which included C-collar as R127 allowed, assistance with transfers, bathing, dressing, hygiene and toileting. R127 had a terminal condition with prognosis of less than six months to live with hospice as ordered. The facility untitled, undated, care sheet identified R127's safety interventions included TAB on w/c, recliner, bed, roam alert, and hourly rounding. During an observation on 10/21/24 at 1:36 p.m., R127 was in his wheelchair in his room, dressed in street clothes, and had removed his gripper socks, which he held in his hands, then placed on bedside table. Bare feet on floor, smiling, talking nonsensical to surveyor. Nursing assistant (NA)-A knocked and entered room, stated R127's TAB alarm was going off, and assisted R127 to reposition in his wheelchair, then left room, without re-applying R127's gripper socks, which continued to lay on his bedside table. During an observation on 10/21/24 at 4:51 p.m., R127 was laying on dining room floor, wheelchair next to him with staff members around him. Emergency medical services (EMS) staff arrived, and R127 hollered out, and moved legs and arms, while EMS staff were assisting R127 to a sling, then onto a stretcher. During an observation on 10/22/24 at 9:02 a.m., R127 was laying in bed covered with blankets and no shirt, with a high back Broda wheelchair next to the foot of the bed. R127's eyes were closed, the door was open, lights were off. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/22/24 at 1:20 p.m., two staff members were in R127's room, one was leaving, the other staff member was showing R127 how to use the call light. R127 had a C collar around his neck, was dressed in street clothes sitting in the Broda wheelchair, with feet elevated, a pillow under his knees and one on his lap. R127 was alert, and the television was on. At 1:44 p.m. R127 was lying on the floor partly in his doorway, a pillow was under his head and RN-H was in his room taking R127's vital signs. R127's wheelchair was between him and the bed. At 1:51 p.m. RN-H, NA-A and NA-C assisted R127 off the floor with the Hoyer lift, and transferred R127 to bed. RN-A entered room, and began asking questions about the fall to the staff members in the room, while RN-H completed an assessment of R127. R127 denied any pain at that time, and did not express signs of pain or discomfort. Review of R127's incident reports from 10/17/24 to 10/22/24, revealed the following: -on 10/17/24 at 9:00 p.m., R127 was found lying on the floor in front of the bathroom door in his room at the foot of the bed. R127's wheelchair TAB alarm went off. R127 unable to communicate what led to the fall. No injuries. Bed TAB alarms set and placed, call light within reach. -on 10/18/24 at 11:55 p.m., trained medication aide (TMA) walked by R127's room as TABS alarm went off, R127 was standing in doorway when lost balance and fell to the floor as witnessed by TMA. Abrasion to left upper back. Place wheelchair by bed when in bed. -on 10/19/24 at 10 p.m., R127 unwitnessed fall, R127 type of fall- out of bed, slid out of chair, no injuries. R127 assisted to bed. -on 10/21/24 at 4:40 p.m., R127 found face down on dining room floor, gripper socks in place. R127 hit head on the floor and left shoulder noted to be painful to touch. R127 did not tolerate being moved by staff, EMS contacted to assist with getting R127 off floor. R127 transported to emergency department. -on 10/22/24 at 1:45 p.m. unwitnessed fall, in R127's room, fell out of wheelchair. Review of R127's incident reports from 10/17/24, to 10/19/24, lacked documentation of a comprehensive assessment. Review of R127's progress notes from 10/16/24 to 10/22/24, identified the following: -10/17/24 at 6:11 a.m., R127 attempted to self transfer and was found on floor in room laying in front of the bathroom/sink area around 9:00 p.m. No injuries, bed TAB alarms set and in place. -10/19/24 at 5:56 a.m., TMA walked by R127 room as TABS went off, was standing in doorway when lost balance and fell to floor, witnessed by TMA. Abrasion to left upper back, no other injuries. -10/19/24 at 10:00 p.m., R127 slid out of chair, aides assisted and placed in bed, sleeping well. -10/20/24 at 6:23 a.m., R127 awake since 2 a.m. with terminal restlessness. Refused Seroquel, took morphine (opioid), continues to self transfer and refuse cares from staff, will continue to re-approach and notify day staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/21/24 at 12:49 p.m., interdisciplinary team (IDT) reviewed falls from 10/1724, 10/18/24, and 10/19/24. On 10/17/24, R127 found on floor in front of bathroom door by bathroom sink, staff responded to TAB alarms, did not have call light on. R127 last toileted at 8 p.m. On 10/18/24, staff walked by room as tabs alarm went off and found standing in doorway when lost balance and fell . On 10/19/24, slid out of chair at 10:00 p.m. Any further root cause analysis: poor cognition, safety awareness, weakness, need for assistance with ADLs and hospice. Initial interventions implemented, staff to assist to bed around 8:30 p.m. Has the intervention been effective? yes. -10/21/24 at 1:13 p.m., John Hopkins Fall Risk and Fall Prevention Analysis Tool Observation reviewed by IDT. High fall risk, previous falls at assisted living when getting out of bed. Current fall interventions include upon admission silent tab alarms to bed/wheelchair and recliner, carpet flooring, gripper strips in front of toilet, gripper socks when not wearing shoes and keeping frequently used items in reach. Previous falls reviewed by IDT and staff to assist to bed around 8:30 p.m. Care plan updated. -10/21/24 at 5:02 p.m., Staff heard R127 fall in dining room, was laying on the floor with his left arm/shoulder behind him did not hit head. R127 guarding left arm and shaking. R127 did not tolerate being moved by staff and unable to get Hoyer (mechanical lift) sling in place. EMS contacted to assist with getting R127 from floor. Hospice updated, who stated to give dosage of morphine and they would send someone to evaluate. EMS placed C collar on R127 and transported to emergency department. -10/21/24 at 9:20 p.m., R127 returned from emergency department at 7:00 p.m., new orders: other interventions for fall, tilt Broda wheelchair. Family wish to not seek treatment and utilize comfort measure. -10/22/24 at 2:13 a.m., R127 restless, continued to attempt to remove neck brace, attempted self transfer out of bed (OOB). Transferred to commons area via wheelchair. Given snack, call placed to hospice, ok per family to remove neck brace for comfort and alleviate agitation. -10/22/24 at 4:24 p.m., one time only occupational therapy (OT) evaluation completed. Provided R127 with auto-lock manual wheelchair, which allowed R127 to self propel using lower extremities, if desired with supervision. OT also placed Dycem (non-slip material) under wheelchair cushion to prevent R127 from sliding. Arms also elevated to provide extra comfort/support and prevent leaning. OT informed nursing of changes via e-mail and also encouraged staff to reach out if further questions or concerns. -10/22/24 at 6:59 p.m., R127 laying in doorway of room, on left side. R127 was previously in Broda chair. No injuries noted, assisted off floor with Hoyer lift and placed in bed. One to one provided by staff at this time. Review of R127's progress notes from 10/16/24 to 10/22/24, identified the following. -On 10/17/24, R127's Progress Notes lacked documentation of a comprehensive assessment and a review or adjustment of the current fall preventions interventions. -On 10/18/24, R127's Progress Notes lacked documentation of a comprehensive assessment and a review or adjustment of the current fall preventions interventions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--On 10/19/24, R127's Progress Notes lacked documentation of a comprehensive assessment and a review or adjustment of the current fall preventions interventions. -On 10/21/24, during IDT review a root cause analysis indicated R127 had falls on 10/17/24, 10/18/24, and 10/19/24, related to poor cognition, safety awareness, weakness, and need for assistance with ADLs and hospice. The analysis further indicated falls occurred from both bed and chair. Staff to assist to bed around 8:30 p.m. The note lacked further analysis of R127's falls and indicated interventions were effective. -On 10/21/24, and 10/22/24, R127 had additional falls. During interview on 10/22/24 at 2:03 p.m., TMA/NA-C stated the Broda was a new wheelchair for R127 after R127 fell last evening. NA-C indicated she had observed R127, then within two minutes R127's tab alarm was going off, and found him on the floor. NA-C indicated they had last checked and changed R127 at 11:45 a.m. before lunch, then when brought back to his room had repositioned him and he was dry at that time. NA-C stated R127's fall interventions were the TAB alarms in bed and wheelchair, hourly rounding and indicated she checked on him more frequently. NA-C stated R127 often refused his medications, and felt that may have also contributed to R127's falls. NA-C stated resident interventions were listed on the facility care sheets, and if NA-C had questions, she would ask the nurse. During an interview on 10/22/24 at 2:13 p.m., RN-H stated had been notified of R127's fall so completed an assessment. RN-H indicated was not very familiar with R127, so was unaware of current fall prevention interventions in place. RN-H stated was aware R127 had fallen yesterday, and had TAB alarms in place. During an interview on 10/22/24 at 2:24 p.m., NA-A stated was present when R127 fell yesterday, and hospice had ordered the Broda wheelchair for R127, which was new that day. NA-A stated R127's fall interventions included TAB alarms, hourly checks, and bed in low position. During an interview on 10/23/24 at 11:46 a.m. clinical coordinator RN-A reviewed R127's falls with surveyor. RN-A stated hourly rounds and TAB alarms were initiated when R127 was admitted due to history of falls prior to admission. RN-A indicated R127's fall on 10/17/24, included a new intervention to assist R127 to bed around 8:30 p.m. R127's fall on 10/18/24, did not identify new interventions. R127's fall on 10/19/24, did not identify new interventions. RN-A stated R127's root cause for those three falls was poor cognition, safety awareness, and weakness. RN-A stated she was not a part of the IDT meetings to review R127's falls, and confirmed the IDT fall review on 10/21/24 identified R127's interventions were effective. RN-A indicated felt R127's interventions were not effective, since R127 fell again on 10/21/24, and 10/22/24. RN-A verified the new intervention for R127 to be assisted to bed around 8:30, was not included on the facility care sheets, which were updated and printed daily. RN-A also reviewed R127's care plan and confirmed no additional fall interventions were in place. RN-A indicated hospice had been involved in R127's falls and had recently adjusted medications, and added the Broda wheelchair. RN-A stated R127 fell from the Broda wheelchair yesterday, so they now got OT involved who initiated a new wheelchair with anti-lock breaks. RN-A stated she had also now added a perimeter mattress for R127. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 12:24 p.m., director of nursing (DON) stated the usual facility practice for fall prevention included on admission a fall risk assessment to be completed, then if moderate or high risk, they completed the Fall Prevention Analysis Tool which was reviewed the by the IDT team huddle meeting, to determine if immediate interventions put in place by the nurse were appropriate. DON indicated her expectations was when a resident fell , the nurse assessed the resident for injuries, and discussed with team what precipitated the fall and what interventions to put in place. DON indicated the IDT team reviewed the falls the next day to evaluate the documentation of the fall, interventions in place, and to brainstorm for additional interventions. DON stated R127's IDT fall review meeting on 10/21/24, included to add assisting R127 to bed at 8:30 p.m. which was then added to the care plan. DON confirmed the IDT meeting on 10/21/24, documented the interventions in place were effective, but then indicated they answered the question when the new intervention was put in place, so it was not a good response to assume it was effective. DON indicated the root cause of R127's falls was cognition, and indicated R127 required more supervision, which they had implemented last evening after R127's last fall, with one to one staff supervision. DON indicated the facility would continue one to one supervision until R127 was more settled to the facility, and they were now reviewing R127 for possible pain as well. During a follow-up interview and document review on 10/23/24 at 12:58 p.m., DON verified that the care plan identified R29 was to be toileted every two hours. Each incident report was reviewed with the DON. DON reviewed the fall from 7/27/24 at 2:30 p.m., and was not able to verify when R29 had last been toileted. The 7/27/24 incident report lacked documentation of when R29 had last been toileted. DON reviewed the fall from 8/12/24 at 9:26 a.m. The report identified the last time R29 had been toileted was at 7:13 a.m., R29 was toileted 13 minutes after the two-hour toileting time. Bowel and bladder assessment reviewed and no changes were made to the care plan related to toileting needs. DON verified the 10/5/24 fall that R29 continued to be on an every two-hour toileting plan. R29 had last been toileted at 4:00 a.m., and R29 fell at 640 a.m. DON verified that R29 should have been toileted at 6:00 a.m. DON verified on 10/5/24 resident was 40 minutes over due to be toileted. No changes were made to the toileting plan after the fall. DON verified R29's fall on 10/17/24 at 6:00 p.m., was 60 minutes overdue. Dycem in wheelchair was put in place right after the fall, as R29 fell from wheelchair. DON stated R29 did refuse toileting at times and stated the facility did not have a process to document that. The facility policy titled Fall Prevention And Follow Up dated 8/7/24, identified the purpose to prevent falls and/or reduce the total number of falls. The policy identified a pre-admission screen for [TRUNCATED]

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	10/23/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583 Based on observation, interview and document review, the facility failed to maintain the water and ice machines in a sanitary manner to prevent potential contamination for 69 residents who currently received water and ice from the ice machines. In addition, the facility failed to maintain the coffee machine on the Meadow [NAME] unit in a sanitary manner to prevent potential contamination for the residents who currently used the coffee machine. Findings include: On 10/21/24 at 11:49 a.m., an initial tour was conducted on all units and the following concerns were identified: -The water and ice machine located outside the main dining room on the Meadow [NAME] unit was observed to have an encrusted hard white flaky substance build up under the ice and water dispenser. The tip of the ice dispenser had an encrusted hard white flaky substance around the inside and the outside of the ice dispenser. The grate inside of the tray of the ice machine had an encrusted hard white flaky substance build up on top of the grate where the ice and water came out. -The coffee machine located outside of the main dining room on the Meadow [NAME] unit was observed to have an encrusted hard white flaky substance build up on the center nozzle where the hot water was dispensed. -The sink located outside the main dining room on the Meadow [NAME] unit observed to and encrusted hard white flaky substance build up covering the entire sink and facet. -The water and ice machine located outside the main dining room on the Harbor Springs unit was observed to have an encrusted hard white flaky substance build up under the ice and water dispenser. The tip of the ice dispenser had an encrusted hard white flaky substance around the inside and the outside of the ice dispenser. The grate inside of the tray of the ice machine had an encrusted hard white flaky substance build up on top of the grate where the ice and water came out. -The water and ice machine located outside the main dining room on the Cedar Ridge unit was observed to have an encrusted hard white flaky substance build up under the ice and water dispenser. The tip of the ice dispenser had an encrusted hard white flaky substance around the inside and the outside of the ice dispenser. The grate inside of the tray of the ice machine had an encrusted hard white flaky substance build up on top of the grate where the ice and water came out. During observations on 10/21/24 at 4:55 p.m. and 6:08 p.m., the water and ice machines continued to have an encrusted hard white flaky substance build up on them. The coffee machine continued to have an encrusted hard white flaky substance build up on the center nozzle. The sink continued to have an encrusted hard white flaky substance build up covering the entire sink and facet. (continued on next page)

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	10/23/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 10/23/24 at 8:01 a.m., dietary supervisor (DS) confirmed the above findings and indicated the encrusted hard white flaky substance build up was lime scale and it had been an issue for awhile. DS stated the ice and water machines all needed to be cleaned to remove the build up. During a follow-up interview on 10/23/24 at 8:13 a.m., DS indicated the coffee machine was cleaned but the sink and ice machines still needed to be cleaned. DS stated there were weekly cleaning schedules but it did not include de-scaling the ice and water machines, sink or coffee machine. During an interview on 10/23/24 at 1:48 p.m., dietary manager (DM) confirmed the above findings and indicated she was aware there was a lime scale build up on the sink. DM indicated she was not aware of the lime scale build up on the coffee machine. DM stated she would need to talk to the ice and water machines service provider to help get them cleaned. Review of facility policy titled, Cleaning & Sanitation, dated 7/22, indicated equipment and utensils used in food preparation, storage, and service would be cleaned and sanitized to prevent the transmission of disease organisms to consumers. The facility indicated the coffee maker manufacturer was Folgers and all ice and water machines were Hoshizake America Inc. The facility was not able to locate manufacturer's manuals for any machine.