| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245428 | A. Building<br>B. Wing | 12/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Essentia Health Homestead | 115 10th Avenue Northeast<br>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 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><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 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to implement a grievance process for 1 of 8 residents reviewed who expressed care concerns to the facility. Findings include: R1's annual Minimum Data Set, dated [DATE], identified intact cognition and diagnosis of fractures, heart disease and dependence on enabling machines. R1's care plan dated 12/18/25, identified an alteration in mobility related to fracture of lumbar spine, weakness and pain. The care plan directed staff to transfer R1 using a mechanical lift. An electronic (e)-mail from R1 to the director of nursing (DON) and administrator dated 11/12/25, indicated the following:R1 wrote, Asking for help with two issues. On 10/12/25, during transfer to the shower chair something went wrong and R1 ended up with a giant and very painful bruise on the inside of his leg. After the incident for approximately two plus weeks, it was too painful to transfer, so other than two times he did not get up for lunch and except for shower days he remained in bed. Recently at 3:00 p.m., R1 asked to transfer from the bed to the recliner and was told staff would be too busy to transfer him back to bed until around 8:00 p.m. R1 wrote that he recently asked five times to be transferred into his recliner for lunch and had been turned down because staff could not fit him in. R1 also identified a concern related to a pillow that was missing from his room that enabled him to sit up straight in his chair. During interview on 12/16/25 at 9:50 a. m., R1 stated he sustained an injury related to a transfer from his bed to a shower chair. R1 said after he recovered from the injury that left him unable to transfer due to the pain, one of the staff told him he had lost his spot and not enough staff were available to help him out of bed. R1 further stated he had concerns related to a pillow that was missing and said he needed to the pillow to remain upright when seated in his chair. R1 said he sent an e-mail to the DON and the administrator expressing concerns about not getting transferred from the bed and also about the pillow. R1 said neither had responded and said it had been very disappointing. R1 said by chance someone from Essentia came by to see him and asked how things were going and he reported the concerns to her. R1 said a few days later someone from therapy came and brought him a pillow and when he asked for a transfer, he was transferred out of bed. During interview on 12/17/25, at 8:44 a.m., Essentia Health care coordinator (CC) stated she had visited with R1 on 11/17/25, and he expressed concerns about wanting to get up during the day, and about a missing pillow. The CC stated she had spoken with the DON about R1's concerns. The CC said R1 sent her an e-mail on 11/19/25, and said nothing had happened so she had reached out to the social worker. The CC said she received another e-mail from R1 on 11/20/25, that the concerns had been taken care of. During interview on 12/17/25 at 2:05 p.m., the administrator stated the facility grievance officer was the DON. The administrator said she had received an e-mail from R1 that had been sent to the DON and herself about transfer times and staff reporting they were too busy and also about the pillow. The administrator said the DON had told her she would handle it. The administrator said the concern should have been written up as a grievance and said she did not know why it had not happened. Facility policy Resident Grievances dated 4/12/24, indicated a resident's right to voice a grievance orally or submit a formal, written grievance or an anonymous grievance. The facility will take prompt efforts to respond to and resolve grievances, including facility acknowledgment of the grievance and actively working toward a resolution. The grievance official or designee may assign the investigation, evaluation and determination of action steps to a member of the interdisciplinary team. The grievance official or designee will oversee the process and review all information and action steps and if needed, will work with the Interdisciplinary team member to formulate a response to the resident or resident representative. The grievance official or a member of the team will communicate the findings and grievance decision to the resident or resident representative. The grievance official or designee will track the grievance through to conclusion. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure staff utilized the proper sling sizes when performing transfers via mechanical lift for 4 of 5 residents (R1, R2, R4, R5) who utilized a mechanical lift for transfers. Findings include: R1's annual Minimum Data Set, dated [DATE], identified intact cognition and diagnosis of fractures, heart disease, obesity and dependence on enabling machines. R1's care plan dated 12/18/25, identified an alteration in mobility related to fracture of lumbar spine, weakness and pain. The care plan directed staff to transfer R1 using a mechanical lift but lacked evidence of a sling size. R1's Essentia Lift and Move Profile dated 9/20/25 indicated the need for a full body lift, indicated he was not able to lift himself into a standing position and indicated he did not weigh less than 265 pounds (lb.) The assessment indicated sling size LL (purple), 220-350 lbs. R1's care plan dated 10/8/25, identified an alteration in physical mobility related to fracture to lumbar spine with surgical fixation, weakness, pain and medications. The care plan directed staff to assist with transfers using a mechanical lift but lacked evidence of a sling size. R1's Progress Notes identified the following:10/15/25, Bruise noted to R1's right inner thigh measuring 9.7 centimeters (cm) x 5.8 cm. Very dark in color and is swollen enough to see dimples where each piece of hair inserts into the skin. Swelling, hard and approximately the size of a softball. The skin surrounding the contusion was reddish blue/purple and measured 25 cm x 26.5 cm. R1 stated pain rated 3-5 out of 10 resting but increased to 7-9 out of 10 when area was touched. R1 stated it was from the lift sling. Bruise was consistent with where the sling crossed under the right thigh and where it hooked to the machine. R1's records lacked evidence the facility to any further action to reduce the likelihood of another injury such as, assessment of possible sling or lift concerns, or addressing staff training. During interview on 12/16/25 at 9:50 a.m., R1 stated when he was injured during a transfer, and said sometime between the transfer from the bed to the shower chair he ended up getting a bruise on the inside of his right thigh that was gigantic. R1 said it was very painful and said a couple days later a nurse looked at it and called the physician right away to look at it. R1 said the bruise prevented him from getting out of bed for several days. During observation on 12/16/25 at approximately 11:15 a.m., nursing assistant (NA)-A and NA-B prepared to transfer R1 using the mechanical lift. The lift sling applied had royal blue edging (according to the size chart on the assessment indicated XL (308-440lbs.). A sling with orange edges (XXL, 440-550 lbs.) was on the chair next to R1's bed. R2's Resident Face Sheet indicated diagnosis of respiratory disease, dementia with mood disturbance, chronic pain and delusions. R2's Essentia Lift and Move Profile dated 11/15/25, indicated the use of a mechanical lift. The profile did not identify a sling size. R2's care plan dated 9/25/25, identified an alteration in mobility related to obesity, weakness, age and back pain. The care plan directed staff to transfer R2 with a mechanical lift but lacked evidence of a sling size. During observation on 12/16/25, at 11:30 a.m., R2 was seated in a wheelchair. Underneath R2 was a sling with purple edges, size LL according to the sizing chart. R2's weight on 12/12/25 indicated 138 lbs. According to the sizing chart on the lift and move profile 138lbs. indicated a medium sling. R4's Resident Face Sheet indicated diagnosis of Parkinson's disease, dementia, artificial knee joint and osteoarthritis. R4's Essentia Lift and Move Profile dated 11/29/25, indicated the need for a mechanical lift, indicated she was unable to stand and weighed less than 256 lbs. The profile indicated a sling size M (yellow) 121-165 lbs. R4's care plan dated 11/26/25, identified an alteration in physical mobility related to weakness, advanced age, Parkinson's disease and dementia. The care plan indicated the use of a mechanical lift for all transfers but lacked evidence of a sling size. During observation on 12/16/25 at 11:30 a.m., R4 was seated in the dining room in her wheelchair. R4 had a sling underneath her with purple edges (LL) 220-350 lbs. R5's Resident Face Sheet identified diagnosis that included diabetes, heart failure, end stage renal disease and above knee amputation. R5's care plan dated 11/18/25, identified impaired mobility and indicated use of a mechanical lift with amputee sling for all transfers but lacked evidence of a sling size. R5's Essentia Lift and Move Profile dated 10/14/25, indicated the use of a mechanical lift and a [NAME] sling (large) 166-219 lbs. During interview on 12/16/25 at 12:41 p.m., NA-A stated the sling size should be on the care plan. NA-A said they used the purple sling for R2 and said it was a size medium. For R1, they used an orange sling because it was a little bigger and had more padding, and staff used the purple edged sling to transfer R4. NA-A said he did not know where to look to determined what slings should be used and stated R5 also used a mechanical lift with a Yellow (medium) edged sling. During interview on 12/16/25 at 12:55 p.m., the interim director of nursing (DON) stated sling sizes were based on weight. The Interim DON said the |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure an un-licensed nursing student (NS) was supervised during resident medication administration, including significant medication such as insulin, liquid morphine and other controlled substances. In addition, NS did not possess a nursing license, competencies, or skills set to provide necessary resident nursing services nor other certification required for medication administration. This had the likelihood for a serious adverse outcome and placed 4 of 4 residents (R2, R3, R6, R7) in immediate Jeopardy (IJ). The IJ began on 12/12/25, when the NS was observed administering insulin to a resident without direct supervision by a licensed nurse. The administrator was notified of the immediate jeopardy at 5:05 p.m. on 12/16/25. The immediate jeopardy was removed on 12/17/25, but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R2's Resident Face Sheet indicated diagnosis of respiratory disease, dementia with mood disturbance, chronic pain and delusions. R2's care plan dated 9/25/25, identified a risk for alteration in comfort related to pain and identified the use of antipsychotic medication and indicated medications per orders. R2's Physician's Order Report dated 12/17/25, identified the following order: -12/26/23, Hydromorphone- schedule II (controlled substance) liquid; 1 milligram (mg)/milliliter (ml). Amount 2 ml's by mouth every hour as needed. Up to 24 times per day. R2's Individual Narcotic Record identified hydromorphone 1 mg/ml. The record indicated the NS administered the medication on 11/10/25. R2's Medication Administration Record (MAR) dated December 2025, indicated the NS administered R hydromorphone 1 mg/ml medication on 12/5/25 and 12/12/25. R6's Resident Face Sheet indicated diagnosis of pain, hypertension, respiratory failure and diabetes. R6's care plan dated 11/26/25, identified altered endocrine function related to type II diabetes. The care plan directed staff to monitor blood glucose per physician orders and monitor signs and symptoms of hypo or hyperglycemia. The care plan further directed staff to administer medications and ordered. R6's Physician Order Report dated 12/17/25, identified the following orders: -3/26/25, hydrocodone-acetaminophen- schedule II tablet 5 mg-325 mg. Amount 1 tab twice daily as needed. -9/9/24, Accuchecks, notify certified nurse practitioner if below 70 readings are noted. -4/3/25, Humolog KwikPen Insulin (insulin lispro) pen; 100 unit/ml; amount eight units subcutaneous (sq) (fatty tissue just under the skin). Give eight units three times daily with meals. -4/4/25, Lantus U-100 Insulin (insulin glargine) solution; 100 unit/ml. Amount 40 units sq. Once daily between 6:00 a.m. and 10:00 a.m. R6's Individual Narcotic Record identified hydrocodone/acetaminophen- schedule II 5mg/ 325mg, one tab as needed. The record indicated NS administered the medication on 11/10/25. R6's Medication Administration Record (MAR) dated December 2025, indicated the NS performed accuchecks and administered medication, including insulin, to R6 on 12/5/25 and 12/12/25. During observation on 12/12/25 at 11:34 am., the NS administered insulin to R6 via insulin pen, unsupervised. When interviewed, the NS stated she was working at the facility as part of an apprenticeship program and said she was still in school. The NS stated, I can do basically almost anything except a select few things. The NS stated she did not perform treatments but passed medications, completed blood glucose checks and gave insulin. NS said she normally checked with the nurse when giving insulin because she was not comfortable with it but acknowledged she had not checked with the nurse when she gave R6's insulin during observation. NS also indicated the program was newer and there were a lot of things that were not clear regarding skills she was allowed to perform. When asked how she knew what skills she could and could not perform, NS said she had a sheet somewhere but did not have it with her. At 12:36 p.m., the NS confirmed she was not a trained medication aide. On 12/12/25 at 12:06 p.m., the NS was observed performing a blood glucose check independently, without supervision. It was noted during all observations of NS medication administration, Registered Nurse (RN)-A was seated in a glass enclosed office, located behind the nurse station, not in sight of NS during her task. R7's Resident Face Sheet indicated diagnosis of Alzheimer's, dementia, anxiety, depression and chronic pain. R7's care plan dated 12/16/25, identified pain and directed staff to administer medications per orders and monitor and record effectiveness. The care plan identified the use of psychotropic medications and directed staff to monitor for effectiveness and adverse consequences. R7's Physician Order Report dated 12/17/25, identified the following medications: -10/23/25, Tramadol- schedule IV tablet 25 mg. Amount: 75 mg by mouth two times daily. -11/12/25, Lorazepam- schedule IV tablet; 0.5 mg by mouth. Can take 0.5 mg every four hours as |