DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 14, 2026

Administrator

Hendricks Community Hospital

503 E LINCOLN STREET

HENDRICKS, MN 56136

RE: CCN:245467

Cycle Start Date: June 25, 2026

Dear Administrator:

On June 25, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102 Marshall, Minnesota 56258-2504
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 25, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 25, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245467	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDRICKS COMMUNITY HOSPITAL	503 E LINCOLN STREET , HENDRICKS, Minnesota, 56136

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 6/23/26 through 6/25/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		
F0000	INITIAL COMMENTS On 6/23/26 through 6/25/26, a standard recertification survey (S5467038-0) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54673004C (237087561). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		
F0565 SS = E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and	F0565		

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 reverse for further 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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F0565 SS = E	Continued from page 1 participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the Resident Council's concerns during 3 of 3 months of minutes reviewed (March, April, and May 2026) were addressed with potential or actual resolution and/or responses brought back to the resident council for discussion and documented in the Resident Council minutes. Findings include: Resident council meeting was held on 6/24/26 at 2:35 p.m., with R4, R10, R22, and R34. During the	F0565		

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F0565 SS = E	Continued from page 2 meeting the residents identified they had concerns regarding the menu options and the tenderness of the meat served, especially the roast beef. They expressed having difficulty chewing the meat that was served and said they had requested other items be added to the menu, such as chili. They have requested the dietary manager (DM) attend resident council so they could express their concerns directly, however, she had not attended. They stated they have no way to know if the DM knew what their concerns were. They identified no staff had communicated with them what was going to be done to address their concerns. These requests had been vocalized in resident council to the Activity Director (AD) on multiple occasions over the past several months. They had voted for the AD to be the staff person that would represent the resident council at the facility; however, they were not certain if their concerns had been relayed to the DM. Review of resident council minutes identified in: March 2026, Resident Council minutes under the dietary old business identified residents discussed their love of meals and snacks and some of their favorite food items. Dietary new business noted resident's favorite dishes for traditional Easter meals with requests for grilled lunches through summer months and incorporating more fruits into snacks. The Resident Council minutes made no mention of the concerns with the menu plan, or tough difficult to chew meat, or that the Resident Council would like the DM to attend a council meeting. April 2026, Resident Council minutes under dietary old business identified residents discussed their favorite dishes for traditional Easter meals. They requested grilled lunches through summer months and incorporating more fruits into snacks. New business identified they discussed "Muffins and Moms" event and that residents had no feedback regarding their meals or snacks for the month. The Resident Council Minutes made no mention that residents wanted the DM to attend a meeting or that they had concerns with the menu plan or tough difficult to chew meat. May 2026 Resident Council minutes under dietary old business identified they discussed "Muffins and Moms" event and that residents had no feedback on their meals or snacks for the month. Under new business the minutes noted residents enjoyed taco in a bag in May and would like to have it again in June. They discussed having fresh fruits, breakfast	F0565		

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F0565 SS = E	Continued from page 3 sandwiches, and requested less carrots as a side. The council minutes again made no mention the residents had expressed concerns regarding the tenderness of the meat, the menu plan, or that they had requested the presence of the DM at the Resident Council meeting. Interview on 6/24/26 at 3:21 p.m., with the DM identified she was aware of some concerns that came from resident council. The AD communicated the concerns through email and the DM said she “does what she can” to address those concerns. She Identified she was aware the council had some concerns and wanted her to attend the meeting, but she had not been able to because she is only at the facility 3 days a week and has had staffing shortages in the kitchen that she had been covering. Review of the 3/30/26, email sent from the AD to the DM identified resident council was requesting grilled foods, breakfast for dinner, fresh fruits, baked potatoes, a waffle bar, and ice cream sundae bar. The DM replied saying they could possibly grill food once weekly, fresh fruits will be coming on the spring/summer menu soon, potato choices will be changing, waffle bar could be an activity and snack, and they could do a sundae bar. The email made no mention that the Resident Council had concerns regarding the meat or that they wanted the DM to attend the meeting. Interview on 6/25/26 at 9:00 a.m., with the Activity Director, identified when the Resident Council brings concerns to the meeting, she would reach out to the appropriate department manager by email. If she had not received a response within a week, she would follow up with them again. Once she received a response she would follow up with the council at the next meeting. She identified she did not get all the council’s concerns or the DM’s response documented in the resident council meeting minutes. She reviewed the Resident Council process policy and identified that there was a form she was not aware of that was to be used, and stated she would be using that for documentation going forward. Interview on 6/25/26 at 11:18 a.m., with the director of nursing (DON) identified it is her expectation that the AD document any concerns and the resolution in the Resident Council meeting minutes and bring the information back to the Resident Council to be reviewed at the next meeting.	F0565		

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F0565 SS = E	Continued from page 4 Review of February 2026, Resident Council policy identified a designated staff will facilitate and record meeting minutes per council approval. Previous meetings minutes, including department responses, will be read at the beginning of the resident council meeting for resident approval. Designated staff will follow the Resident Council Agenda to record resident concerns, comments, questions, and suggestions. Resident council minutes will be shared with the department leaders once per month and concerns will be addressed in writing.	F0565		
F0868 SS = E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee.	F0868		

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F0868 SS = E	Continued from page 5 The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the medical director (MD-A) attended QAPI meetings for 4 of 4 quarters. Findings include: Review of the QAPI meeting minutes submitted for the months of June, August, Sept and Oct 2025, and Jan and April 2026, identified the facilities quarters were Quarter 1: July-Sept, Quarter 2: Oct-Dec, Quarter 3: Jan-March, and Quarter 4: April-June. Of the months submitted, in: June 2025: MD-A is listed on the attendance sheet, but he had not signed off as having attended the meeting. The remaining months of August, September and October 2025, and January and April 2026, MD-A's name was not on sign in sheet and there was no evidence to support he attended at least quarterly as required. Interview on 6/25/26 at 1:11 p.m., with the director of nursing (DON) identified she had overseen QAPI since January 2026. In review and discussion of the above meeting minutes/agendas, she agreed MD-A was not in attendance at any of their QAPI meetings. The DON agreed the facility needed to ensure the medical director was attending as required. Review of the February 2026, QAPI policy identified the QAPI committee was to include the medical director and other appropriate staff. QAPI was to meet at least 4 times per year to oversee and direct facility activities. There was no mention in the policy of how to ensure the medical director (or his or her appropriate designee) attended meetings as required.	F0868		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications	F0554		

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F0554 SS = D	Continued from page 6 if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to determine whether a resident was safe to self-administer 2 nebulized medications for 1 of 1 resident (R6) who received 2 medications administered by nebulizer. Findings include: Observation on 6/25/26 at 8:41 a.m. as licensed practical nurse (LPN)-A administered R6's two ordered nebulized medications identified LPN-A assembled the nebulizer mask, tubing, and medication cup, emptied the single dose vial of Arformoterol Tartrate (a long-acting bronchodilator prescribed for the long-term twice daily maintenance treatment of airflow blockage), 15micrograms (mcg)/2mililiters (ml) into the nebulizer medication cup, attached the medication to the mask and positioned the mask on R6's face. He turned on the nebulizer and left the room while R6 received her medication dose. Prior to leaving the room, LPN-A informed R6 he would return in 10 minutes to give the 2nd medication. R6 was on her back in bed with the head of her bed elevated and did not reply as LPN-A left the room Observation on 6/25/26 at 8:53 a.m., identified LPN-A returned to R6's room, turned off the nebulizer, added the single dose vial of Budesonide (a liquid corticosteroid used to decrease airway inflammation) 0.5miligram(mg)/2ml to R6's nebulizer medication cup, and reapplied the mask, after turning on the nebulizer machine. He then verbalized he would return in 10 minutes to discontinue the treatment. LPN-A then left the room as R6 was receiving her treatment. Interview on 6/25/26 at 8:55a.m. with LPN-A reported he did not believe R6 had an order on file to self-administer her nebulized medications, but he felt it was acceptable to leave her unattended during administration of her nebulizer medications. Subsequent interview at 9:57 a.m. with LPN-A identified he had checked the medical record and R6 did not have an order to self-administer her nebulized medications, and as a result he should have remained in attendance during the	F0554		

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F0554 SS = D	Continued from page 7 administration. Interview on 6/25/26 at 10:02 a.m. with registered nurse (RN)-A identified case managers were responsible for completing assessments for residents for residents to self-administer medications, including nebulized medications. Upon review of R6's medical record two previous assessments for self-administration of medication had been completed since her admission on 2/12/26, and neither identified she was competent to self-administer her medications. Interview on 6/25/26 at 3:55 p.m., with the director of nursing (DON) identified her expectation for self-administration assessments to be completed for all residents prior to allowing them to remain unattended during administration of any medications. Review of the June 2026, Self-Administration of Medications policy identified an assessment was to be completed and reviewed by the interdisciplinary team (IDT). An assessment was to be completed quarterly, if there was a change in medical condition, mental status, or as needed. The results were to be documented in the resident's medical record and care plan. Documentation of a physician order for self-administration was to be obtained and include which medications the resident was able to self-administer.	F0554		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12	F0605		

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F0605 SS = D	Continued from page 8 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F0605		

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F0605 SS = D	Continued from page 9 (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a timely review with a rationale for a as needed (PRN) psychoactive medication was completed for 1 of 7 sampled residents (R10). Additionally, the facility failed to ensure target symptoms/behaviors were identified for an antidepressant medication to ensure monitoring for effectiveness for 1 of 7 sampled residents (R3).	F0605		

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F0605 SS = D	Continued from page 10 Findings include: R10's 5/13/26, accepted quarterly Minimum Data Set (MDS) assessment identified R10's cognition was intact. R10 had diagnoses of heart failure, high blood pressure, renal insufficiency (kidney disfunction), and seizure disorder. There were no identified diagnoses of anxiety. R10's 3/27/26, physician's "Comfort Kit" order identified lorazepam (antianxiety medication) 0.5 milligrams (mg) orally every 4 hours PRN for anxiety. If anxiety not improved in ½ hour, staff may repeat one time. R10's 6/24/26, printed Medication Administration Record (MAR) identified an order for lorazepam 0.5 mg every 4 hours PRN, comfort measures only with no end date identified. Interview on 6/24/26 at 10:18 a.m., with registered nurse (RN)-C identified that R10 had an order for lorazepam with no end date, because she was currently on comfort cares (end of life treatment). The pharmacist continued to make recommendations to establish an end date or review date and that was done every 30 days for R10's lorazepam. She confirmed the pharmacist had made a recommendation on 5/22/26,to identify a rationale to continue R10's lorazepam PRN order or discontinue. RN-C stated she noted the recommendation on 5/27/26 and took the recommendation physically to the physician's office connected to the facility. RN-C said with the transition to the new electronic record system, she had forgotten to check on the status of the pharmacy recommendation. Typically, she would have followed up with the physician regarding pharmacy recommendations that had not been addressed. She reported she had walked over to the physician's office today (6/24/26) and found that the pharmacy recommendation was laying in a pile of papers on a desk and had not been reviewed yet by the physician. The physician did review and documented for staff to continue for 3 more months. She confirmed that the last review had been done on 4/9/26 for 60 days and that the lorazepam PRN order should have been addressed no later than 6/8/26, 17 days ago. She revealed that R10's lorazepam 0.5 mg PRN order had come from the order for a comfort kit due to R10's declining health and wanting to be kept comfortable. The facility had	F0605		

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F0605 SS = D	Continued from page 11 obtained the order for the comfort kit to ensure they had medications available if needed. Interview on 6/25/26 at 11:10 a.m., with the director of nursing (DON) identified the facility has had some concerns with providers acting timely on pharmacy recommendation and that had addressed at the provider meetings. The facility has had to “keep on” the providers to get pharmacy recommendations addressed timely. The DON reported that with the recent mitigation to the new electronic record system, the facility must not have followed up with the provider to ensure the pharmacy recommendation was acted upon timely for R10. A policy on PRN psychoactive medications was requested but not provided. R3’s admission record identified she admitted to the facility in February of 2024. R3’s 5/13/26, accepted comprehensive Minimum Data Set (MDS) assessment identified R3 cognition was intact. R3 had diagnoses of anemia, atrial fibrillation, coronary artery disease, renal insufficiency, arthritis, thyroid disorder, and depression. R3’s current physician order identified Celexa 20 milligrams (mg) every day with no associated diagnosis. Review of R3’s medical record identified that the Celexa was last increased on 1/8/26 from 10 mg to 20 mg. There was no indication of target symptoms/behaviors for the Celexa. R3’s undated, care plan identified although there was a section on R3’s psychosocial well-being with a goal to demonstrate her ability to cope with her hospitalization/illness, there was no mention of R3 having existing depression or taking an antidepressant medication with any identified target symptoms/behaviors that may increase with end of life, or for monitoring for the effectiveness of the antidepressant. Interview on 6/25/26 at 11:34 a.m. with registered nurse (RN)-B confirmed that R3 had nothing on her care plan that identified R3 had depression or that she was taking an antidepressant medication and no	F0605		

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F0605 SS = D	Continued from page 12 mention of target symptoms/behaviors that the antidepressant medication was treating for monitoring purposes. The target symptoms/behaviors were typically identified on the care plan. Interview on 6/25/26 at 4:17 p.m., with the director of nursing (DON) identified that each resident receiving a psychoactive medication should have target symptoms/behaviors identified for monitoring for effectiveness of the medication. A policy was requested for psychoactive medication was requested but not received.	F0605		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer.	F0628		

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F0628 SS = D	Continued from page 13 Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge;	F0628		

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F0628 SS = D	Continued from page 14 (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).	F0628		

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F0628 SS = D	Continued from page 15 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by:	F0628		

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F0628 SS = D	Continued from page 16 Based on interview and document review the facility failed to notify the ombudsman of a discharge for 1 of 2 sampled residents (R52). Findings include: R52's 4/22/26, accepted discharge Minimum Data Set (MDS) assessment identified R52 had been discharged to home/community with return not anticipated. R52's 4/16/26, discharge summary identified that R52 had discharge with home health services following completing therapy services. Interview on 6/25/26 at 3:30 p.m., with registered nurse (RN)-A and social service designee (SSD) both identified the facility only notified the ombudsman when there was an emergency discharge to the hospital or a resident leaves the facility against medical advice. The SSD reported the facility did not notify the ombudsman of any planned discharges and confirmed the ombudsman was not notified for R52's discharge back to the community. Interview on 6/25/26 at 4:17 p.m., with director of nursing (DON) identified she was unaware that the facility had not been notifying the ombudsman about all discharges. She confirmed the facility had a policy and it identified to notify the ombudsman of all discharges. Review of December 2025, Transfer or Discharge Notice policy identified a copy of a transfer or discharge would be sent to the ombudsman.	F0628		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F0656		

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F0656 SS = D	Continued from page 17 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 5 sampled residents (R3) with a diagnosis of depression. Findings include: R3’s admission record identified she admitted to the facility in February of 2024. R3’s 5/13/26, accepted comprehensive Minimum	F0656		

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F0656 SS = D	Continued from page 18 Data Set (MDS) assessment identified R3 cognition was intact. R3 had diagnoses of anemia, atrial fibrillation, coronary artery disease, renal insufficiency, arthritis, thyroid disorder, and depression. R3's current physician order identified Celexa 20 milligrams (mg) every day. Review of R3's medical record identified that the Celexa was last increased on 1/8/26 from 10 mg to 20 mg. R3's undated, care plan identified although there was a section on R3's psychosocial well-being with a goal to demonstrate her ability to cope with her hospitalization/illness, there was no mention of R3 having existing depression or taking an antidepressant medication with any identified target symptoms/behaviors that may increase with end of life, or for monitoring for the effectiveness of the antidepressant. Interview on 6/25/26 at 11:34 a.m. with registered nurse (RN)-B identified the facility care plans were still a "work in progress" as the facility had just switched to a new electronic medical record system. She confirmed that R3 had nothing on her care plan that identified R3 had depression or that she was taking an antidepressant medication. There were no target symptoms/behaviors that the antidepressant medication was treating for monitoring purposes. The care plan lacked what staff are to do as interventions if R3 displayed symptoms of depression and normally all that information would be addressed on the resident's care plan. RN-B identified R3 had started the antidepressant prior to admission to the facility. Interview on 6/25/26 at 4:17 p.m., with the director of nursing (DON) identified that each resident should have a person-centered care plan developed. R3's care plan should have addressed her depression and what her target symptoms/behaviors were and what staff were to do if she displayed those behaviors. She agreed target symptoms/behaviors should be identified in order to monitor for effectiveness of the medication. Review of July 2025, Care Plan policy identified a resident's care plan would be developed by the interdisciplinary team including participation by the resident. The resident's care plan would include	F0656		

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F0656 SS = D	Continued from page 19 medications used as an intervention for the residents' medical needs. The residents' care plan would be updated as needed and reviewed at minimum quarterly.	F0656		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to revise the care plan for 1 of 13 sampled residents (R10) with a diagnosis of end stage kidney disease. Findings include: R10's 5/13/26, accepted quarterly Minimum Data Set (MDS) assessment identified R10's cognition was intact. R10 had diagnoses of heart failure, high blood	F0657		

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F0657 SS = D	Continued from page 20 pressure, renal insufficiency (kidney dysfunction), chronic kidney disease, and end stage renal disease. R10's 5/20/26, physician visit note identified consideration for palliative/hospice care had been previously discussed. R10 was interested in this when the time comes for her kidneys. She anticipated that her nephrologist would inform her of that. R10's 6/11/26, nephrology visit note identified chronic kidney disease, stage 4 with bilateral hydronephrosis (enlarged kidney affecting the body's ability to excrete urine), pyuria (pus in urine), and hematuria (blood in urine). Different forms of renal replacement therapy were discussed, and it was noted R10 had declined dialysis. R10's current, undated care plan identified staff were to watch for signs and symptoms of bladder infection, however; there was no mention R10 had end stage kidney disease or that R10 had declined dialysis treatment and chose to remain comfortable at the facility or what staff should watch for if her kidneys failed to operate and function. Interview on 6/25/26 at 11:10 a.m., with the director of nursing (DON) identified each resident should have a person-centered care plan. The care plan should be reviewed and revised as needed as care needs change. She agreed that when R10 had declined the dialysis treatment and requested to be kept comfortable at the facility that the facility should have updated R10's care plan to reflect that change. Review of July 2025, Care Plan policy identified a resident's care plan would be developed by the interdisciplinary team including participation by the resident. The residents' care plan would be updated as needed and reviewed at minimum quarterly.	F0657		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral	F0693		

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F0693 SS = D	Continued from page 21 fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff followed the facility policy to appropriately verify gastrostomy (G) tube placement prior to feedings and medication administration for 1 of 1 resident (R6) reviewed with a feeding tube. Findings include: R6's 5/24/26 accepted quarterly Minimum Data Set (MDS) assessment identified she had moderate cognitive impairment, required staff assistance for all activities of daily living (ADLS), had impairment of upper and lower extremities, and used a wheelchair for mobility. She had a feeding tube in place and received 51% or more of her total calories through the feeding tube. Average fluid intake was 501cc or more per day via the feeding tube. R6 received crushed medication via the feeding tube including an antidepressant, diuretic, opioid, blood pressure, medication for acid reflux, nausea and antiplatelet medications. R6 was admitted in February 2026, with diagnoses of oropharyngeal dysphagia (difficulty initiating a swallow from the mouth into the throat, feeding by G-tube, severe physical deconditioning, and cognitive impairment. She was admitted with a (gastric tube-PEG -a surgically placed tube through the abdominal wall directly into the stomach), and orders for Isosource (lactose-reduced food) with fiber 0.07 grams/1.5 kilo (k) calorie (Cal)/milter (ml)	F0693		

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F0693 SS = D	Continued from page 22 900 ml/day. Free water was to be administered five times daily at 300 ml via PEG tube. Free water flush 300 ml via G-tube bolus four times daily (QID). Give 150 ml before feeding/medication and 300 ml all other times. R6's current, undated care plan identified she was at risk for impaired nutritional status, evidenced by the need for G-tube feedings. The identified goal was maintaining nutritional status and avoiding weight loss. R6 was to be weighed weekly. Feeding was identified as 900 ml of Iso-source 1.5 formula with a note to refer to orders for further details. Positioning: keep patient upright (30-45 -degree angle) during feeding and for 30-60 minutes afterward to prevent aspiration. Flushing: flush the tube with 150ml of warm water before and after each feeding or medication administration. May have risk for dehydration related to being on tube feedings. Follow registered dietitian recommendations for free water flushed. Notify the provider for tube dislodgement or concerns with patency. Observation on 6/25/26 at 8:23 a.m., with licensed practical nurse (LPN)-A as he prepared to administer R6's physician ordered medications. LPN-A checked the orders for medications, set-up and crushed each medication, placing them into a medication cup. He then took the medications to R6's room applied personal protective equipment (PPE), washed his hands and applied gloves. He explained to R6 he had her medications to administer through her G-tube. LPN-A retrieved a graduated container and filled it with 300 ml of tap water. He then mixed 90 ml of water into the crushed medication. He elevated the head of the bed to 45 degrees. LPN-A exposed R6's feeding tube, opened a 30 ml syringe, removed the plunger and inserted the syringe into the G-tube port. He opened the stop cock and reported he did that to let any air escape. LPN-A poured 90 cc of water in 30 ML intervals and allowed it to flow via gravity. When LPN-A opened the stop cock to allow air to escape a small amount of liquid was noted where the tube entered the abdomen. LPN-A continued to administer the water, then poured the medications into the G-tube and flushed with the remaining water. He then re-clamped the G-tube and told R6 he had also given her medication for nausea with her other medications LPN-A reported this was the normal procedure he followed for administering R6's medications and water. When finished LPN-A took the graduated container and syringe into the bathroom and rinsed and then placed on a paper towel to air dry.	F0693		

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F0693 SS = D	Continued from page 23 Interview on 6/25/26 at 8:43 a.m. with LPN-A identified he did not routinely check G-tube placement before administering medications or water, as he did not believe he needed to. He further stated when the tube had been changed the placement had been verified by x-ray. When asked about any fluid in the G-tube he reported he thought there was some liquid from the last feeding that came out when the air went out the tube, but he was not certain. Interview on 6/25/26 at 10:02 a.m., with registered nurse (RN)-A reported she did not think they were still supposed to check for G-tube placement prior to administration of medications or fluids, but she would need to check the policy to see what it directed. Interview on 6/25/26 at 3:55 p.m., with the director of nursing (DON) reported she thought there was a provider order for R6 that they did not need to check placement for her G-tube. She stated she thought this was because R6 had the G-tube for a long time. Review of the current physician orders with the DON failed to identify an order regarding checking placement of R6's G-tube. Review of the August 2025, policy Gastrostomy tube, PEG (Percutaneous Endoscopic Gastrostomy) tube care identified the Procedure: Place equipment and supplies at bedside where they will be easily accessed. Perform hand hygiene, Don clean gloves. Observe and document external bumper length, verifying the bumper has not migrated. There should be approximately 1 centimeter (cm) between the skin and external bumper. Administering a feeding/checking placement Remove the tube cap or plug by closing the tube. Use a syringe to inject 5-10 ml of air into the tube to clear it.	F0693		

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F0693 SS = D	Continued from page 24 Aspirate gastric contents with the syringe Connect the syringe and infuse water, feeding and or medications Once administration is completed flush with water according to MD order. Document time, feeding if administered, water, and amount administered, tolerance to administration, appearance of skin surrounding the tube, tube patency, and verification of tube placement. Medication Administration: Medications as ordered by provider The amount of flush to be ordered by the MD. Liquid dosage forms are preferred if possible, and pharmacy will determine if ordered medications can be crushed. Liquefy medications in 15-30 ml of water. Check proper placement of the G-tube prior to administration. Flush the tube with water prior to and following administration of the medication Document medication administration	F0693		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F0761		

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F0761 SS = D	Continued from page 25 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure 1 of 1 resident (R48) discontinued controlled narcotic medication was not stored with in-use medications in 1 of 2 medication carts. Findings include: Observation and physician order review on 6/24/26 at 2:30 p.m. with licensed practical nurse (LPN)-B and trained medication aide (TMA)-A as they performed the shift change narcotic count in 1 of 2 medication carts identified there was 1 blister pack card containing 30 Lorazepam 0.5milligram (mg) tablets with the printed pharmacy label identifying it had been dispensed on 6/2/26 for R48. The physician order recorded in the electronic medical record identified the order for Lorazepam 0.5mg by mouth (PO) every (Q) 6 hours (H) as needed (PRN) with a start date of 6/2/26 and the medication was discontinued on 6/16/26. Interview on 6/24/26 at 2:40 p.m. with LPN-B and TMA-A identified the card containing R48's Lorazepam had remained in the in-use narcotic box located on the medication cart co-mingled with other in-use medications and noted it should have been removed and destroyed when the order was discontinued. Interview on 6/24/26 at 2:49 p.m. with registered nurse (RN)-A identified the procedure when a controlled medication was discontinued was the nurse on duty should have pulled the discontinued medication from the active medications and destroyed with two nursing staff in attendance. Interview on 6/24/26 at 3:12 p.m. with the director of nursing (DON) identified when a controlled	F0761		

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F0761 SS = D	Continued from page 26 medication was discontinued it should be removed from the active medication and destroyed with two nursing staff in attendance. A policy for storage and disposal of controlled medications was requested but not received by the end of the survey period.	F0761		

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	245467	A. BUILDING **01 - MAIN BUILD...** B. WING	**06/23/2026**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 6/23/2026. At the time of this survey, Hendricks Community Hospital (Nursing Home) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		07/23/2026

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 reverse for further 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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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Hendricks Community Hospital Nursing Home was constructed as follows: The original building was constructed in 1969, is one-story, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction; The first addition was constructed in 1987, is one-story, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction; The second addition was constructed in 1993, is one-story, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction. The facility was inspected as one building. The nursing home is separated from a critical access hospital by a two-hour firewall, and the opening	K0000		07/23/2026

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K0000 Bldg. 01	Continued from page 2 protective consisted of a labeled, self-closing, positive latching, 90-minute fire-rated door assembly. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. Resident Rooms are protected with automatic smoke detectors, which are interconnected to the building fire alarm control panel [FACP]. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		07/23/2026
K0521 SS = F Bldg. 01	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.4, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/23/2026 between 10:45 AM and 01:30 PM, it was revealed by a review of available documentation that at the time of the survey, the damper inspection report provided by the facility identified multiple dampers as "inaccessible." Facility staff were unable to explain the designation or verify whether the affected dampers had been inspected and tested as required. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0521	The facility failed to inspect fire dampers as revealed by the damper inspection report provided by the facility identifying multiple dampers as “inaccessible”. Tesseir Company contacted to evaluate the identified dampers and develop a plan. Company will complete the required inspections and correct any and all deficiencies necessary to ensure the fire dampers are accessible. Completion: 8/14/26 Responsibility: Maintenance Supervisor The plan of correction has been updated to reflect the completion date within the 70-day timeframe.	08/14/2026

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K0711 SS = F Bldg. 01	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire safety plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/23/2026 between 10:45 AM and 01:30 PM, it was revealed by a review of available documentation that at the time of the survey the fire safety plan that was provided at the time of the survey did not include the transmission of the alarms to the fire department. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0711	The facility failed to implement a fire safety plan as it was revealed at survey that the fire safety plan did not include the transmission of the alarms to the fire department. The fire safety plan will be reviewed and policy updated to state that when a fire alarm is activated, the alarm is transmitted to the alarm company. The monitoring alarm company will immediately notify dispatch, and dispatch will notify local fire department for emergency response. After review and update, all staff will be educated on procedure and policy. Completion: 7/31/26 Responsibility: Maintenance Supervisor	07/31/2026
K0901 SS = F Bldg. 01	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	K0901	The facility failed to provide a Risk Assessment per NFPA 99. NFPA 99-2012 Utility Risk Assessment was front and back which reflected the same assessment. The oxygen section was completed as part of the assessment and will be retained and readily available for review. The facility will review and complete if needed a documented NFPA 99 (2012 Edition) Risk Assessment to identify the applicable risk category for building systems and equipment as required. Completion: 7/31/26	07/31/2026

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K0901 SS = F Bldg. 01	Continued from page 4 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/23/2026 between 10:45 AM and 01:30 PM, it was revealed by a review of available documentation that the risk assessment for Chapter 11 of NFPA 99 (2012 edition), Health Care Facilities Code, was not filled out, and oxygen was being used in the facility. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0901	Continued from page 4 Responsibility: Maintenance Supervisor; Administrator	07/31/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.	K0918	The facility failed to test the Emergency Power Supply System 1. The four-hour load bank test will be serviced by a qualified vendor and documentation will be maintained on-site. A preventative maintenance schedule will be implemented to ensure the testing is completed every 36 months. 2. The diesel fuel will be tested by a qualified vendor and results will be maintained on-site. The annual fuel testing will be added to the preventative maintenance schedule to ensure ongoing compliance. 3. Maintenance Supervisor purchased a tester that will be used for testing batteries properly on a monthly basis. Monthly generator inspection documentation will be reviewed to ensure all required testing is completed and recorded. Completion: 8/14/26 Responsibility: Maintenance Supervisor The plan of correction has been updated to reflect the completion date within the 70-day timeframe.	08/14/2026

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HENDRICKS COMMUNITY HOSPITAL	**503 E LINCOLN STREET , HENDRICKS, Minnesota, 56136**

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K0918 SS = F Bldg. 01	Continued from page 5 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.3.7.1, 8.3.8, 8.4.9, 8.4.9.1, and 8.4.9.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 06/23/2026 between 10:45 AM and 01:30 PM, it was revealed by a review of available documentation that at the time of the survey, the facility could not provide documentation showing that a four-hour load bank test had been completed on the emergency generator within the last 36 months. 2. On 06/23/2026 between 10:45 AM and 01:30 PM, it was revealed by a review of available documentation that at the time of the survey, the facility could not provide documentation showing that the diesel fuel for the emergency generator had been tested to ASTM standards within the last year. 3. On 06/23/2026 between 10:45 AM and 01:30 PM, it was revealed by a review of available documentation that at the time of the survey, the facility could not provide documentation showing the batteries for the emergency generator had the electrolyte specific gravity tested or conductance testing completed monthly. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0918		08/14/2026
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable	K0921	The plan of correction has been revised. The facility contacted the contracted provider, Avera Biomed, and it was documented that the completion of inspection and testing of patient care-related electrical appliances and equipment was completed. These documents will be maintained on-site and readily available for review.	07/27/2026

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K0921 SS = F Bldg. 01	Continued from page 6 patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect patient care related electrical appliances and equipment (PCREE) per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.2, 10.3, and 10.5.2.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/23/2026 between 10:45 AM and 01:30 PM, it was revealed by a review of available documentation that at the time of the survey, the facility could not provide documentation showing that the patient care-related electrical appliances and equipment (PCREE) in the facility had been inspected or tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0921	Continued from page 6 The plan of correction completion date has been updated to reflect the day the documentation was received from the contracted provider.	07/27/2026
K0222 SS = E Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be	K0222	The facility failed to maintain emergency egress doors and gates. The chapel door was adjusted to ensure it opened readily without excessive force.	06/30/2026

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K0222 SS = E Bldg. 01	Continued from page 7 equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS	K0222	Continued from page 7 Completion : 6/24/26 The courtyard gate latch was lowered from 83 inches to 60 inches and verified to be readily openable from the interior. Completion: 6/30/26 Responsibility: Maintenance Supervisor	06/30/2026

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K0222 SS = E Bldg. 01	Continued from page 8 Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain emergency egress doors and gates per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.1, 7.2.1.1.1, 7.2.1.4.5.1, 7.2.1.5.1, 7.2.1.5.3, 7.2.1.5.10.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 06/23/2026 at 12:35 PM, it was revealed by observation that the exit door in the chapel was difficult to open. The crash bar did not operate properly when pushed straight on and would only release the door when pressure was applied at an angle. 2. On 06/23/2026 at 12:49 PM, it was revealed by observation that the courtyard gate, which served an area accessed by at least two building exits, was not readily openable from the egress side. The latch was mounted approximately 83 inches above grade, and the release handle was located on the exterior side of the gate. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0222		06/30/2026
K0226 SS = E Bldg. 01	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This STANDARD is NOT MET as evidenced by:	K0226	The plan of correction has been revised. Designated Company, Thermal Solutions INC, has been on site since 7/27/26 completing the necessary sealing of penetrations and a facility wide inspection will be completed to identify any additional unsealed penetrations and these will be repaired. The plan of correction completion date has been updated to ensure proper time-frame of completion.	08/14/2026

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K0226 SS = E Bldg. 01	Continued from page 9 Based on observation and staff interview, the facility failed to maintain fire barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.5, 7.2.4.3.1, and 8.3.1.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/23/2026 at 12:22 PM, it was revealed by observation that multiple unsealed penetrations were observed in the 2-hour fire-rated wall separating the nursing home and hospital. The penetrations were located above the fire doors at the entrance to the hospital corridor. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0226		08/14/2026
K0321 SS = E Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms	K0321	Midwest Glass arrived today and completed the inspection and repair of the door to ensure the door securely latches. The plan of correction completion date has been updated to reflect the completion date.	07/28/2026

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K0321 SS = E Bldg. 01	Continued from page 10 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, sections 5.1.3.2 and 5.2.4.2 (8). These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 06/23/2026 at 12:39 PM, it was revealed by observation that the laundry soiled utility room was provided with two separate doors. The door located on the right side failed to latch when closed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0321		07/28/2026
K0324 SS = E Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.	K0324	The facility failed to install the required safety features for cooking equipment as evidenced by the oven located in the activity room near the nursing home serving kitchen does not have a locked switch, or a switch located in a restricted location, that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. Maintenance Supervisor ordered a key switch timer for the oven to ensure the equipment is equipped with required safety control in place. Installation will be completed upon receipt of the device. Upon installation of the key switch timer, the Maintenance Supervisor will verify proper function of the device. Completion: 7/31/26 Responsibility: Maintenance Supervisor	07/31/2026

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K0324 SS = E Bldg. 01	Continued from page 11 Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to install the required safety features for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.3 (9) and 19.3.2.5.4. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/23/2026 at 12:44 PM, it was revealed by observation that the oven located in the activity room near the nursing home serving kitchen does not have a locked switch, or a switch located in a restricted location, that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0324		07/31/2026
K0363 SS = E Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided	K0363	The facility failed to maintain corridor doors per NFPA 101 1. The door to resident room 204 was immediately addressed and appropriate maintenance intervention was used to correct the sticky door handle. Additionally, medical supplies hanging on the door were removed and relocated to prevent interference with proper door closure. LTC DON informed. Rounding will be completed monthly to include observations of doors, hardware, and items attached to doors to ensure compliance with safety requirements. 2. The door to the storage room was replaced with a new handle. Review of handles will be addressed in above audit. Completion: 7/17/26	07/17/2026

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K0363 SS = E Bldg. 01	Continued from page 12 with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 06/23/2026 at 12:54 PM, it was revealed by observation that the door to Resident Room 204 did not latch properly due to a sticking door handle and medical supplies hanging on the door that interfered with door operation. 2. On 06/23/2026 at 1:00 PM, it was revealed by observation that the door to the storage room across from resident room 208 did not latch properly due to the latch being stuck inside the door. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0363	Continued from page 12 Responsibility: Maintenance Supervisor; Environmental Services; DON	07/17/2026
K0372 SS = E Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING	K0372	The plan of correction has been revised. Designated Company, Thermal Solutions INC, has been on site since 7/27/26 completing the necessary sealing of penetrations and a facility wide inspection will be completed to identify any additional unsealed penetrations and these will be repaired.	08/14/2026

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K0372 SS = E Bldg. 01	Continued from page 13 Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/23/2026 at 12:32 PM, it was revealed by observation that an unsealed penetration was observed in the smoke barrier above the smoke barrier doors near Resident Room 201 and the medication room. The penetration was caused by an electrical conduit passing through the barrier above the HVAC ductwork. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0372	Continued from page 13 The plan of correction completion date has been updated to ensure proper time-frame of completion.	08/14/2026
K0712 SS = C Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by:	K0712	The facility failed to conduct fire drills; it was revealed by a review of available documentation that the fire drills conducted on January 22, 2026, at 8:30 p.m., April 27, 2026, at 7:00 p.m., and December 19, 2025, at 2:30 p.m. were initiated by coded announcement and did not include activation of the fire alarm system. The facility will ensure all fire drills between 6am and 9pm are conducted in accordance with the NFPA requirements, including appropriate scheduling, activation of the fire alarm system and completion of required documentation. Monthly audits will be completed to review and identify any concerns that need to be corrected. The facility will incorporate these audits into our QAPI program to ensure ongoing compliance. Completion: 8/14/26	08/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245467	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/23/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDRICKS COMMUNITY HOSPITAL	**503 E LINCOLN STREET , HENDRICKS, Minnesota, 56136**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0712 SS = C Bldg. 01	Continued from page 14 Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 19.7.1.7, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/23/2026 between 10:45 AM and 01:30 PM, it was revealed by a review of available documentation that the fire drills conducted on January 22, 2026, at 8:30 p.m., April 27, 2026, at 7:00 p.m., and December 19, 2025, at 2:30 p.m. were initiated by coded announcement and did not include activation of the fire alarm system. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0712	Continued from page 14 Responsibility: Maintenance Supervisor; DON; Administrator The plan of correction completion date has been updated to reflect the completion date within the 70-day timeframe.	08/14/2026