Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 29, 2023

Administrator
Evansville Care Center
649 State Street Northwest
Evansville, MN 56326

RE: CCN: 245510
Cycle Start Date: December 19, 2023

Dear Administrator:

On December 19, 2023, 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:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 March 19, 2024 (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 June 19, 2024 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

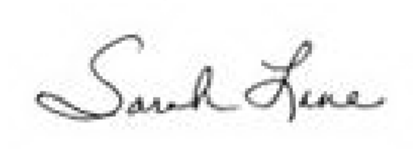
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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December 29, 2023

Administrator
Evansville Care Center
649 State Street Northwest
Evansville, MN 56326

Re: State Nursing Home Licensing Orders
Event ID: 4G0X11

Dear Administrator:

The above facility was surveyed on December 17, 2023 through December 19, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

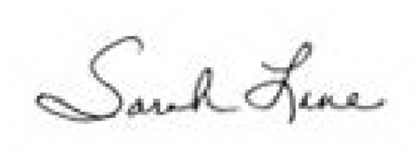
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245510	A. BUILDING _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE CARE CENTER	649 STATE STREET NORTHWEST EVANSVILLE, MN 56326

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E 000	Initial Comments On 12/17/23 to 12/19/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1),	E 041		1/31/24

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

Electronically Signed | 01/05/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 041	Continued From page 1 §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the	E 041		

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E 041	Continued From page 2 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..	E 041		

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E 041	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete weekly inspections of the generator. This deficient practice had the potential to affect all 20 residents residing in the facility. Findings include: On 12/19/2023, between 9:00 a.m. and 1:00 p.m., it was revealed by a review of available documentation of the emergency generator maintenance and testing weekly generator inspections were not performed from 1/01/2023 to 12/19/2023. An interview with Maintenance Director verified these deficient findings at the time of discovery.	E 041	Through documentation review, it was determined that weekly maintenance and testing of the generator was not completed. Documentation was available at the time of inspection but was missed by Fire Marshal. Per Fire Marshal, review of the missed documents will be done at re-inspection. An audit for generator inspection with an outside entity was added to the annual maintenance log. Annual inspection was scheduled with outside company. They did not give a date certain, but suggested it would be done by 1/31/24. Education provided to all staff on 1/11/24.	
F 000	INITIAL COMMENTS On 12/17/23 to 12/19/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaint was reviewed with no deficiency cited. H55107926C (MN00089344). 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	F 000		

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F 000	Continued From page 4 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 that substantial compliance with the regulations has been attained.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with personal hygiene for 1 of 2 residents(R11) reviewed for activities of daily living (ADL)'s. Findings include: R11's quarterly Minimum Data Set (MDS) dated 11/22/23, identified R11 had moderate cognitive impairment and had diagnosis which included hypertension (elevated blood pressure), Diabetes Mellitus (DM), and hemiplegia (paralysis of one side of the body). Identified R11 required extensive assistance with ADL's which included bed mobility, transfers, and personal hygiene. R11's current care plan revised 7/24/23, indicated R11 was dependent with ADL's which included dressing, bathing, and grooming. Indicated staff were to assist R11 with grooming daily.	F 677	R11 interviewed and care plan, care sheet and charting were updated to reflect resident's preferences. Policies and procedures for ADLs reviewed and updated. All nursing staff will be educated on the policies and procedures. An audit was conducted on all residents during their routinely scheduled bath to identify any further residents affected. The situation was determined to be isolated to R11. All care plans have been updated to reflect residents' preferences. DON or designee will complete random unannounced observational audits for 10% of all dependent residents daily for 7 days; then 2x a week for 30 days or until 100% compliance is achieved. All audit outcomes shall be presented to the QAA Committee for review &/or comment. Corrective actions will be completed by January 12th 2024.	1/12/24

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F 677	Continued From page 5 R11's resident care sheet revised 12/17/23, indicated R11 required staff assistance with hygiene. R11's comprehensive Care Area Assessment (CAA) dated 6/8/23, identified R11 required staff assistance with ADL's. During an observation on 12/17/23 at 10:57 a.m., R11 was seated in a recliner in his room and had several gray 1/2 inch long facial hairs present on his cheeks, chin and above his lips. During an interview on 12/17/23 at 11:03 a.m., R11 stated he required assistance from staff to shave. R11 stated he preferred to be shaved every day or when facial hair was present. R11 indicated he had not been shaved since last week. During an observation on 12/17/23 at 6:09 p.m., R11 was seated in a recliner in his room and continued to have several gray 1/2 inch long facial hairs present on his cheeks, chin, and above his lips. During an observation on 12/18/23 at 8:28 a.m., R11 was seated in the dining room and continued to have several gray 1/2 inch long facial hairs present on his cheeks, chin, and above his lips. During an interview on 12/18/23 at 9:07 a.m., nursing assistant (NA)-A stated R11 required staff assistance to shave facial hair. NA-A stated she had had not offered to assist R11 with shaving and was unsure the last time R11 had been shaved. During an interview on 12/18/23 at 9:11 a.m.,	F 677		

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F 677	Continued From page 6 licensed practical nurse (LPN)-A stated R11 required staff assistance to shave his facial hair. RN-A verified R11 had several long facial hairs and was unsure when the last time R11 had been shaved. LPN-A stated her expectation was R11 would have been shaved daily or when facial hair was present. During an interview on 12/18/23 at 1:10 p.m., director of nursing (DON) indicated R11 required staff assistance with shaving. DON stated her expectation was R11 would have been shaved daily or when facial hair was present. A policy for activities of daily living (ADL's) was requested however, one was not provided.	F 677		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		1/12/24

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F 880	Continued From page 7 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

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	245510	A. BUILDING _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 8 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal laundry was transported in a manner that prevented risk of contamination for 2 of 3 hallways observed for linen transportation. Findings include: Review of Centers for Disease Control (CDC) guidance, Appendix D - Linen and Laundry Management updated 5/4/23, identified linens must be sorted, packaged, transported, and stored in a manner that prevented risk of contamination by dust, debris, soiled linens or soiled items. During an observation on 12/18/23 at 11:07 a.m., in the north hallway, social services housekeeping manager (SS)-A exited the laundry room with the laundry cart uncovered and pushed the laundry cart down the west hallway. SS-A proceeded to R21's room, removed laundry from the uncovered cart, placed the laundry in R21's closet, exited R21's room with empty hangers and hung the hangers in the cart. SS-A removed laundry from the uncovered cart, placed the laundry in R1's closet, exited R1's room with empty hangers and hung the hangers in the cart. SS-A removed laundry from the uncovered cart, placed the laundry in R8's closet, exited R8's room with empty hangers and hung the hangers	F 880	The laundry cart was inspected, and the cover is sufficient and in proper order. Sanitizer in each room located and in working order. Identified staff educated on the need for the cart to be covered and proper hand hygiene practices. Policies and procedures for laundry handling reviewed and updated. All staff will be educated in policies and procedures on 01/11/2024. Infection control nurse or designee will complete laundry audits during linen pass daily for 7 days; then 2x a week for 30 days or until 100% compliance is achieved. All audit outcomes shall be presented to the QAA Committee for review &/or comment. Corrective actions will be completed by January 12th, 2024.	

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F 880	Continued From page 9 in the cart. SS-A pushed the uncovered cart down the hallway, removed laundry from the uncovered cart, placed the laundry in R4's closet, exited R4's room with empty hangers and hung the hangers in the cart. SS-A proceeded to R10's room, removed laundry from the uncovered cart, placed the laundry in R10's closet, exited R10's room with empty hangers and hung the hangers in the cart. SS-A removed laundry from the uncovered cart, placed the laundry in R12's closet, exited R12's room with empty hangers and hung the hangers in the cart. SS-A removed laundry from the uncovered cart, placed the laundry in R18's closet, exited R18's room with empty hangers and hung the hangers in the cart. SS-A removed laundry from the uncovered cart, placed the laundry in R14's closet, exited R14's room with empty hangers and hung the hangers in the cart. SS-A removed laundry from the uncovered cart, placed the laundry in R15's closet, exited R15's room with empty hangers and hung the hangers in the cart. SS-A removed laundry from the uncovered cart, placed the laundry in R15's closet, exited R15's room with empty hangers and hung the hangers in the cart. SS-A removed more laundry from the cart and placed in R15's closet. SS-A pushed the cart past the exercise group in the lounge area and returned it to the laundry room. SS-A did not sanitize her hands and the laundry cart remained uncovered during the entire observation. During an interview on 12/18/23 at 3:13 p.m., SS-A verified she removed clothes from the uncovered cart, placed them in the residents' closets, took back any hangers to the uncovered cart and did not sanitize her hands. SS-A verified	F 880		

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F 880	Continued From page 10 the expectation of staff would be to sanitize hands on the way out of rooms or in the hallway and to keep the laundry cart covered. SS-A stated the purpose of keeping the cart covered and for completing hand hygiene was to prevent the spread of infection between residents. During an interview on 12/18/23 at 3:19 p.m., the director of nursing (DON) verified the expectation of staff delivering laundry was to keep the laundry cart covered during delivery and to complete hand hygiene in between. DON stated these practices were important to prevent contamination from the environment and cross contamination of surfaces. Review of a facility policy titled Laundry Washing/Deliver Policy dated 10/26/23, indicated laundry should be packaged, transported and stored in a manner that ensured cleanliness and protected the laundry from dust and soil. Clothing would be taken out of cart and covered again while unattended in the hallways. Laundry staff would sanitize hands on the way out of the resident room.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 883		1/31/24

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F 883	Continued From page 11 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and	F 883		

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F 883	Continued From page 12 (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R3 and R13) were offered or received pneumococcal vaccinations in accordance with the Center for Disease Control (CDC) recommendations. Findings include: Review of the current CDC recommendations dated 3/15/2023, revealed older adults who received Pneumococcal conjugate vaccine (PCV13) at any age and Pneumococcal polysaccharide vaccine (PPSV23) before age 65 years, the CDC recommended they receive one dose of PCV20 or PPSV23. Review of R3's facesheet identified R3, age 79 was admitted to the facility on 1/10/17. Review of R3's Minnesota Immunization Information Connection (MIIC) undated, identified R3 had received the PPSV23 on 11/01/1998, and 11/2/2006, and the PCV13 on 11/7/2016. R3's medical record lacked documentation R3 had been offered or received the PCV20 vaccine or an additional dose of PPSV23. Review of R13's facesheet identified R13, age 78 was admitted to the facility on 10/31/23. Review of R13's MIIC undated, identified R13 had received the PPSV23 on 10/24/2002, and on 10/2/2009, and the PCV13 on 7/27/2016. R13's medical record lacked documentation R13 had been offered or received the PCV20 vaccine or	F 883	All current resident records reviewed and all residents that have been identified eligible for PCV 20 will be offered the vaccination via a consent/declination form. The nursing admission packet was reviewed, and consents and education have been added. Education will be provided to all current residents or resident represenitives on eligibility of the vaccination and VIS will be provided. Policies and procedures for vaccinations including pneumococcal vaccinations reviewed and updated. All staff will be educated through in-service. Audits of vaccine acceptance/declination will be conducted by the infection control nurse monthly indefinitely. All audit outcomes shall be presented to the QAA Committee for review &/or comment. Corrective actions will be completed by January 31st, 2024.	

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F 883	Continued From page 13 an additional dose of PPSV23. During an interview on 12/19/23 at 8:34 a.m., infection preventionist (IP) confirmed R3 and R13 had not been offered or received the pneumococcal vaccines as recommended by the CDC. IP indicated she was aware of the new CDC guidelines from 3/23, however misunderstood the guidelines for those residents who had previously received both the PCV13 and PPSV23 vaccine. IP stated her expectation was the facility would offer and administer all vaccinations per CDC recommendations. During an interview on 12/19/23 at 8:45 a.m., director of nursing (DON) stated she was aware of the CDC guidelines from 3/23, and would review the guidelines again to assure she understood them. Review of a facility policy titled SNF Vaccination of residents-Influenza, pneumococcal, revised 10/26/23, indicated pneumococcal vaccinations would be offered and administered to all eligible residents as appropriate.	F 883		

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	245510	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE CARE CENTER	**649 STATE STREET NORTHWEST** **EVANSVILLE, MN 56326**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/19/2023. At the time of this survey, Evansville Care Center 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.	K 000		

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

Electronically Signed | 01/05/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
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.

Evansville Care Center is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1968 and was determined to be of Type I(332) construction. In 1988, additions were added to the south of the Main Lounge and to the west of the North Wing that were determined to be of Type V(111) construction. In 1998 an addition was added to the end of West Wing that was determined to be of Type V(111) construction. Because the original building and

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	245510	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/19/2023**

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K 000	Continued From page 2 the additions meet the construction types allowed for existing buildings, the facility was surveyed as one building. The facility is completely fire sprinkler protected. The facility has a fire alarm system with smoke detectors in the corridors and areas open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 37 beds and had a census of 24 at the time of the survey.	K 000		
K 281 SS=D	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide the level of lighting as required by the Life Safety Code, (NFPA 101) 2012 edition section 7.8.1.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/19/2023, between 0900am and 100pm, it	K 281	Two doors were found to only have one bulb for illumination and are not backed up with generator power. New light fixtures were installed on the east wing and lower-level with two bulbs on each egress. An audit to check outside lighting/bulbs was added to the monthly maintenance log. Electrician ordered light fixtures to be installed. Date certain 1/31/24.	1/31/24

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K 281	Continued From page 3 was revealed by observation that the exterior lights for door at end of East Wing and outside of the door on the lower level egress discharges had only one bulb for illumination and / or were not back up with emergency generator power. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 281		
K 321 SS=E	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 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet)	K 321		1/12/24

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K 321	Continued From page 4 g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have a patterned impact on the residents within the facility. Findings include: On 12/19/2023, between 0900am and 100pm, it was revealed by observation that following storage room did not have a self-closing device; 1) Lower Level Office 2 storage room 2) Lower Level main storage room 3) Patient room (RM 106) that was converted to storage room. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 321	Three rooms were found to be storage areas and did not have self-closing device on door. Two self-closing devices have been installed in lower-level office two and lower-level main storage area. Room 106 was cleaned and items removed from room. An audit to check rooms as storage was added to monthly maintained log to ensure proper closures on rooms that are used for storage. Date certain 1/12/24.	
K 363 SS=D	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	K 363		12/20/23

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K 363	Continued From page 5 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 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 REQUIREMENT 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. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/19/2023, between 0900am and 100pm, it was revealed by observation that the resident room door 112 does not latch.	K 363	One door was found not to latch. The latch on room 112 was adjusted so the door latches when closed. An audit to check door latches was added to the monthly maintenance log. Date certain 12/20/23.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245510	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE CARE CENTER	**649 STATE STREET NORTHWEST** **EVANSVILLE, MN 56326**

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K 363	Continued From page 6 An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 363		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 12/19/2023, between 0900am and 100pm, it was revealed by observation that there was a penetration running through fire walls in furnace room on lower level. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 372	A penetration running through fire walls in furnace room was found. Holes were repaired to ensure fire wall integrity. An audit to ensure all fire walls are in compliance after construction/additions/changes was added to the monthly maintenance log. Date certain 12/28/23.	12/28/23

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	245510	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/19/2023**

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K 918 SS=F	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. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation	K 918	Through documentation review, it was	1/31/24

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	245510	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/19/2023**

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K 918	Continued From page 8 and staff interview, the facility failed to install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 5.6.5.2, 5.6.5, 5.6.5.6, 5.6.5.6.1, 5.6.6, 8.3.8,8.4.1, 8.4.2.1, 8.4.2.3,8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 12/19/2023, between 0900am and 100pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing weekly generator inspections were not performed from 01/01/2023 to 12/19/2023. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 918	determined that weekly maintenance and testing of the generator was not completed. Documentation was available at the time of inspection but was missed by Fire Marshal. An annual inspection was scheduled with outside company. They did not give a date certain, but suggested it would be done by 1/31/24.	

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/17/23 to 12/19/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. In addition, a complaint survey was completed.	2 000		

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2 000	Continued From page 1 The following complaint was reviewed during the survey with no licensing order issued. H55107926C (MN00089344). Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be	2 000		

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2 000	Continued From page 2 corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with personal hygiene for 1 of 2 residents(R11) reviewed for activities of daily living (ADL)'s. Findings include: R11's quarterly Minimum Data Set (MDS) dated 11/22/23, identified R11 had moderate cognitive impairment and had diagnosis which included hypertension (elevated blood pressure), Diabetes Mellitus (DM), and hemiplegia (paralysis of one side of the body). Identified R11 required extensive assistance with ADL's which included	2 850	Corrected.	1/12/24

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2 850	Continued From page 3 bed mobility, transfers, and personal hygiene. R11's current care plan revised 7/24/23, indicated R11 was dependent with ADL's which included dressing, bathing, and grooming. Indicated staff were to assist R11 with grooming daily. R11's resident care sheet revised 12/17/23, indicated R11 required staff assistance with hygiene. R11's comprehensive Care Area Assessment (CAA) dated 6/8/23, identified R11 required staff assistance with ADL's. During an observation on 12/17/23 at 10:57 a.m., R11 was seated in a recliner in his room and had several gray 1/2 inch long facial hairs present on his cheeks, chin and above his lips. During an interview on 12/17/23 at 11:03 a.m., R11 stated he required assistance from staff to shave. R11 stated he preferred to be shaved every day or when facial hair was present. R11 indicated he had not been shaved since last week. During an observation on 12/17/23 at 6:09 p.m., R11 was seated in a recliner in his room and continued to have several gray 1/2 inch long facial hairs present on his cheeks, chin, and above his lips. During an observation on 12/18/23 at 8:28 a.m., R11 was seated in the dining room and continued to have several gray 1/2 inch long facial hairs present on his cheeks, chin, and above his lips. During an interview on 12/18/23 at 9:07 a.m., nursing assistant (NA)-A stated R11 required staff	2 850		

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2 850	Continued From page 4 assistance to shave facial hair. NA-A stated she had had not offered to assist R11 with shaving and was unsure the last time R11 had been shaved. During an interview on 12/18/23 at 9:11 a.m., licensed practical nurse (LPN)-A stated R11 required staff assistance to shave his facial hair. RN-A verified R11 had several long facial hairs and was unsure when the last time R11 had been shaved. LPN-A stated her expectation was R11 would have been shaved daily or when facial hair was present. During an interview on 12/18/23 at 1:10 p.m., director of nursing (DON) indicated R11 required staff assistance with shaving. DON stated her expectation was R11 would have been shaved daily or when facial hair was present. A policy for activities of daily living (ADL's) was requested however, one was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to ensure all residents are shaved per their preference. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 850		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection	21375		1/12/24

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21375	Continued From page 5 control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal laundry was transported in a manner that prevented risk of contamination for 2 of 3 hallways observed for linen transportation. Findings include: Review of Centers for Disease Control (CDC) guidance, Appendix D - Linen and Laundry Management updated 5/4/23, identified linens must be sorted, packaged, transported, and stored in a manner that prevented risk of contamination by dust, debris, soiled linens or soiled items. During an observation on 12/18/23 at 11:07 a.m., in the north hallway, social services housekeeping manager (SS)-A exited the laundry room with the laundry cart uncovered and pushed the laundry cart down the west hallway. SS-A proceeded to R21's room, removed laundry from the uncovered cart, placed the laundry in R21's closet, exited R21's room with empty hangers and hung the hangers in the cart. SS-A removed laundry from the uncovered cart, placed the laundry in R1's closet, exited R1's room with empty hangers and hung the hangers in the cart. SS-A removed laundry from the uncovered cart, placed the laundry in R8's closet, exited R8's room with empty hangers and hung the hangers in the cart. SS-A pushed the uncovered cart down the hallway, removed laundry from the uncovered cart, placed the laundry in R4's closet, exited R4's	21375	Corrected.	

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21375	Continued From page 6 room with empty hangers and hung the hangers in the cart. SS-A proceeded to R10's room, removed laundry from the uncovered cart, placed the laundry in R10's closet, exited R10's room with empty hangers and hung the hangers in the cart. SS-A removed laundry from the uncovered cart, placed the laundry in R12's closet, exited R12's room with empty hangers and hung the hangers in the cart. SS-A removed laundry from the uncovered cart, placed the laundry in R18's closet, exited R18's room with empty hangers and hung the hangers in the cart. SS-A removed laundry from the uncovered cart, placed the laundry in R14's closet, exited R14's room with empty hangers and hung the hangers in the cart. SS-A removed laundry from the uncovered cart, placed the laundry in R15's closet, exited R15's room with empty hangers and hung the hangers in the cart. SS-A removed laundry from the uncovered cart, placed the laundry in R15's closet, exited R15's room with empty hangers and hung the hangers in the cart. SS-A removed more laundry from the cart and placed in R15's closet. SS-A pushed the cart past the exercise group in the lounge area and returned it to the laundry room. SS-A did not sanitize her hands and the laundry cart remained uncovered during the entire observation. During an interview on 12/18/23 at 3:13 p.m., SS-A verified she removed clothes from the uncovered cart, placed them in the residents' closets, took back any hangers to the uncovered cart and did not sanitize her hands. SS-A verified the expectation of staff would be to sanitize hands on the way out of rooms or in the hallway and to keep the laundry cart covered. SS-A stated the purpose of keeping the cart covered and for	21375		

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21375	Continued From page 7 completing hand hygiene was to prevent the spread of infection between residents. During an interview on 12/18/23 at 3:19 p.m., the director of nursing (DON) verified the expectation of staff delivering laundry was to keep the laundry cart covered during delivery and to complete hand hygiene in between. DON stated these practices were important to prevent contamination from the environment and cross contamination of surfaces. Review of a facility policy titled Laundry Washing/Deliver Policy dated 10/26/23, indicated laundry should be packaged, transported and stored in a manner that ensured cleanliness and protected the laundry from dust and soil. Clothing would be taken out of cart and covered again while unattended in the hallways. Laundry staff would sanitize hands on the way out of the resident room. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to hand hygiene and procedures to prevent contamination during transport of laundry. The DON or designee could educate staff on the policies and the quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and	21426		1/12/24

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21426	Continued From page 8 maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete Tuberculosis (TB) symptom screening for 4 of 5 residents (R5, R13, R20 and R276) reviewed for TB testing. Findings include: Review of R5's face sheet identified R5 was admitted to the facility on 6/12/23. R5's medical record lacked documentation the baseline TB symptom screening had been completed. Review of R13's face sheet identified R13 was admitted to the facility on 10/31/23. R13's medical record lacked documentation the baseline TB symptom screening had been completed.	21426	Corrected.	

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21426	Continued From page 9 Review of R20's face sheet identified R20 was admitted to the facility on 12/13/22. R20's medical record lacked documentation the baseline TB symptom screening had been completed. Review of R276's face sheet identified R276 was admitted to the facility on 11/27/23. R276's medical record lacked documentation the baseline TB symptom screening had been completed. During an interview on 12/18/23 at 4:50 p.m., infection preventionist (IP) confirmed TB symptom screenings had not been completed for R5, R13, R20, and R 276. IP stated her expectation was the screenings would have been completed. During an interview on 12/18/23 at 4:55 p.m., director of nursing (DON) confirmed the TB symptom screenings should have been completed upon admission. DON stated her expectation was the screenings would have been completed upon admission. Review of a facility policy undated, titled TB Screening for Residents of Traditional Facility-Based settings indicated to determine the TB disease status of residents nursing would have completed a risk assessment for TB disease. Identified all residents would have TB screenings. SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise the current TB policy to ensure residents are screened for symptoms of TB when admitted to the facility. The Quality Assurance and Assessment committee could randomly audit	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00110	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE CARE CENTER	649 STATE STREET NORTHWEST EVANSVILLE, MN 56326

(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) COMPLETE DATE
21426	Continued From page 10 records to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21426		