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	03/12/2025

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40948 Based on interview the facility failed to ensure residents' mail and packages were delivered on Saturdays for 2 of 2 residents (R2, R8) who voiced concerns with mail delivery. This deficient practice had the potential to affect all 20 residents residing in the facility. Findings include: R8's quarterly Minimum Data Set (MDS) dated [DATE], identified R8 was cognitively intact. R2's quarterly MDS dated [DATE], identified R2 was cognitively intact. During an interview on 3/11/25 at 1:10 p.m., at the resident meeting, R8 stated she did not receive mail or packages on Saturdays. R8 stated when packages were set to arrive late Friday or early Saturday, R8 would not receive them until Monday. R2 stated he did not receive mail or packages on Saturdays. R2 stated he received notifications when packages arrive at the facility on Saturday; however, would not receive the packages until Monday. R2 stated mail and packages come in through the main hospital and is sorted there and then delivered to the nursing home. During an interview on 3/12/25 at 2:34 p.m., the activities director (AD) stated when COVID started the mail delivery shifted from being delivered to the nursing home to being delivered to the hospital. The normal process was explained: mail/packages come in through the hospital and are sorted and then placed in the mailroom to be picked up by nursing home staff. When the mailroom is checked by staff on Saturdays there are usually no mail/packages for the nursing home, but AD was not sure if there were staff in the hospital to sort the mail. Any mail/packages delivered on Saturday would have to wait until Monday to be delivered. AD stated she would have to look into mail/packages for the resident on Saturdays, because they deserve to get their mail/packages quickly. An interview was conducted on 3/12/25 at 5:38 p.m., with director of nursing (DON), registered nurse (RN)-A, licensed social worker (LSW), and health unit coordinator (HUC). The HUC stated mail and packages came in through the hospital, they were sorted there and then placed in mailroom for nursing home staff to come down to pick it up. The LSW stated the areas where the was mail and packages were sorted was not staffed on weekends so anything that came in over the weekend would have to wait until Monday to be delivered to the resident. They were not sure if the city was delivering mail on Saturdays. The DON, RN-A, HUC and LSW all stated residents have the right to have received mail on Saturday. (continued on next page)

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

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Patient Rights and Responsibilities policy dated 9/5/23, identified residents have the right to promptly receive mail/packages.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 42075 Based on observation, interview and document review, the facility failed to ensure required nurse staffing information was consistently posted on a daily basis. This had potential to affect all 20 residents, staff, and visitors who may wish to view the information. Findings include: On 3/10/25 at 6:09 p.m., upon entering the unit, the facility nurse staff posting was hanging on a cork board on the wall across from the dining room. The staff posting was dated 3/9/25. The document listed staff scheduled hours per shift for each nursing job class. However, the posting was dated 3/9/25, one day prior. On 3/11/25 at 8:40 a.m., the cork board across from the dining room where the nurse staff posting was hanging the day prior was observed. The same section of the cork board was empty and the nurse staff posting was not hanging on the cork board. On 3/11/25 at 11:55 a.m., the director of nursing (DON) stated the night nurse was responsible for completing the daily staff posting for the following day. The most recent form was completed for 3/9/25, which was removed and another form for 3/10/25 and 3/11/25 were not completed. The DON stated the staff posting was expected to be posted and updated daily. It was important so residents, staff and visitors knew how many staff were working each shift, the hours per shift and their role. The Staffing Nursing Hours policy revised 2/13/24, identified staffing hours would be posted in a prominent place daily, would be clear, readable and easily accessible to residents and visitors. The posting would include the following: facility name, current date, total number and actuall hours worked by RN (not including the DON, assistant DON, or unit managers), licensed practical nurses (LPN) or licensed vocational nurses (as defined under state law), and certified nurse aides (NA), and the resident census.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40948 Based on interview and document review the facility failed to identify a diagnosis for a medication for 1 of 5 residents (R4) reviewed for unnecessary medications. Findings include: R4's annual Minimum Data Set (MDS) dated [DATE], identified R4 had diagnoses of dementia with behavioral disturbance, bi-polar disorder (a chronic mental health condition characterized by significant and persistent shifts in mood), and manic depression. The MDS identified R4 received an antidepressant. R4's order summary report dated 1/15/25, included an order for escitalopram (a medication used to treat depression) 10 milligram (mg) tablet, take 15 mg each morning. The medication order failed to include a diagnosis or indication for use. During an interview on 3/12/25 at 5:23 p.m., registered nurse (RN)-A stated each prescribed medication needed a diagnosis or reason for use. RN-A had entered R4's escitalopram order after a medication change and forgot to put the diagnosis in. During an interview on 3/12/25 at 5:25 p.m., the director of nursing (DON) stated it was expected all medications would include a diagnosis or indication for use. It was important to have the diagnosis or indication of use to ensure R4 had not received the medication unnecessarily. The facility's Medication Order Transcription policy dated 10/17/24, identified medication orders mush include medication, dose, frequency, route, and diagnosis or indication for use.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42075 Based on observation, interview and document review the facility failed to ensure medications were properly labeled to prevent medication errors for 1 of 7 residents (R11) observed during medication pass. Findings include: R11's quarterly minimum data set (MDS) identified R11 had moderate cognition and a diagnosis of chronic obstructive pulmonary disease (COPD). R11's physician orders report dated 2/12/25 through 3/12/25, identified R11 was to receive anoro ellipta (umeclidinium-vilanterol) 62.5-25 mcg/actuation - administer 1 puff into the lungs one time a day with a start date of 7/24/24. On 3/12/25 at 7:18 a.m., licensed practical nurse (LPN)-A was observed during a medication pass. LPN-A removed a foil container from a medication cart. Inside the container was an inhaler with R11's name and a label identifying the medication as anoro ellipta 62.5-25 mcg/act LPN-A stated the inhaler belonged to R11 although it did not have a label identifying how the medication should be administered. LPN-A stated most-likely the facility received the inhaler in a box labeled with the residents identifying information and the instructions for use. LPN-A stated the box must have been thrown away. Prior to administering the medication, LPN-A would check the physicians orders for a current order and instructions. LPN-A further stated all medications should have a resident label and instructions from the pharmacy. On 3/12/25 at 1:24 p.m., the director of nursing (DON) stated all medications in the medication cart should have a label that includes the medication name, pharmacy it came from, date of order, expiration date, residents name and the orders/instructions for use. If the label did include all the appropriate information the nurse should remove the medication from the cart, not use the medication and contact the pharmacy right away. The Medication Management policy dated 8/8/24 identified prior to administering a medication staff were to compare the medication and dosage schedule on the medication administration record (MAR) to the medication label and review each for the right patient, right medication, right dose, right time and right route of administration.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 42075 Based on interview and document review, the facility failed to accurately submit hours for the payroll-based journal system (PB&J) staffing data to Centers for Medicare and Medicaid Services (CMS). This had the potential to affect all 20 residents residing in the facility. Findings include: The facility's PB&J data for quarter four submitted to CMS for 7/1/24 through 9/30/24, identified the facility was triggered for excessively low weekend staffing, and failed to have licensed nursing coverage 24 hours/day for the following days: 31 out of 31 days during the month of July 2024, 31 out of 31 days during the month of August 2024, and 30 out of 30 days during the month of September 2024. In addition the report identified the facility triggered for no registered nurse (RN) coverage for eight consecutive hours for the following days: 31 out of 31 days during the month of July 2024, 8/1/24, 8/5/24, 8/9/24, 8/15/24, 8/19/24, 8/21/24, 8/23/24, 8/24/24, 8/25/24, 8/26/24, 8/27/24, 8/28/24, 8/29/24, 9/3/24, 9/4/24, 9/6/24, 9/7/24, 9/8/24, 9/20/24, 9/21/24, 9/22/24, 9/24/24, and 9/25/24, The facility payroll and working schedules were reviewed for 7/1/24 through 9/30/24, and identified the following: - There were licensed nursing staff 24 hours/day for all 92 days identified on the PB&J report. - There was RN coverage 8 consecutive hours for all 54 days identified on the PB&J report. During joint interview with director of nursing (DON) and RN-A on 8/27/25 at 6:02 p.m., the DON stated the PB&J data was entered by the administrator. Both the DON and RN-A stated there was always a nurse in the facility. If there was a nurse call-in and they were unable to find a replacement the previous shift would be mandated to stay. On 3/12/25 at 7:39 p.m., the administrator stated the nursing hours were entered by an off-site corporate staff member and the administrator double checked the information by running a report. The administrator stated she knew there was a corporate wide problem regarding how the information was pulled, although did not know how to correct the issue. The administrator stated accurate PB&J information is important because it showed how many, and they type of staff working, and they are working as a corporate agency on correcting the issues. A policy/procedure regarding PBJ data submission was requested but not provided.