| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245212 | A. Building<br>B. Wing | 12/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Essentia Health Oak Crossing | 1040 Lincoln Avenue<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to consistently follow provider's orders for one of five residents (R1) investigated for unnecessary medication. Findings Include: R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 was cognitively intact and had diagnoses which included: heart failure, respiratory failure, anxiety and depression. R1's MDS identified R1 received diuretics (medication to help remove excess fluids). R1's care plan revised 12/3/25, identified R1 was at risk for cardiac complications related to history of respiratory failure and diagnoses of congestive heart failure (CHF), atrial fibrillation (A-Fib, irregular heart and often rapid heart rhythm) and hypertension (HTN, high blood pressure). Approaches identified R1 sometimes refused to have my weight obtained, monitor for signs and symptoms and monitor vital sign as per protocol or as ordered. R1's Physician Order Report signed 11/28/25, included the following:-Daily Weights for heart failure, start date 11/10/25 Review of R1's Medication Administration Record dated 11/10/25 to 11/30/25, identified the following:-Daily Weights for heat failure-11/10/25, not administered: other comment: weight was inaccurate, we will reweigh tomorrow-11/12/25, not administered: resident unavailable-11/13/25, not administered: resident unavailable-11/15/25, not administered: other-11/17/25, not administered: other comment: not obtained-11/18/25, not administered: other comment: staff unable to attain-11/19/25, not administered: other-11/20/25, not administered: other comment: not obtained-11/22/25, not administered: other comment: -11/24/25, not administered: other-11/25/25, not administered: other comment: -11/26/25, not administered: other comment: -11/27/25, not administered: other-11/28/25, not administered: other comment: unable to obtain-11/29/25, not administered: refused-11/30/25, not administered: refusedR1's weights were not obtained sixteen out of twenty-one days as ordered. Review of R1's Medication Administration Record dated 12/1/25 to 12/3/25, identified the following:-Daily Weights for heat failure-12/1/25, not administered: refused-12/2/25, not administered: refusedR1's weights were not obtained two out of three days as ordered. Review of R1's progress notes 11/10/25 to 12/2/25, identified the following:-11/10/25-routine visit by nurse practitioner (NP)-A, orders received for daily weights-11/10/25-will pass along to get accurate reweigh tomorrow, R1 showed weight loss todayR1's medical record lacked further documentation related to R1's missed weights, education to R1 for risks verses benefits, or notification to NP-A of missed weights. During interview on 12/2/25 at 4:15 p.m., R1 indicated was fine with them doing daily weights and had not refused. R1 stated weights were probably needed because of her heart medications. During interview on 12/3/25 at 9:24 a.m., nursing assistant (NA)-A indicated she was not assigned to work with R1 this a.m. NA-A stated R1 did not complain and R1 had a good mood. NA-A indicated the nurses gave them a list every morning on who required weights and shown surveyor the daily list for weights they kept at the desk. R1 was on the list for weights that morning. During interview on 12/3/25 at 9:54 a.m., licensed practical nurse (LPN)-A stated usually did not work with R1. LPN-A indicated the nurses gave the list of those who needed weights every morning during report. At 10:00 a.m. LPN-A stated she had educated the nursing assistants to obtain R1's weight and spoke to R1 also. LPN-A reviewed R1's weighs on R1's electronic medical record and verified R1 had several days her weights were not<br>(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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | obtained. LPN-A stated was not aware why R1's weights had not been obtained, but indicated they were important to complete because R1 had heart conditions, and they needed to monitor R1's weights for possible fluid buildup. During interview on 12/3/25 at 10:04 a.m., registered nurse (RN)-A verified R1 had multiple weights missed, and indicated her expectation would be that the weights would be completed as ordered. RN-A stated that if weights were not done daily, would expect the provider to be notified. RN-A indicated it was important to monitor R1's weights to monitor her fluid status related to her CHF. During interview on 12/3/25 at 10:31 a.m., director of nursing (DON) verified R1 had multiple weights not completed as ordered. DON stated it was important to complete R1's weights because of her CHF, and to make sure R1 was not retaining excess fluid. DON indicated would expect nursing staff to contact the provider if the weights were not being completed. During a telephone interview on 12/3/25 at 10:46 a.m., NP-A indicated she had ordered daily weights for R1, because R1 had heart failure. NP-A indicated would expect facility to contact her for any weight gain of three pounds in one day, or five pounds in a week. NP-A stated would expect the facility to contact her if R1's weights were not being completed and why. NP-A indicated daily weights were important to be completed so could dose heart medications and diuretics. The facility policy titled Activities Of Daily Living (ADLs) standards Of Care dated 9/10/25, identified the RN was responsible to communicate the plan of care and changes to the care team. The policy further identified weights were required monthly, and for accurate weight recording, utilize the same scale for routine weights. The facility policy titeld Notification Of Change dated 9/15/25, included the nurse to educate the resident and/or representative about the proposed plan to treat, manage or monitor the resident's change in condition, risks and benefits of the proposed treatment change and provide an opportunity for the resident to make an informed choice of the treatment or alternative they prefer. Communicate the resident's preferences to the provider if it differs from the provider's proposed plan. Update the resident's care plan, transcribe and implement the provider's orders. |