STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essentia Health Homestead	115 10th Avenue Northeast Deer River, MN 56636

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 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and document review the facility failed to develop policies and procedures for when to report a suspected crime to law enforcement. This had the potential to affect all residents residing in the facility.Findings include:The facility Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy dated 11/24, identified local law enforcement would be notified of any reasonable suspicion of a crime against a resident in the facility. the policy included reporting a suspected crime and/or alleged sexual abuse must be immediately reported to local law enforcement to be investigated; however, lacked further examples of crimes that should be reported.During interview on 7/30/25 at 4:19 p.m., the director of nursing (DON) stated the facility abuse policy identified allegations of drug diversion should be reported to the state agency within 24 hours of suspicion and should be reported to MN Board of Nursing. The DON did not recall what the policy identified regarding what suspected crimes should be reported or when they should be reported to law enforcement (LE).During interview on 7/30/25 at 5:23 p.m., the administrator stated she was uncertain what crimes should be reported to LE . The facility abuse policy identified allegation of drug diversion should be reported to the state agency within 24 hours of suspicion. The administrator stated the abuse policy was vague and failed to identify examples of crimes that should be reported to LE and the timeframe for reporting those crimes. The administrator stated the policy needed to be reviewed and be more detailed.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to report allegations of drug diversion to the state agency (SA) and law enforcement within 24 hours for 4 of 4 residents (R1, R2, R3, R4) reviewed for drug diversion. This had the potential to affect all residents who were prescribed narcotics.Findings include:R1's quarterly Minimum Data Set, dated [DATE], identified R1 was cognitively intact and had diagnoses including quadriplegia and neurogenic bladder. R1 required assistance for activities of daily living (ADL's), had functional limitation in range of motion with bilateral upper and lower extremities and used a motorized wheelchair for locomotion. R1 had almost constant pain which occasionally affect sleep. R1's pain was rated #7 on a 0-10 scale (0=no pain, 10=worst pain) and received scheduled and as needed (PRN) opioid medications for pain.R1's physician orders report dated 6/30/25 through 7/30/25, identified orders for oxycodone 10 mg tablet give 1 tablet orally every 4 hours as needed for pain.R2's significant change MDS dated [DATE] identified R2 had functional limitation in bilateral upper and lower extremities, required staff assistance with all ADLs except eating and diagnoses included chronic osteomyelitis, paraplegia, chronic pain syndrome, and chronic pressure ulcers. R2 had almost constant pain that was rated #8/10. R2's pain frequently affected sleep and interfered with therapy and day-to-day activities, and almost constantly interfered with therapy activities. R2 received scheduled and PRN pain medication. R2's cognition section was not completed on assessment.R2's physicians orders report dated 6/30/25 through 7/30/25, identified orders for morphine immediate release 15 mg tablet give one tablet by mouth every 6 hours as needed for pain.R3's quarterly MDS dated [DATE], identified R3 was cognitively intact, and diagnoses included arthritis, osteoporosis, dementia, bipolar disorder and muscle weakness. R3 refused to ambulate, was independent with manual wheelchair locomotion and required assistance with all other ADL's. R3 had almost constant pain that was rated a #7/10. R3's pain occasionally affected day-to-day activities, rarely affected sleep, and received scheduled and PRN pain medication.R3's physician orders report dated 6/30/25 through 7/30/25, identified orders for oxycodone 5 mg tablet give 2.5 mg (half tablet) orally every 6 hours as needed for pain. R4's quarterly MDS dated [DATE], identified R4 was cognitively intact, and diagnoses included Guillain-Barre syndrome, trigeminal neuralgia, and quadriplegia. R4 had functional limitation in both lower extremities, was independent with ADL's and used a walker and motorized wheelchair for mobility. R4 had almost constant pain that was rated #7/10. R3's pain frequently affected sleep and interfered with therapy and day-to-day activities. R4 received scheduled and PRN pain medication. R4's physician orders report dated 6/30/25 through 7/30/25, identified R4 had orders for pregabalin 150 mg give 1 tablet by mouth three times daily and tramadol 50 mg give 1-2 tablets orally every six hours as needed for painThe facility reported incident submitted to the SA on 7/14/25 at 5:30 p.m., identified the facility found evidence of diversion of narcotic pain medication of one or more residents. A facility provided list identified R1, R2, R3, R4 were including in the list of residents whos medication were divertedOn 7/30/25 at 10:43 a.m., registered nurse (RN)-A stated the narcotic medications are counted by the outgoing and incoming nurse at the start of every shift. RN-A stated on 7/1/25, RN-A worked the morning shift starting at 6:00 a.m. and was counting narcotics with the outgoing nurse who was also alleged perpetrator (LPN-A). When we got to R3's medication, the number of pills left had not matched the narcotic record. LPN-A stated she forgot to write the administrations into the record and proceeded to write in the book. RN-A didn't think anything of it because everyone got busy at times and write the administrations into the record at the end of the shift. Later that morning R3 requested pain medication. RN-A reviewed the narcotic record and couldn't read LPN-A's handwriting. RN-A looked at the MAR and the administration was not signed off. RN-A immediately reported to the DON. RN-A stated there was another resident that complained the oxycodone medication had not tasted bitter like it should when LPN-A gave the medication. On 7/30/25 at 4:19 p.m., DON stated she and the administrator suspected LPN-A may have diverted narcotic pain medication because RN-A reported LPN-A had documented narcotic medication administrations while they were counting out at the end of LPN-A's shift. Later that morning RN-A checked the book to see when the last dose was given and couldn't read LPN-A's writing. The DON stated according to the facility abuse policy suspected drug diversion should be reported to the SA within 24 hours of notification. The DON was uncertain if suspected drug diversion should be reported to local law enforcement (LE). DON stated the incident was not reported to the SA within the required 24-hour timeframe because they didn't want to make an allegation unless they were sure it occurred; however it had not been reported to