DEPARTMENT OF HEALTH AND HUMAN SERVICES | CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 4TBH
Facility ID: 00340

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245467**

2. STATE VENDOR OR MEDICAID NO. (L2) **204342400**

3. NAME AND ADDRESS OF FACILITY
(L3) **HENDRICKS COMMUNITY HOSPITAL**
(L4) **503 E LINCOLN STREET**
(L5) **HENDRICKS, MN** (L6) **56136**

4. TYPE OF ACTION: **7** (L8)

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **09/24/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **58** (L18)

13.Total Certified Beds **58** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	58			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 09/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/25/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **04/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245467

September 25, 2015

Mr. Jeffrey Gollaher, Administrator
Hendricks Community Hospital
503 E Lincoln Street
Hendricks, Minnesota 56136

Dear Mr. Gollaher:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 15, 2015 the above facility is certified for or recommended for:

58 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 58 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 25, 2015

Mr. Jeffrey Gollaher, Administrator
Hendricks Community Hospital
503 E Lincoln Street
Hendricks, Minnesota 56136

RE: Project Number S5467025

Dear Mr. Gollaher:

On August 20, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 6, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 24, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 8, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 6, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 15, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 6, 2015, effective September 15, 2015 and therefore remedies outlined in our letter to you dated August 20, 2015, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245467	A. Building B. Wing	9/24/2015

Name of Facility	Street Address, City, State, Zip Code
HENDRICKS COMMUNITY HOSPITAL	503 E LINCOLN STREET HENDRICKS, MN 56136

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0176** Reg. # **483.10(n)** LSC	**09/15/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	**09/15/2015**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	**09/15/2015**
ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	**09/10/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**09/10/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	**09/15/2015**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	**09/15/2015**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	**09/15/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**09/15/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	**09/15/2015**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	**09/15/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	**09/15/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	**09/15/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	**09/11/2015**	ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KS/kfd	09/25/2015	03048	09/24/2015

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/6/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245467	01 - MAIN BUILDING 01	9/8/2015

Name of Facility	Street Address, City, State, Zip Code
HENDRICKS COMMUNITY HOSPITAL	503 E LINCOLN STREET HENDRICKS, MN 56136

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 08/18/2015	ID Prefix Reg. # NFPA 101 LSC K0047	Correction Completed 08/20/2015	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 08/12/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GS/kfd	09/25/2015	35482	09/08/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/4/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 4TBH
Facility ID: 00340

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245467**

2. STATE VENDOR OR MEDICAID NO. (L2) **204342400**

3. NAME AND ADDRESS OF FACILITY
(L3) **HENDRICKS COMMUNITY HOSPITAL**
(L4) **503 E LINCOLN STREET**
(L5) **HENDRICKS, MN** (L6) **56136**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/06/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **58** (L18)

13. Total Certified Beds **58** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	58			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Pamela Hovdet, HFE NE II 08/31/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/21/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21.
1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 20, 2015

Mr. Jeffrey Gollaher, Administrator
Hendricks Community Hospital
503 E Lincoln Street
Hendricks, Minnesota 56136

RE: Project Number S5467025

Dear Mr. Gollaher:

On August 6, 2015, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Kathryn.serie@state.mn.us
Office: (507) 476-4233
Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 15, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 15, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 November 6, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 6, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245467	A. BUILDING ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDRICKS COMMUNITY HOSPITAL	**503 E LINCOLN STREET HENDRICKS, MN 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
F 000	INITIAL COMMENTS 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. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=E	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assess the ability to self administer medications for 5 of 11 residents (R4, R5, R9, R51, R52) observed to self administer medications. Findings include: It was observed on 8/3/15, at 11:25 a.m. while interviewing R52 in a room shared with his spouse (R51) that two medication cups were left sitting on a small table in between two recliners occupied by R51 and R52. One medication cup	F 176	Resident assessments will be completed to determine ability to safely self administer medication. If assessed as capable, a physician order will be secured. Policy has been reviewed and updated. The resident assessment tool has been updated. Education to nursing and TMA staff will be conducted by 9/10/15. Monitoring of staff compliance to assure medication administration practices are followed will be implemented. Three medication passes will be monitored/week for a minimum of 5	9/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE — 08/28/2015

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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	245467	A. BUILDING ______ B. WING ______	08/06/2015

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F 176	Continued From page 1 had two large white oblong tablets along with a few smaller tablets in it and the other medication cup contained pudding with a spoon sticking out of it. R52 stated his wife R51 likes to take the pills right before dinner and she takes them with pudding. While interviewing R52, it was noted that R51 took the medication in the cup mixed with the pudding. During the supper meal on 8/4/15, at 5:52 p.m. it was noted that both R51 and R52 were seated at a dining room table. It was noted that registered nurse (RN)-D placed a plastic medication cup next to R51 and another plastic medication cup next to R52. Both cups had medication mixed with applesauce. It was observed that RN-D left the table to dish up more medications from the medication cart located in the hallway outside of the dining room. She left prior to either R51 or R52 taking their respective medications. RN-D had her back to both residents as they consumed their medications. When interviewed on 8/3/15, at 11:58 a.m. RN-C stated there are some residents they routinely leave medications with so they can take them after the nurse has set them up into the medication cup. RN-C stated R51 and R52 eat breakfast in their room so their medications are left with them. RN-C added some residents request to have their medications left with them and staff will accommodate them as long as the resident is trustworthy and there is no cognitive impairment or history of refusing mediations. RN-C further stated they consider medication self administration when the resident can identify their own medication and demonstrate the ability to set up their medication. They also require a self administration assessment and physician's order.	F 176	residents per medication pass. The Director of Nursing or designee will monitor effectiveness of correction. Audit outcomes and will be evaluated by Quality Assurance.	

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Both an assessment and physician order was lacking in the records for R51 and R52.

It was observed during the evening meal on 8/4/15, at 5:45 p.m. that RN-D delivered liquid potassium mixed with juice to the table where R4 was seated. R4 was seated at the table with 3 other residents. R4 left the table area at 6:36 p.m. and the medication had not yet been consumed. The medication remained at the table during the entire evening meal until 6:55 p.m. when the dietary aide cleared the table, dumped the contents of the juice glass into a bucket of remaining juices left on the tables and not consumed.

When interviewed on 8/4/15, at 7:32 p.m. RN-D confirmed she had mixed the liquid potassium in a smaller plastic cup with juice.

When interviewed on 8/6/15, at 11:54 a.m. RN-C stated the nurses know that they need to make sure R4 receives her medication as she doesn't always want to take her medication and this has been a problem. RN-C reiterated the nurses should know better than this.
R5 failed to have an assessment conducted to identify her ability to safely self administer medications.

During observation of the noon meal on 8/3/15, at 11:52 a.m. R5 was observed seated at the dining room table with a plastic medication cup located on the table in front of her which contained crushed medication mixed in applesauce. There were three other residents seated at the table. The medication cup remained at the table throughout the noon meal until R5 self administered the medications at 12:10 p.m.

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Licensed practical nurse (LPN)-A was noted to leave the dining room area at the time of the observation and was in a location where she unable to visualize R5.

During observation of the evening meal on 8/4/15, at 5:15 p.m. R5 was again observed to have a plastic medication cup located on the table in the dining room table where she was seated. It contained crushed medication in applesauce. There were three other residents seated at the table with her. R5 self administered the medications at 5:32 p.m. Registered nurse (RN)-G, who left the medications placed on the table, left the dining room area multiple times and was unable to monitor and/or continuously visualize R5 during the observation.

When the medical record was reviewed, it lacked any assessment related to R5's ability to self administer medications.

During interview on 8/5/15, at 12:43 p.m. RN-C verified R5 lacked a self administration of medication assessment. There also were no orders from the physician identifying R5 as able to safely self administer her own medications. RN-C verified the medications should not be left on the table for self administration unless there was an assessment to identify the resident was safe to do so and then a physician order for self administration of medications would be required. R9 failed to have an assessment conducted to identify her ability to safely self administer medications.

During observation of the supper meal on 8/4/15, at 5:27 p.m. R9 was observed seated in her wheelchair at the dining room table with a white

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paper medication cup on the table in front of her that contained medication while R9 was sleeping with her chin resting against her chest. There were three other residents seated at the table with her. R9 was observed to have the medications sitting on the table until her supper meal came at 5:53 p.m. Staff proceeded to wake R9 up to eat and then R9 proceeded to self administer her medications independently prior to eating supper. RN-G, who left the medications placed on the table, left the dining room area multiple times and did not have R9 within view during the observation.

During review of R9's medical record it was noted R9 lacked an assessment to identify her ability to self administer medications.

When physician orders were reviewed, they indicated R9 may self administer AM (morning) oral medications after set up by nurse.

During interview on 8/6/15 at 2:13 p.m. RN-C confirmed R9 lacked a self administration assessment and only had physician orders to: self administer AM oral meds after set up by nurse. RN-C verified the medications should not be left on the table for self administration unless there was an assessment to identify the resident was safe and when the resident was sleeping and stated "this is unsafe practice and the medication should not have been left with the resident."

The facility had developed a Medication Administration Orientation worksheet, undated, which was used to train staff on the facility standard for medication administration. Item 8. d. on the orientation sheet identified staff were to observe residents during the administration to

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F 176	Continued From page 5 ensure the medication was taking appropriately.	F 176		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to promote a dignified dining experience by serving breakfast on Styrofoam plates and bowls and using plastic utensils for 24 of 24 residents (R4, R5, R6, R7, R8, R9, R11, R13, R16, R22, R23, R25, R27, R28, R31, R34, R41, R44, R45, R47, R51, R52, R56 and R61) observed being served breakfast in their rooms. Findings include: During observation on 8/3/15, at 9:30 a.m. three stainless steel carts containing breakfast items were located in the dining room and at the end of the East and West hallways. Each of the carts contained oatmeal, bread for toast, 1/2 gallon milk cartons, yogurt and various juices. Nursing assistants were observed to prepare breakfast items located on the carts and place the food items onto Styrofoam plates and/or bowls. Thin, white plastic silverware was retrieved from the cart with the food item and delivered to each resident located on the east and west halls and who preferred to eat in their room for the breakfast meal;(R4, R5, R6, R7, R8, R9, R11,	F 241	Regular ceramic dishes and metal reusable silverware replaced utilization of Styrofoam or plastic 8/11/2015. Breakfast cart policy was updated to state that real silverware, plates and bowls will be used in the dining room. Styrofoam and plastic plates/silverware were removed from all locations in the Nursing Home and replaced with reusable utensils and dishware. Staff meeting 9/10/15 to go over correct tableware and utensil utilization for meals. Dietary manager or designee will audit bi-weekly to assure policy compliance.	9/15/15

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R13, R16, R22, R23, R25, R27, R28, R31, R34, R41, R44, R45, R47, R51, R52, R56 and R61)

During observation on 8/5/15, at 7:30 a.m. breakfast items were delivered to residents via the carts in the main dining room, the East and West halls. Styrofoam plates/bowls and thin, white plastic silverware were available on the east and west hall carts as part of the breakfast meal service. At 7:34 a.m. nursing assistant (NA)-B, located on the west wing prepared breakfast items from the cart and served the residents with the Styrofoam dishes.

The cart designated for the main dining room contained regular ceramic dishes and metal reusable silverware that were utilized for serving breakfast food to the residents who were eating their meal in the main dining room.

On 8/5/15, at 7:53 a.m. NA-C prepared food from the cart and served breakfast items to residents located on the east wing. NA-C served toast, hot and/or cold cereals, milk, juice and coffee. The food items were served on the Styrofoam plates and bowls and plastic silverware was provided with the meal.

The following morning, on 8/6/15, at 8:30 a.m. the breakfast meal was again prepared from the carts and served on the disposable dishes to residents located on the east and west halls. NA's on both East and West Wings verified this had been the practice to serve breakfast on Styrofoam plates/bowls and use plastic silverware for as long as they could recall. When questioned if there was a reason for this practice, they replied, "that is just the way it is".

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F 241	Continued From page 7 When interviewed on 8/5/15, at 9:00 a.m. NA-B verified that residents were served breakfast on Styrofoam dishes and thin, white plastic silverware was utilized on a daily basis as that was the practice. NA-B indicated she felt there was an issue with using Styrofoam and plastic, but didn't have any say in the matter. During an interview on 8/5/15, at 9:30 a.m. NA-C also verified that Styrofoam dishes and plastic silverware were used to serve breakfast to residents located in their rooms on a daily basis. NA-C indicated she was not aware of a reason for using disposable verses reusable dishware. NA-C further indicated she thought it would be nice if they used regular dishes related to safety for the residents handling the plates. When interviewed on 8/05/15, at 8:19 a.m. the dietary manager (DM) indicated the use of the Styrofoam disposable dishes and plastic spoons had been used on carts as "that is what the process has been since July 2014" when she started in her position. The DM further indicated she didn't feel the practice of using Styrofoam and plastic was dignified. When interviewed on 8/06/15, at 10:42 a.m. R50 indicated she didn't have an issue with the use of plastic silverware because she knew staff were busy but stated she would never use paper/Styrofoam plates/bowls at home and would prefer to have glass or ceramic dishes. R50 further indicated she had noticed the silverware used was of poor quality as it was very thin and would easily break when used. On 8/06/15, at 10:32 a.m. the director of nursing (DON) stated she was not aware of resident's	F 241		

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F 241	Continued From page 8 concerns regarding the use of Styrofoam dishes and plastic silverware but further indicated she didn't think it was appropriate. She also added that she has a family member living in facility and didn't feel it was appropriate. She stated that Styrofoam dishes presented a safety concern (flimsy) related to the risk of spills. Review of the facility policy: Policy and Procedure Manual Hendricks Community Hospital Association Subject: Breakfast Cart Section Dietary Policy No: 8711.145.01 effective 7/03, Revised 01/09 05/15 Procedure: 3.1.1 Breakfast carts are stocked by dietary with plates/silverware/glasses/cups and condiments 3.1.7 D. Staff are to pick up dirty dishes & put in dirty bus tubs once resident is done with breakfast. The facility policy makes no reference to use of disposable dishes or utensils.	F 241		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision;	F 272		9/15/15

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F 272	Continued From page 9 Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to conduct an initial comprehensive assessment related to pressure ulcer risks to prevent further skin breakdown for 1 of 2 residents (R61) identified with pressure ulcers and failed to conduct an initial comprehensive assessment for the use of an indwelling Foley catheter for 1 of 2 residents (R61) reviewed for urinary catheter use. Findings include: R61 was admitted on 6/11/15 with diagnoses which included: right heel ulcer, right foot ulcers on the 4th and 5th digits, morbid obesity, sepsis,	F 272	Bowel and Bladder and Skin assessment for R61 completed 8/27/15. All residents with pressure ulcers and Foley catheters were reviewed and evaluated for completion of assessments. Education relevant to the Resident Assessment Instrument (RAI)will be conducted with Nurse Managers, RNs and WOCN by September 10, 2015 An audit of thoroughness and completion of comprehensive assessments will be done on 2 residents per week. The DON	

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F 272	Continued From page 10 cellulitis, depression, atrial fibrillation and chronic kidney disease. R61's admission Minimum Data Set (MDS) assessment dated 6/18/15, identified R61 with one (1) stage two pressure ulcer and one (1) unstageable pressure ulcer, both were present upon admission. The admission MDS assessment failed to include any Care Area Assessment (CAA) related to the identified skin issues/pressure ulcers. When the medical record was reviewed, it lacked any comprehensive assessment of R61's skin since admission. R61's medical record contained a Braden Scale (assessment to identify pressure ulcer risk) in the assessment section but lacked any documentation (blank). A Pressure Ulcer Risk assessment was identified to be conducted along with the Braden scale, but was not completed. There was no evidence in the medical record to identify R61 was assessed for any risk factors. R61's physician orders dated 8/3/15, identified R61 with pressure ulcers located on his right toes on the 4th and 5th digits. R61 was further identified with a right heel pressure ulcer. During observation of morning cares on 8/5/15 at 9:55 a.m. registered nurse (RN)-D entered R61's room to perform wound treatment to the right heel. RN-C removed the gauze wrap from around R61's right heel and then removed a 4 x 4 gauze dressing. The dressing adhered to the wound and was moistened prior to removal. After the dressing was removed, R61 was noted to have a baseball circumference area covered with black scab which encompassed the entire heel region. RN-D redressed the wound after cleansing it with	F 272	or designee will monitor effectiveness of correction. Audit outcomes will be evaluated by Quality Assurance.	

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F 272	Continued From page 11 wound cleaner. After the heel was treated, RN-D treated the toes. R61 was noted to have pressure ulcers on the fourth and fifth digits of his right foot, which were approximately the size of a pencil eraser. The wounds were noted to be red in color and open. RN-D cleansed the wounds with wound cleaner and then replaced a sleeve between the toes to keep them separated after placing a fibrocol dressing over both open areas. During interview on 8/6/15, at 9:37 a.m. RN-A stated a wound nurse visited weekly to review the wounds on R61's right foot and toes. After reviewing R61's medical record RN-A verified there is was no Braden Scale assessment, no Pressure Ulcer Risk assessment nor tissue perfusion assessment as expected per policy. RN-A stated the facility typically conducted a tissue perfusion assessment to identify the lying and seating repositioning needs of the resident. The skin assessment should include an evaluation of the skin integrity & tissue tolerance (ability of the skin & its supporting structures to endure the effects of pressure without adverse effects) after pressure to that area has been reduced or redistributed. R61 was admitted with an indwelling Foley catheter and the rationale for it's continued use was identified on the physician orders as chronic urinary incontinence related to immobility. R61's admission Minimum Data Set (MDS) assessment dated 6/18/15, identified R61 with an indwelling Foley catheter. The MDS lacked a Care Area Assessment (CAA) related to urinary status which included the continued use of the Foley catheter. During review of R61's medical record an assessment for urinary status could not	F 272		

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F 272	Continued From page 12 be located. An assessment was lacking which included consideration of the risks & benefits of an indwelling catheter; the potential for removal of the catheter and consideration of complications resulting from the use of the indwelling catheter. The admission physician orders dated 8/3/15, identified that R61's Foley Catheter, #16 French (Fr) should be changed monthly or as needed. The physician orders identified the rationale for the catheter as chronic urinary incontinence related to immobility. When interviewed on 8/6/15, at 9:37 a.m. registered nurse (RN)-A confirmed R61's medical record lacked a urinary assessment and also verified a CAA had not been completed with the admission MDS assessment.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is	F 278		9/10/15

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F 278	Continued From page 13 subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to accurately reflect limitation in range of motion status on the Minimum Data Set (MDS) assessment for 1 of 1 resident (R6) reviewed who experienced a trigger finger on the left middle finger. Findings include: During observation on 8/3/15, at 11:41 a.m. R6 was noted to have the middle finger of her left hand folded/curled into her palm. When questioned whether she was able to move the finger, R6 attempted and then responded, "No". R6 was observed to grab the left middle finger with her right fingers and attempt to extend the finger but was unable. R6 was then observed to wince and state, "Ouch" when attempting to manipulate/extend the left middle finger. During a subsequent observation on 8/5/15, at 11:31 a.m. R6 was seated in the dining room with her left hand middle finger pressing against her palm. When R6 was questioned whether she could bend this finger, she responded, "No". R6 indicated it hurt when she attempted to extend	F 278	RN assessment and OT evaluation completed 8/17/2015 for R6. Therapy treatment plan initiated and continues relevant to residents left hand finger's functional limitations. Correction Plan: Education to nursing staff to assure thoroughness and accuracy of resident functional assessments are completed and care planned with the multidisciplinary team will be conducted by 9/10/15. An audit will be implemented to track accuracy and thoroughness of MDS quarterly ROM assessments via a random selection of resident reviews bi-monthly. The DON or designee will be responsible for monitoring outcomes and reporting to Quality Assurance.	

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F 278	Continued From page 14 the finger. R6 was noted to have no protection to palm on the left hand nor any device applied to correct the contracture. During review of R6's medical record there was a progress note dated 2/18/15, at 2:41 p.m. which indicated that R6 had an appointment at the clinic with a provider to examine her (L) hand middle finger that was locked in curled position - "trigger finger". The physician recommended a pulley release of finger to straighten it out and relieve the pain. The physician noted contact would be with the responsible party for R6 and a decision for what plan of treatment would be made. During review of R6's care plan, dated 6/6/15, the care plan identified R6 with limited physical mobility related to arthritis in knees/legs. The care plan identified R6 would maintain range of motion (ROM) through interventions including: 1. Ambulate with assist of one staff with the support of a gait belt and four wheeled walker twice daily. 2. Active ROM exercises 5 minutes twice a day with cares seven days per week. 3. Small group exercises 5 days per week. During review of R6's quarterly Minimum Data Set (MDS) assessments, dated 3/6/15 and 6/5/15, the identification of the functional limitation of ROM to R6's left middle finger was lacking. During interview on 8/6/15, at 11:10 a.m. registered nurse (RN)-A verified the functional limitation in R6's left middle finger and verified the last two (2) quarterly assessments failed to accurately reflect the resident's status related to this limitation.	F 278		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		9/10/15

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F 282 SS=D	Continued From page 15 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide toileting services as directed by the written plan of care for 1 of 1 resident (R6) reviewed with urinary incontinence and failed to follow the care plan to monitor lab results for 1 of 5 residents (R49) reviewed for unnecessary medications. Findings include: Staff failed to provide toileting as directed on the written plan of care for R6. R6 had current diagnoses identified on the diagnosis list as: Osteoarthrosis, glaucoma, hypertonic bladder, dementia, anxiety and depression. R6's care plan dated 6/6/15, identified R6 as frequently incontinent. The care plan identified the following interventions for management of urinary status: 1. Will be clean, dry and odor free with no skin breakdown or signs of urinary tract infection (UTI). 2. Assist resident with toileting, transfers, changing pad, pericare and clothes adjustment. 3. Offer toilet every 2 hours. 4. Notify nurse if res. complains of urinary problems such as burning, frequency or pain. 5. Uses Tena day regular daytime and Tena brief	F 282	Reviewed R6 care plan. Staff informed care plan and CNA assignment sheets as current relevant for resident's toileting needs. August 27, 2015. Staff education on responsiveness to following resident care plans as noted on CNA work sheets will be conducted by September 10, 2015. An audit of resident care plan follow through will be implemented via a random selection of residents and observation of toileting frequency and documentation of care during selected time in a given shift. This will be conducted on a weekly basis. Audit outcomes will be monitored by the DON or designee and evaluated by Quality Assurance. R49 digoxin level was drawn on 8/6/2015. Physician notified. An audit of all residents on digoxin to assure they have had care planned lab work drawn will be implemented. Thereafter, a monthly audit will be done to assure routine lab work is completed via a random audit of 10 residents/month. The DON or designee will be responsible for monitoring outcomes and reporting to	

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F 282	Continued From page 16	F 282		

medium. at night for incontinence product.

During observation on 8/5/15, at 6:55 a.m. R6 was noted to be lying supine in bed with her eyes closed and remained in bed in this same position until 10:22 a.m. (3 1/2 hrs. later). At this time nursing assistant (NA)-D entered room to provide morning cares. At 10:25 a.m. NA-D and NA-H assisted R6 to transfer from her bed to the bathroom with the use of a walker and assisted R6 onto the toilet. It was noted the incontinent brief was urine soaked when removed and that R6 voided once assisted on the toilet. At approximately 10:30 a.m. NA-D was interviewed about the last time R6 was assisted with any toileting needs. NA-D stated she was unsure when R6 was last toileted and/or was offered toileting.

During review of R6's bladder assessment dated 9/4/14, it identified R6 as incontinent of bladder related to impaired mobility/ambulation. Contributing factors included abnormal labs, Alzheimer's disease/dementia, arthritis, and fall history. The assessment further identified R6 was able to verbalize the need to toilet and should be offered toilet every 2 hours. The type of incontinence was identified as urge incontinence.

During interview on 8/6/15, at 9:14 a.m. NA-F indicated that R6 required assistance with transferring to toilet and needed staff to stay with her when on toilet.

During interview with registered nurse (RN)-C on 8/6/15, at 9:48 a.m. it was verified R6 should be offered to toilet at least every two hours and if staff waited longer than two hours they were not following the written plan of care for R6.

Quality Assurance.

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F 282	Continued From page 17 The written plan of care for R49 was not implemented as it identified the following: obtain and monitor lab/diagnostics as ordered. R49's physician orders dated 7/23/15, identified R49 with a prescription for Digoxin (Cardiac medication to regulate heart) 0.25 milligrams (mg) on odd days and 0.125 mg on even days. The physician orders further identified R49 would have an annual Digoxin level completed annually in August. During review of R49's medical record a Digoxin level was unable to be identified. When interviewed on 8/6/15, at 9:48 a.m. RN-C verified the medical record lacked a Digoxin level. RN-C stated there was an order from the physician in September 2014 for the level to be drawn but it had been missed. RN-C stated the last Digoxin level was completed in August 2013 (2 years ago) and should have been performed in August 2014. RN-C verified the annual Digoxin lab had been missed by the physician and nursing staff. During interview with the consultant pharmacist on 8/6/14, at approximately 10:30 a.m. the pharmacy consultant reviewed R49's medical record and verified the Digoxin level had not been completed as ordered. The pharmacy consultant confirmed the Digoxin lab value test should be monitored annually as identified by the physician.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314		9/15/15

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F 314	Continued From page 18 individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide repositioning services based on a comprehensive assessment to reduce the risk of further skin breakdown for 1 of 2 residents (R61) reviewed who currently had pressure ulcers. Findings include: R61 was admitted on 6/11/15 with diagnoses which included: right heel ulcer, right foot ulcers on the 4th and 5th digits, morbid obesity, sepsis, cellulitis, depression, atrial fibrillation and chronic kidney disease. R61's admission Minimum Data Set (MDS) assessment dated 6/18/15, identified R61 with one (1) stage two pressure ulcer and one (1) unstageable pressure ulcer, both were present upon admission. The admission MDS assessment failed to include any Care Area Assessment (CAA) related to the identified skin issues/pressure ulcers. When the medical record was reviewed, it lacked any comprehensive assessment of R61's skin since admission. R61's medical record contained a Braden Scale (assessment to identify pressure ulcer risk) in the assessment section but lacked any documentation (blank). A Pressure Ulcer Risk assessment was identified to be conducted	F 314	A comprehensive assessment and care plan was completed on 8/27/2015 for R61. Policy and procedure for skin integrity was reviewed and is current. All residents with pressure ulcers will be reviewed to assure thoroughness and accuracy of comprehensive assessments. Staff education on accountability to following resident care plans as noted on CNA work sheets will be conducted by September 10, 2015. An audit of resident plan follow through will be implemented via a random selection of residents and observation of repositioning frequency and documentation of care during selected time in a given shift. This will be conducted on a weekly basis. Audit outcomes will be monitored by the DON or designee and evaluated by Quality Assurance.	

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F 314	Continued From page 19	F 314		

along with the Braden scale, but was not completed. There was no evidence in the medical record to identify R61 was assessed for any risk factors.

R61's physician orders dated 8/3/15, identified R61 with pressure ulcers located on his right toes on the 4th and 5th digits. R61 was further identified with a right heel pressure ulcer.

R61's plan of care plan dated 7/1/15, for skin, identified R61 with three (3) pressure ulcers and potential for pressure ulcer development related to history of ulcers and immobility. The goal listed on the plan of care included that the pressure ulcers would show signs of healing and remain free from infection by/through review date.

Interventions that were included on the care plan were:
1. Administer treatments as ordered and monitor for effectiveness.
2. Assess/record/monitor wound healing weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the wound nurse or physician.
3. Assistance to turn/reposition at least every 2 hours, more often as needed or requested.
4. Apply moisturizer daily to skin. Do not massage over bony prominence's and use mild cleansers for peri-care/washing.
5. Pressure relieving/reducing device 1) on bed - has air mattress; and 2) on Right foot - boot on right foot at all times, please assure that heel is properly placed to offload pressure
6. Follow facility policies/protocols for the prevention/treatment of skin breakdown.

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F 314	Continued From page 20 7. Monitor dressing daily to ensure it is intact and adhering. Report lose dressing to Treatment nurse. During observation of morning cares on 8/5/15, at 6:30 a.m. R61 was observed lying supine (on back) in bed with a pillow under his lower right leg to keep the right heel off the bed. The lower bed also had a bed cradle on it to keep R61's blankets off his feet. At 7:15 a.m. R61 remained in the same position (supine). On 8/5/15, at 7:40 a.m. nursing assistant (NA)-I entered the resident room and stated R61 did not have the boot applied to the right foot as the urinary catheter had leaked during the night and the boot was sent to laundry to be washed. NA-I acknowledged R61 but performed no cares nor repositioning. R61 remained in the supine position until 8:50 a.m. at which time NA-M entered R61's room and elevated the head of the bed to approximately 130 degrees so R61 could eat breakfast in bed. NA-M delivered toast, coffee and juice on the tray table and left the room without any repositioning. R61 remained on his back in bed through 9:28 a.m. (3 hrs) when NA-I re-entered the room to assist R61 to get up for the day. After entering the room on 8/5/15, at 9:28 a.m. NA-I was questioned about the last time R61 was last repositioned. NA-I indicated it had about 6:00 a.m. NA-I stated she had not repositioned R61 yet and was unsure when the staff from night shift had last repositioned R61. NA-I began to perform morning cares at 9:30 a.m. At 9:45 a.m. (3 hours and 45 minutes later) NA-I and NA-E assisted R61 to sit up in bed and pivoted him to a seated position with his legs over the side of the bed. RN-D then entered the room to perform wound cares.	F 314		

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F 314	Continued From page 21 During observation of morning cares on 8/5/15 at 9:55 a.m. registered nurse (RN)-D performed a wound treatment to the right heel. RN-C removed the gauze wrap from around R61's right heel and then removed a 4 x 4 gauze dressing. The dressing adhered to the wound and was moistened prior to removal. After the dressing was removed, R61 was noted to have a baseball circumference area covered with black scab which encompassed the entire heel region. RN-D redressed the wound after cleansing it with wound cleaner. After the heel was treated, RN-D treated the toes. R61 was noted to have pressure ulcers on the fourth and fifth digits of his right foot, which were approximately the size of a pencil eraser. The wounds were noted to be red in color and open. RN-D cleansed the wounds with wound cleaner and then replaced a sleeve between the toes to keep them separated after placing a fibrocol dressing over both open areas. During interview on 8/6/15, at 9:37 a.m. RN-A stated a wound nurse visited weekly to review the wounds on R61's right foot and toes. After reviewing R61's medical record RN-A verified there is was no Braden Scale assessment, no Pressure Ulcer Risk assessment nor tissue perfusion assessment as expected per policy. The skin assessment should include an evaluation of the skin integrity & tissue tolerance (ability of the skin & its supporting structures to endure the effects of pressure without adverse effects) after pressure to that area has been reduced or redistributed. RN-A stated the facility typically conducted a tissue perfusion assessment to identify the lying and seating repositioning needs of the resident and was unsure how the determination of a two (2) hour	F 314		

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F 314	Continued From page 22 reposition schedule was identified since no assessment had yet been completed. RN-A further stated that rolling R61 up in the bed while he remained on his back and buttock did not relieve pressure to the skin and therefore would not meet the definition of repositioning. After reviewing the skin monitoring sheets with RN-A, it was noted the identified wound had remained stable for R61. R61 failed to receive repositioning as directed by the plan of care which identified a repositioning schedule indicating at least every two (2) hours.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to conduct a comprehensive assessment related to the continued use of an indwelling Foley catheter for 1 of 2 residents (R61) reviewed for urinary catheter use and failed to provide timely toileting services for 1 of 1 resident (R6) who experienced urinary incontinence and required extensive	F 315	Reviewed R6 care plan. Staff informed care plan and CNA assignment sheets as current relevant to resident's toileting needs. August 27, 2015. Staff education on responsiveness to following resident care plans as noted on CNA work sheets will be conducted by	9/15/15

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F 315	Continued From page 23 assistance. Findings include: A comprehensive urinary assessment related to the continued use of a Foley catheter was not conducted for R61. R61 was admitted on 6/11/15, with diagnoses including: right heel ulcer, right foot ulcers on the 4th and 5th digits, morbid obesity, sepsis, cellulitis, depression, atrial fibrillation and chronic kidney disease. R61 was admitted with an indwelling Foley catheter and the rationale for it's continued use was identified on the physician orders as chronic urinary incontinence related to immobility. R61's admission Minimum Data Set (MDS) assessment dated 6/18/15, identified R61 with an indwelling Foley catheter. The MDS lacked a Care Area Assessment (CAA) related to urinary status which included the continued use of the Foley catheter. During review of R61's medical record an assessment for urinary status could not be located. An assessment was lacking which included consideration of the risks & benefits of an indwelling catheter; the potential for removal of the catheter and consideration of complications resulting from the use of the indwelling catheter. The admission physician orders dated 8/3/15, identified that R61's Foley Catheter, #16 French (Fr) should be changed monthly or as needed. The physician orders identified the rationale for the catheter as chronic urinary incontinence related to immobility. During review of R61's written plan of care dated	F 315	September 10, 2015. An audit of resident care plan follow through will be implemented via a random selection of 2 residents to observe toileting frequency and documentation of care during selected time in a given shift. This will be conducted weekly. Audit outcomes will be monitored by the DON or designee and evaluated by Quality Assurance. Bowel and bladder assessment for R61 completed 8/27/15. All residents with Foley catheters will be reviewed and evaluated for completion of assessments. Policy for Indwelling Catheter Use reviewed and current. Staff education relevant to the policy will be provided by 9/10/15. An audit of thoroughness and completion of comprehensive assessments will be done on 5 residents/month. The DON or designee will monitor effectiveness of correction. Audit outcomes will be evaluated by Quality Assurance.	

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F 315	Continued From page 24 7/1/15, it was lacking any documentation which included the risks, goals, and/or interventions related to the indwelling Foley catheter. When interviewed on 8/6/15, at 9:37 a.m. registered nurse (RN)-A confirmed R61's medical record lacked a urinary assessment and also verified a CAA had not been completed with the admission MDS assessment. RN-A further stated there had been communication with R61's physician related to the rationale for continued use of the Foley catheter and the physician documented a diagnosis of chronic incontinence related to immobility as the primary reason for the use of the catheter. The medical record lacked justification for an attempt to discontinue the catheter and/or rationale for it's continued use. Staff failed to provide timely assistance with toileting for R6 to maintain as much urinary function as possible. R6 had current diagnoses identified on the diagnosis list as: Osteoarthrosis, glaucoma, hypertonic bladder, dementia, anxiety and depression. During observation on 8/5/15, at 6:55 a.m. R6 was noted to be lying supine in bed with her eyes closed and remained in bed in this same position until 10:22 a.m. (3 1/2 hrs. later). At this time nursing assistant (NA)-D entered room to provide morning cares. At 10:25 a.m. NA-D and NA-H assisted R6 to transfer from her bed to the bathroom with the use of a walker and assisted R6 onto the toilet. It was noted the incontinent brief was urine soaked when removed and that R6 voided once assisted on the toilet. At approximately 10:30 a.m. NA-D was interviewed about the last time R6 was assisted with any toileting needs. NA-D stated she was unsure	F 315		

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F 315	Continued From page 25 when R6 was last toileted and/or was offered toileting. During review of R6's bladder assessment dated 9/4/14, it identified R6 as incontinent of bladder related to impaired mobility/ambulation. Contributing factors included abnormal labs, Alzheimer's disease/dementia, arthritis, and fall history. The assessment further identified R6 was able to verbalize the need to toilet and should be offered toilet every 2 hours. The type of incontinence was identified as urge incontinence. R6's care plan dated 6/6/15, identified R6 as frequently incontinent. The care plan identified the following interventions for management of urinary status: 1. Will be clean, dry and odor free with no skin breakdown or signs of urinary tract infection (UTI). 2. Assist resident with toileting, transfers, changing pad, pericare and clothes adjustment. 3. Offer toilet every 2 hours. 4. Notify nurse if res. complains of urinary problems such as burning, frequency or pain. 5. Uses Tena day regular daytime and Tena brief medium. at night for incontinence product. During interview on 8/6/15, at 9:14 a.m. NA-F indicated that R6 required assistance with transferring to toilet and needed staff to stay with her when on toilet. During interview with registered nurse (RN)-C on 8/6/15, at 9:48 a.m. it was verified R6 should be offered to toilet at least every two hours and agreed the necessary care was not provided.	F 315		
F 318	483.25(e)(2) INCREASE/PREVENT DECREASE	F 318		9/15/15

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F 318 SS=D	Continued From page 26 IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary services to maintain range of motion (ROM) for 1 of 1 resident (R6) in the sample identified with a ROM deficit. Findings include: During observation on 8/3/15, at 11:41 a.m. R6 was noted to have the middle finger of her left hand folded/curled into her palm. When questioned whether she was able to move the finger, R6 attempted and then responded, "No". R6 was observed to grab the left middle finger with her right fingers and attempt to extend the finger but was unable. R6 was then observed to wince and state, "Ouch" when attempting to manipulate/extend the left middle finger. During a subsequent observation on 8/5/15, at 11:31 a.m. R6 was seated in the dining room with her left hand middle finger pressing against her palm. When R6 was questioned whether she could bend this finger, she responded, "No". R6 indicated it hurt when she attempted to extend the finger. R6 was noted to have no protection to palm on the left hand nor any device applied to	F 318	RN Assessment and OT evaluation completed 8/17/2015 for R6. Therapy treatment plan initiated and continues relevant to resident's left hand finger's functional limitation. Correction Plan: All residents at risk will be assessed for limited range of motion to assure they are referred and/or receiving appropriate treatment/services to prevent further functional decline. Staff education to assure thoroughness and accuracy of resident functional assessments are completed and care planned with the multidisciplinary team will be conducted 9/10/15. An audit will be implemented via random selection of 5 residents/month to assure appropriate assessment and referral for treatment. Audit outcomes will be monitored by the DON or designee and evaluated by Quality Assurance.	

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F 318	Continued From page 27	F 318		

correct the contracture.
During review of R6's medical record there was a progress note dated 2/18/15, at 2:41 p.m. which indicated that R6 had an appointment at the clinic with a provider to examine her (L) [left] hand middle finger that was locked in curled position - "trigger finger". The physician recommended a pulley release of finger to straighten it out and relieve the pain. The physician noted that contact would be made with the responsible party for R6 and a decision for what plan of treatment would be made.
During review of R6's care plan, dated 6/6/15, the care plan identified R6 with limited physical mobility related to arthritis in knees/legs. The care plan identified R6 would maintain range of motion (ROM) through interventions including:
1. Ambulate with assist of one staff with the support of a gait belt and four wheeled walker twice daily.
2. Active ROM exercises 5 minutes twice a day with cares seven days per week.
3. Small group exercises 5 days per week.

During review of R6's quarterly Minimum Data Set (MDS) assessments, dated 3/6/15 and 6/5/15, the identification of the functional limitation of ROM to R6's left middle finger was lacking.

When interviewed on 8/6/15, at 10:20 a.m. the activity director (AD) stated the facility used to have daily exercises which were implemented via the activities program but they had not routinely been offered for a while. The AD was unaware of the care plan for R6 included the small group exercises 5 days a week and stated R6 usually slept in during the day and generally would not be out of bed at the time the small group exercises

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F 318	Continued From page 28 were conducted; if they were conducted. During interview on 8/6/15, at 11:05 a.m. nursing assistant (NA)-D stated R6 was supposed to get exercises daily with cares but stated they were usually not completed related to time constraints. When interviewed on 8/6/15, at 11:10 a.m. registered nurse (RN)-A, RN-C and the AD verified R6's ROM program was not being implemented. The staff were unsure who was responsible for which part of the ROM program.	F 318		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		9/15/15

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F 329	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to monitor lab values to assess medication effectiveness for 1 of 5 residents (R49) reviewed for unnecessary medications. Findings include: R49's physician orders dated 7/23/15, identified R49 with a prescription for Digoxin (Cardiac medication to regulate heart) 0.25 milligrams (mg) on odd days and 0.125 mg on even days. The physician orders further identified R49 would have an annual Digoxin level completed annually in August. During review of R49's medical record a Digoxin level was unable to be identified. When interviewed on 8/6/15, at 9:48 a.m. registered nurse RN-C verified the medical record lacked a Digoxin level. RN-C stated there was an order from the physician in September 2014 for the level to be drawn but it had been missed. RN-C stated the last Digoxin level was completed in August 2013 (2 years ago) and should have been performed in August 2014. RN-C verified the annual Digoxin lab had been missed by the physician and nursing staff. During interview with the consultant pharmacist on 8/6/14, at approximately 10:30 a.m. the pharmacy consultant reviewed R49's medical record and verified the Digoxin level had not been completed as ordered. The pharmacy consultant confirmed the Digoxin lab value test should be monitored annually as identified by the physician.	F 329	R49 digoxin level was drawn on 8/6/2015. Physician notified. The policy of Unnecessary Medications was reviewed and is current. Staff education will include policy review by September 10, 2015. An audit of all residents on digoxin to assure they have had care planned lab work drawn will be implemented. Thereafter, a monthly audit will be done to assure routine lab work is completed via a random audit of 10 residents/month. The DON or designee will be responsible for monitoring outcomes and reporting to Quality Assurance.	

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F 329	Continued From page 30 .	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to routinely clean, monitor and sanitize dietary equipment which had the potential to affect all 56 residents residing in the facility. Findings include: During observation of the kitchen on 8/3/15, at 9:07 a.m. the following was noted: (1) One electric can opener located on a stainless steel table near the steam table was noted to have a thick, black build up on the surface of the cutting blade and also on the area surrounding the blade. The dietary manager (DM) verified the food residue came off in chucks when touched and could potentially contaminate food when utilized to open canned items without the proper cleaning. The DM further verified she was not certain when the electric can opener had last been used but thought it was this morning.	F 371	Electric can opener was disposed of on 8/5/2015 Manual can opener was replaces on 8/11/2015 Thorough cleaning of stainless steel cares was completed 8/5/2015 Since 8/6/2015 the temperature logs have been checked daily by management. A cleaning schedule policy was put into place on 8/10/2015 which includes the stainless steel carts and can opener as well as other items in the kitchen. Policy developed for temperature log procedures. Dietary staff meeting held 9/10/2015 for review of the cleaning schedule. Discussion on the importance of cleaning the are you have and signing off on the cleaning sheet. Cleaning list audited 4 times per week by CDM or designee	9/15/15

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F 371	Continued From page 31 (2) A manual can opener was also located on the stainless table and had evidence of thick, black residue surrounding the cutting edge surface which broke/flaked off when touched. The DM verified this particular can opener had been utilized that morning (8/3/15) without cleaning after use. The DM further confirmed a cleaning schedule had not been implemented nor had the equipment been consistently sanitized/cleaned between uses. Three stainless steel carts were observed being utilized for breakfast service on 8/3/15 and 8/6/15. The surface, drawers and tracks of the drawers on the carts contained large amounts of crumbs, spills and food particle build up. Each of the carts contained oatmeal, bread for toast, 1/2 gallon milk cartons, yogurt and various juices. Nursing assistants were observed to prepare breakfast items located on the carts and place the food items onto Styrofoam plates and/or bowls. When interviewed on 8/5/15, at 7:34 a.m. nursing assistant (NA)-B verified the dietary carts were frequently transported down resident hallways soiled with crumbs, spills and food residue from previous usage. She further indicated she had requested the carts be cleaned and they had returned in the same condition. NA-B indicated the appearance of the dietary cart this morning had crumbs and soil on the surface and tract of the cart. She indicated the cart had been in this condition for a "long time". NA-B stated, "there used to be a procedure in which the carts were cleaned after each use and then thoroughly cleansed weekly", but stated she was not aware of this schedule at the present time.	F 371	Temperature list audited 4 times per week by CDM or designee	

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F 371	Continued From page 32 During an interview on 8/05/15, at 7:53 a.m. NA-C indicated she was not aware of a cleaning schedule for the carts and confirmed the carts had crumbs, food residue on the cart surfaces and in the tracks of the drawers; in addition, food routinely spilled into the drawers of the cart when used to prepare resident breakfasts and sometimes spilled under/onto the condiments stored in these dietary carts. The DM was interviewed on 8/5/15, at 8:19 a.m. and verified there was no cleaning schedule for the carts utilized daily to transport, store and prepare food items for residents who routinely ate breakfast in their rooms. The DM indicated the carts are restocked daily with food items, Styrofoam plates/bowls and plastic silverware and dietary staff were expected to wipe down as necessary. Review of the documentation provided from a computer generated listing of cleaning duties confirmed documentation was lacking to indicate this tool had been completed by staff to ensure proper cleaning of the equipment. This tool had been developed by the facility to ensure the completion of the required cleaning duties in the dietary department. Temperature logs located in the dietary area were available/posted near the dishwashing (wash/rinse), refrigerators and freezer equipment. The temperatures logs were noted to have multiple areas left blank, indicating the required temperatures had not been recorded per facility policy. Documentation was lacking to indicate the equipment remained in safe operating condition to maintain dietary sanitization. The DM confirmed the equipment had not been monitored appropriately during the times that were noted to be left blank.	F 371		

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When interviewed on 8/6/15, at 12:30 p.m. the dishwasher/dietary aide (DA)-A confirmed the wash/rinse temperatures on the dishwasher had not been monitored on 8/5/15 and 8/6/15.

Facility Policies Reviewed: Policy and Procedure Manual Section: Dietary
Last revision date: 05/15,
Subject: Breakfast Cart
2.1.5 Dietary & Activity staff work together to clean up plates/silverware/glasses/cups and condiments
3.1.7 All serving utensils may not be left in food. They must be taken out of the food and put on a plate
3.1.9 Dietary Staff once all items are off cart are to wipe down cart & restock cart for morning,
3.1.10 Once a week all items are taken off cart and a assigned dietary aide takes all items out of cart and wash inside and out of cart and restocks cart

Subject: Dietary Weekly Cleaning Effective: 07/15
Policy: The Dietary Kitchen will be cleaned on a weekly basis by Dietary Staff as assigned to each shift.
Procedure:
2.1 weekly the dietary manager puts out a clean list in the kitchen. This list has all shifts that work in a 24 hour period. Along with what needs to be cleaned.
2.2 dietary staff are responsible to look at clean sheet for days duties.
2.3 once cleaning duty is done staff are to initial that job has been completed.
2.4 at the end of the week the dietary manager picks up cleaning list for week and files in the

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F 371	Continued From page 34 office.	F 371		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the safe administration of medications for 5 of 11 residents (R4, R5, R9, R51 and R52) observed to have medications left without observation of ingesting, or left while resident asleep and/or left while other residents were in the area. Findings include:	F 425	Resident assessments will be completed to determine ability to safely self administer medication. If assessed as capable, a physician order will be secured. Policy has been reviewed and updated. The resident assessment tool has been updated. The Medication Administration and Orientation worksheet has been updated to include training of Self Administration of Medications policy.	9/15/15

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F 425	Continued From page 35 It was observed on 8/3/15, at 11:25 a.m. while interviewing R52 in a room shared with his spouse (R51) that two medication cups were left sitting on a small table in between two recliners occupied by R51 and R52. One medication cup had two large white oblong tablets along with a few smaller tablets in it and the other medication cup contained pudding with a spoon sticking out of it. R52 stated his wife R51 likes to take the pills right before dinner and she takes them with pudding. While interviewing R52, it was noted that R51 took the medication in the cup mixed with the pudding. During the supper meal on 8/4/15, at 5:52 p.m. it was noted that both R51 and R52 were seated at a dining room table. It was noted that registered nurse (RN)-D placed a plastic medication cup next to R51 and another plastic medication cup next to R52. Both cups had medication mixed with applesauce. It was observed that RN-D left the table to dish up more medications from the medication cart located in the hallway outside of the dining room. She left prior to either R51 or R52 taking their respective medications. RN-D had her back to both residents as they consumed their medications. When interviewed on 8/3/15, at 11:58 a.m. RN-C stated there are some residents they routinely leave medications with so they can take them after the nurse has set them up into the medication cup. RN-C stated R51 and R52 eat breakfast in their room so their medications are left with them. RN-C added some residents request to have their medications left with them and staff will accommodate them as long as the resident is trustworthy and there is no cognitive impairment or history of refusing mediations.	F 425	Education to nursing and TMA staff will be conducted by 9/10/15. Monitoring of staff compliance to assure medication administration practices are followed will be implemented. Three medication passes will be monitored/week for a minimum of 5 residents per medication pass. The Director of Nursing or designee will monitor effectiveness of correction. Audit outcomes and will be evaluated by Quality Assurance.	

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It was observed during the evening meal on 8/4/15, at 5:45 p.m. that RN-D delivered liquid potassium mixed with juice to the table where R4 was seated. R4 was seated at the table with 3 other residents. R4 left the table area at 6:36 p.m. and the medication had not yet been consumed by R4. The residents seated at the table were within reach of the medication mixed in the juice cup. The medication remained at the table during the entire evening meal until 6:55 p.m. when a dietary aide cleared the table and dumped the contents of the juice glass into a bucket which contained the remaining juices left on the tables and not consumed by the residents.

When interviewed on 8/4/15, at 7:32 p.m. RN-D confirmed she had mixed the liquid potassium in a smaller plastic cup with juice and left on the table.

When interviewed on 8/6/15, at 11:54 a.m. RN-C stated the nurses know that they need to make sure R4 receives her medication as she doesn't always want to take her medication and this has been a problem.
During observation of the supper meal on 8/4/15, at 5:27 p.m. R9 was observed seated in her wheelchair at the dining room table with a white paper medication cup on the table in front of her that contained medication while R9 was sleeping with her chin resting against her chest. There were three other residents seated at the table with her and within reach of the medication. R9 was observed to have the medications sitting on the table until her supper meal came at 5:53 p.m. (25 minutes later). Staff proceeded to wake R9 up to eat and then R9 proceeded to take the medications independently prior to eating supper.

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	245467	A. BUILDING ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDRICKS COMMUNITY HOSPITAL	**503 E LINCOLN STREET HENDRICKS, MN 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
F 425	Continued From page 37 RN-G, who left the medications placed on the table, left the dining room area multiple times and did not have R9 within view during the observation. When interviewed on 8/6/15, at 2:13 p.m. RN-C verified the medications should not be left on the table unless there was an assessment to identify the resident could safely administer and also confirmed that when the resident was sleeping "this is unsafe practice and the medication should not have been left with the resident." During observation of the noon meal on 8/3/15, at 11:52 a.m. R5 was observed seated at the dining room table with a plastic medication cup located on the table in front of her which contained crushed medication mixed in applesauce. There were three other residents seated at the table and within reach of the mediation cup. The medication cup remained at the table throughout the noon meal until R5 self administered the medications at 12:10 p.m. Licensed practical nurse (LPN)-A was noted to leave the dining room area at the time of the observation and was in a location where she unable to visualize R5. During observation of the evening meal on 8/4/15, at 5:15 p.m. R5 was again observed to have a plastic medication cup located on the table in the dining room table where she was seated. It contained crushed medication in applesauce. There were three other residents seated at the table with her. R5 took the medications at 5:32 p.m. Registered nurse (RN)-G, who left the medications placed on the table, left the dining room area multiple times and was unable to monitor and/or continuously visualize R5 during the observation.	F 425		

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F 425	Continued From page 38 During interview with RN-C on 8/5/15, at 12:43 p.m. it was verified the medications should not be left on the table for self-administration as it was not safe practice and was not facility policy. The facility had developed a Medication Administration Orientation worksheet, undated, which was used to train staff on the facility standard for medication administration. Item 8.d. on the orientation sheet identified staff were to observe residents during the administration to ensure the medication was taking appropriately.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review the consultant pharmacist failed to report the necessity of monitoring the blood level of a medication when conducting the monthly drug regimen review to identify irregularities for 1 of 5 residents (R49) reviewed for unnecessary medications. Findings include:	F 428	R49 digoxin level was drawn on 8/6/2015. Physician notified. The policy of Unnecessary Medications was reviewed and is current. Pharmacist will review policy as well as physician standing orders. The Pharmacist monthly review checklist will be updated to include digoxin level monitoring.	9/15/15

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F 428	Continued From page 39 R49's physician orders dated 7/23/15, identified R49 with a prescription for Digoxin (heart medication to regulate heart) 0.25 milligrams (mg) on odd days and 0.125 mg on even days. The physician orders further identified R49 should have a Digoxin blood level completed annually in August. During review of R49's medical record a Digoxin level was unable to be identified. When interviewed on 8/6/15, at 9:48 a.m. registered nurse (RN)-C verified the medical record lacked documentation of a Digoxin level. RN-C confirmed that in September 2014 the physician ordered a blood level be drawn but it had been missed. RN-C further stated the last Digoxin level was completed in August 2013 (2 years ago) and should have been done in August 2014. RN-C verified the annual Digoxin lab had been missed by the physician and nursing staff. During interview with the consultant pharmacist on 8/6/14, at approximately 10:30 a.m. the pharmacy consultant reviewed R49's medical record and verified the Digoxin level had not been completed as ordered. The pharmacy consultant verified the Digoxin level had been missed during his monthly reviews and confirmed the lab test should be monitored annually as identified by the physician.	F 428	An audit of monthly pharmacy reviews of 5 residents will be done to assure the pharmacist has referred residents for appropriate lab work. The DON or designee will be responsible for monitoring outcomes and reporting to Quality Assurance.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		9/15/15

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F 441	Continued From page 40 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to change gloves and/or use proper handwashing during wound care for 1 of 1 resident (R61) reviewed who required dressing changes to pressure ulcers located on	F 441	August 6, 2015: Nurse involved with R61 cares verbalized to Director recognition of her breach in Infection Control standards while changing residents dressing. Nurse reviewed proper standards on proper	

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F 441	Continued From page 41 the foot and failed to establish an infection control program which included ongoing tracking, trending and surveillance of infections which had the potential to affect all 56 residents who resided in the facility. Findings include: During observation of wound cares on 8/5/15, at 9:55 a.m. registered nurse (RN)-D was noted to provide treatments to R61's right heel pressure ulcer and the ulcers located between the forth and fifth digits on the right foot. After staff assisted R61 to be seated on the edge of the bed, RN-D donned gloves and removed the old gauze dressing from around R61's heel and ankle. After the gauze was removed from the heel, it was noted that some of the gauze remained attached/stuck to the scab tissue of the wound. RN-D applied a wound cleanser with spray to saturate the area and detach the gauze from the wound. After RN-D removed the gauze which had visible drainage, clean wound dressing supplies were removed from the resident's drawer with the same gloved hands used to remove the soiled gauze. RN-D proceeded to apply a clean 4 x 4 dressing and wrap with the same gloved hands. RN-D failed to remove the soiled gloves and apply new gloves prior to re-dressing the wound. After the heel wound had been treated and new dressings applied, RN-D applied a clean dressing to the wounds located on R61's forth and fifth digits with the same gloved hands. No handwashing nor a change in gloves was noted throughout the entire procedure when both wounds were treated.	F 441	hand hygiene and glove utilization with Director. Hand Hygiene policy reviewed and is current. Hand Hygiene policy posted for all staff 8/27/2015. Staff education on hand hygiene standards of practice will be reviewed by September 10, 2015. An audit of 5 dressing changes/month will be implemented to focus on hand hygiene standards of practice compliance. Audit outcomes will be monitored by the DON or designee and evaluated by Quality Assurance. Infection Prevention and Control Program reviewed and is current. An updated log system for Nursing Home staff to report resident infections will be developed. Staff will be educated by September 10, 2015 on infection reporting and management of residents. Infection Control Nurse will track and trend Nursing Home infections. Medical Staff oversees the Infection Control program. An audit of staff logging of resident infections and completion of a monthly trend report will be implemented. Audit outcomes will be monitored by the DON or designee and evaluated by Quality Assurance.	

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F 441	Continued From page 42 When interviewed on 8/6/15, at 8:31 a.m. RN-D verified she had not changed her gloves, stating, "I should have changed gloves". Review of the Hand Hygiene policy dated 8/2011, indicated the procedure for hand antisepsis if hands are not visibly soiled use the system approved alcohol-based hand rub for routinely decontaminating hands in all other clinical situations including after removing gloves. The facility's Infection Control Logs were reviewed from 1/1/2015 through 8/2/2015. The logs identified the facility tracked only the name of the resident, source of the infection, date of onset and was not done every month for the entire building. The facility's surveillance processes also lacked identification of the following: location of the resident within the facility, specific symptoms that were present, cultures performed/ organism identified, and the date the infection resolved. Furthermore, the logs lacked analysis and/or investigation of patterns identified. When interviewed on 8/6/15, at 11:28 a.m. the infection control officer (ICO) confirmed a current infection control program which included tracking and trending infections in the nursing home had not been implemented on a monthly basis. The ICO stated she had responsibility for the infection control policies and procedures both in the attached hospital and the nursing home. The ICO indicated they were in the process of addressing this at the quality assurance committee as infection control issues had not been reported in recent months. During an interview with the director of nursing (DON) on 8/6/15, at 11:38 a.m. it was confirmed	F 441		

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F 441	Continued From page 43 the infection control program was in need of some improvement. Review of the facility policy titled, Infection Prevention and Control Program, revised on 11/13, indicated the facility would maintain surveillance of the healthcare facility infection potentials, identify and analyze the incidents and caution of healthcare associated infections. To develop and implement a preventive and/or corrective program to minimize infection hazards. The infection control registered nurse will act as the liaison for all committee members, collecting and correlating data, reporting information on infection control to the proper personnel and teaching and reinforcing infection control policy and procedures.	F 441		
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure resident rooms were kept in good repair for 4 of 56 resident (R18, R35, R8 and R48) rooms who were reviewed during the environmental tour. Findings include: On 8/5/15, at 1:15 p.m. an environmental tour of the facility was conducted with the director of	F 465	The four identified resident room repairs are being addressed by maintenance staff. A policy to define procedure for notification of Nursing Home environmental repairs to Maintenance is being developed. Maintenance staff are on call 24/7. Maintenance is notified by staff for any significant environment safety or repair issues. A log is being developed to be completed by staff to report any	9/11/15

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F 465	Continued From page 44 nursing (DON) and maintenance supervisor (MS) present. The DON and MS confirmed the following findings: (1) It was noted when entering R18's room that an area located on the left wall above the base board had several areas of missing paint and exposed sheet rock, which approximately measured two and half feet long by 6 inches wide (2 1/2 ft x 6 in). (2) It was also noted when entering R35's room that several large scuff marks with paint missing were observed on the wall above the bed and located near the bed side rail. Sheet rock was exposed and measured approximately two feet by one foot (2 ft x 1 ft). (3) There was a large area measuring 3 feet long by 1 foot wide (3 ft x 1 ft) above the base board located next to the TV stand in R8's room. The wall was noted to have black, scuffed areas with gouges. Sheet rock was exposed on the entire noted area. (4) In R48's room, several large areas were observed on the wall above the bed measuring approximately five feet long by 2 feet wide (5 ft x 2 ft). The wall had multiple tears in the wall paper, which was peeling and missing from the wall and exposing the sheet rock. On 8/5/15 at 1:15 p.m. the maintenance staff (MS) confirmed he fixes issues which are written and reported by either staff and/or housekeeping. MS indicated he was unaware of the areas noted during the tour; he does not keep a work log and currently is not conducting routine environmental	F 465	non-immediate needs. This is to be reviewed by maintenance staff weekly. Documentation of repair completion will be noted on the log. Staff education to include but not limited to maintenance staff, nursing staff, activity staff and environmental service staff will be completed by September 10. An audit will be implemented to monitor effectiveness of staff reporting, documentation of environmental repair issues and timeliness of repairs. Maintenance is developing a facility round template for monthly rounding of the environment.	

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F 465	Continued From page 45 tours. MS stated "I should know about this and they should be fixed; I don't feel the system is working and we need to come up with something different." On 8/5/15, at 1:15 p.m. the director of nursing (DON) confirmed the findings and was not aware of the noted areas, but stated "there is always room for improvement." A facility maintenance policy was requested on 8/6/15, and the DON indicated the facility did not have a policy which addressed routine maintenance in the facility.	F 465		

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K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 4, 2015. At the time of this survey, Hendricks Community Hospital Nursing Home was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/28/2015

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		

Continued From page 1

By email to:
Marian.Whitney@state.mn.us
<mailto:Marian.Whitney@state.mn.us> and
Angela.Kappenman@state.mn.us
<mailto:Angela.Kappenman@state.mn.us>

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

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 nursing home is separated from a critical access hospital by a two-hour fire wall, and the opening protective consisted of a labeled, self-closing, positive latching, 90-minute fire rated

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K 000	Continued From page 2 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 facility has a capacity of 58 beds and had a census of 56 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area in accordance with the following requirements of 2000 NFPA 101, Section 8.4.1 and/or 19.3.5.4.	K 029	All unapproved door hold open devices on all the storage rooms and all Hazardous area doors have been removed by the maintenance department	8/18/15

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K 029	Continued From page 3 Findings include: On 8/4/15 between 9:30 AM and 12:30 PM, observation revealed: Unapproved door hold open devices observed on the doors to the Storage Room Door (over 50 sq ft), Clean Utility Room by room 317 and several over doors within the East Pod. All Hazardous Area Doors need to be checked to ensure all unapproved hold open devices are removed. These findings was confirmed with the Chief Building Engineer (JB) at the time of discovery.	K 029		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation, the facility has failed to provide several operational exit signs that marks the means of egress path in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.5.2. The deficient practice could affect residents, staff and visitors, if the lack of properly illuminated exit sign prevented a means of egress from being utilized in a timely manner in an emergency situation. Findings include:	K 047	The exit signs in Physical Therapy, Chapel, Main Entrance and through out the Nursing Home have been fixed by the maintenance department. Monthly checks will be done to make sure they are working.	8/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245467	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/04/2015

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HENDRICKS COMMUNITY HOSPITAL	503 E LINCOLN STREET HENDRICKS, MN 56136

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K 047	Continued From page 4 On facility tour between 9:30 AM and 12:30 PM on 08/04/2015, it was observed that the illuminated exit signs that are located in the physical therapy area, chapel and at the main building entrance and exit were in-operative due to burnt out light bulbs that are located within the device. This deficient practice was verified by the Maintenance Supervisor (JB).	K 047		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow fire development	K 056	The sprinkler head that did not match the rest of the sprinklers was replaced by Building Sprinkle INC. All sprinkler heads are uniform throughout the Nursing Home.	8/12/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	245467	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/04/2015**

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K 056	Continued From page 5 that would reduce the egress conditions affecting all residents, staff and visitors of the facility. Findings include: On facility tour between 09:30 AM and 12:30 PM on 8/4/2015, it was observed that there were two types of fire sprinklers (fusible link and glass bulb) within the Main Nurses Station. Only one style of fire sprinkler head is allowed within a fire compartment. This was confirmed by Maintenance Supervisor (JB).	K 056		

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
August 20, 2015

Mr. Jeffrey Gollaher, Administrator
Hendricks Community Hospital
503 E Lincoln Street
Hendricks, Minnesota 56136

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5467025

Dear Mr. Gollaher:

The above facility was surveyed on August 3, 2015 through August 6, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule

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 me.

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00340	A. BUILDING: ______ B. WING ______	08/06/2015

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2 000	Initial Comments	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:
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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota

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2 000	Continued From page 1 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 corrected prior to electronically submitting to the Minnesota Department of Health. On August 3rd, 4th, 5th and August 6th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 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		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and	2 540		9/15/15

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2 540	Continued From page 3 N. resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to conduct an initial comprehensive assessment related to pressure ulcer risks to prevent further skin breakdown for 1 of 2 residents (R61) identified with pressure ulcers and failed to conduct an initial comprehensive assessment for the use of an indwelling Foley catheter for 1 of 2 residents (R61) reviewed for urinary catheter use. Findings include: R61 was admitted on 6/11/15 with diagnoses which included: right heel ulcer, right foot ulcers on the 4th and 5th digits, morbid obesity, sepsis, cellulitis, depression, atrial fibrillation and chronic kidney disease. R61's admission Minimum Data Set (MDS) assessment dated 6/18/15, identified R61 with one (1) stage two pressure ulcer and one (1) unstageable pressure ulcer, both were present upon admission. The admission MDS assessment failed to include any Care Area Assessment (CAA) related to the identified skin issues/pressure ulcers. When the medical record was reviewed, it lacked any comprehensive assessment of R61's skin since admission. R61's medical record contained a Braden Scale (assessment to identify pressure ulcer risk) in the assessment section but lacked any documentation (blank). A Pressure Ulcer Risk assessment was identified to be conducted along with the Braden scale, but was not completed. There was no evidence in the medical record to identify R61 was assessed for any risk factors.	2 540	Corrected	

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2 540	Continued From page 4 R61's physician orders dated 8/3/15, identified R61 with pressure ulcers located on his right toes on the 4th and 5th digits. R61 was further identified with a right heel pressure ulcer. During observation of morning cares on 8/5/15 at 9:55 a.m. registered nurse (RN)-D entered R61's room to perform wound treatment to the right heel. RN-C removed the gauze wrap from around R61's right heel and then removed a 4 x 4 gauze dressing. The dressing adhered to the wound and was moistened prior to removal. After the dressing was removed, R61 was noted to have a baseball circumference area covered with black scab which encompassed the entire heel region. RN-D redressed the wound after cleansing it with wound cleaner. After the heel was treated, RN-D treated the toes. R61 was noted to have pressure ulcers on the fourth and fifth digits of his right foot, which were approximately the size of a pencil eraser. The wounds were noted to be red in color and open. RN-D cleansed the wounds with wound cleaner and then replaced a sleeve between the toes to keep them separated after placing a fibrocol dressing over both open areas. During interview on 8/6/15, at 9:37 a.m. RN-A stated a wound nurse visited weekly to review the wounds on R61's right foot and toes. After reviewing R61's medical record RN-A verified there is was no Braden Scale assessment, no Pressure Ulcer Risk assessment nor tissue perfusion assessment as expected per policy. RN-A stated the facility typically conducted a tissue perfusion assessment to identify the lying and seating repositioning needs of the resident. The skin assessment should include an evaluation of the skin integrity & tissue tolerance (ability of the skin & its supporting structures to	2 540		

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2 540	Continued From page 5 endure the effects of pressure without adverse effects) after pressure to that area has been reduced or redistributed. R61 was admitted with an indwelling Foley catheter and the rationale for it's continued use was identified on the physician orders as chronic urinary incontinence related to immobility. R61's admission Minimum Data Set (MDS) assessment dated 6/18/15, identified R61 with an indwelling Foley catheter. The MDS lacked a Care Area Assessment (CAA) related to urinary status which included the continued use of the Foley catheter. During review of R61's medical record an assessment for urinary status could not be located. An assessment was lacking which included consideration of the risks & benefits of an indwelling catheter; the potential for removal of the catheter and consideration of complications resulting from the use of the indwelling catheter. The admission physician orders dated 8/3/15, identified that R61's Foley Catheter, #16 French (Fr) should be changed monthly or as needed. The physician orders identified the rationale for the catheter as chronic urinary incontinence related to immobility. When interviewed on 8/6/15, at 9:37 a.m. registered nurse (RN)-A confirmed R61's medical record lacked an urinary assessment and also verified a CAA had not been completed with the admission MDS assessment. SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice staff related to the necessary assessments required for incontinence and pressure ulcers. A system could be developed to track the completion of the	2 540		

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2 540	Continued From page 6 assessment process and an audit could be reported to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to accurately reflect limitation in range of motion status on the Minimum Data Set (MDS) assessment for 1 of 1 resident (R6) reviewed who experienced a trigger finger on the left middle finger. Findings include: During observation on 8/3/15, at 11:41 a.m. R6 was noted to have the middle finger of her left hand folded/curled into her palm. When questioned whether she was able to move the finger, R6 attempted and then responded, "No". R6 was observed to grab the left middle finger with her right fingers and attempt to extend the finger but was unable. R6 was then observed to wince and state, "Ouch" when attempting to manipulate/extend the left middle finger. During a subsequent observation on 8/5/15, at 11:31 a.m. R6 was seated in the dining room with	2 550	Corrected	9/10/15

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2 550	Continued From page 7	2 550		

her left hand middle finger pressing against her palm. When R6 was questioned whether she could bend this finger, she responded, "No". R6 indicated it hurt when she attempted to extend the finger. R6 was noted to have no protection to palm on the left hand nor any device applied to correct the contracture.
During review of R6's medical record there was a progress note dated 2/18/15, at 2:41 p.m. which indicated that R6 had an appointment at the clinic with a provider to examine her (L) hand middle finger that was locked in curled position - "trigger finger". The physician recommended a pulley release of finger to straighten it out and relieve the pain. The physician noted contact would be with the responsible party for R6 and a decision for what plan of treatment would be made.
During review of R6's care plan, dated 6/6/15, the care plan identified R6 with limited physical mobility related to arthritis in knees/legs. The care plan identified R6 would maintain range of motion (ROM) through interventions including:
1. Ambulate with assist of one staff with the support of a gait belt and four wheeled walker twice daily.
2. Active ROM exercises 5 minutes twice a day with cares seven days per week.
3. Small group exercises 5 days per week.

During review of R6's quarterly Minimum Data Set (MDS) assessments, dated 3/6/15 and 6/5/15, the identification of the functional limitation of ROM to R6's left middle finger was lacking.

During interview on 8/6/15, at 11:10 a.m. registered nurse (RN)-A verified the functional limitation in R6's left middle finger and verified the last two (2) quarterly assessments failed to accurately reflect the resident's status related to

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2 550	Continued From page 8 this limitation. SUGGESTED METHOD OF CORRECTION: The director of nursing could develop a system to track the accuracy of the quarterly assessments after providing inservice to the assessment nurses'. An audit could be developed, tracked and reported thru the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide toileting services as directed by the written plan of care for 1 of 1 resident (R6) reviewed with urinary incontinence and failed to follow the care plan to monitor lab results for 1 of 5 residents (R49) reviewed for unnecessary medications. Findings include: Staff failed to provide toileting as directed on the written plan of care for R6. R6 had current diagnoses identified on the diagnosis list as: Osteoarthrosis, glaucoma, hypertonic bladder,	2 565	Corrected	9/10/15

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2 565	Continued From page 9 dementia, anxiety and depression. R6's care plan dated 6/6/15, identified R6 as frequently incontinent. The care plan identified the following interventions for management of urinary status: 1. Will be clean, dry and odor free with no skin breakdown or signs of urinary tract infection (UTI). 2. Assist resident with toileting, transfers, changing pad, pericare and clothes adjustment. 3. Offer toilet every 2 hours. 4. Notify nurse if res. complains of urinary problems such as burning, frequency or pain. 5. Uses Tena day regular daytime and Tena brief medium. at night for incontinence product. During observation on 8/5/15, at 6:55 a.m. R6 was noted to be lying supine in bed with her eyes closed and remained in bed in this same position until 10:22 a.m. (3 1/2 hrs. later). At this time nursing assistant (NA)-D entered room to provide morning cares. At 10:25 a.m. NA-D and NA-H assisted R6 to transfer from her bed to the bathroom with the use of a walker and assisted R6 onto the toilet. It was noted the incontinent brief was urine soaked when removed and that R6 voided once on the toilet. At approximately 10:30 a.m. NA-D was interviewed about the last time R6 was assisted with any toileting needs. NA-D stated she was unsure when R6 was last toileted and/or was offered toileting. During review of R6's bladder assessment dated 9/4/14, it identified R6 as incontinent of bladder related to impaired mobility/ambulation. Contributing factors included abnormal labs, Alzheimer's disease/dementia, arthritis, and fall history. The assessment further identified R6 was able to verbalize the need to toilet and should be	2 565		

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2 565	Continued From page 10	2 565		

offered toilet every 2 hours. The type of incontinence was identified as urge incontinence.

During interview on 8/6/15, at 9:14 a.m. NA-F indicated that R6 required assistance with transferring to toilet and needed staff to stay with her when on toilet.

During interview with registered nurse (RN)-C on 8/6/15, at 9:48 a.m. it was verified R6 should be offered to toilet at least every two hours and if staff waited longer than two hours they were not following the written plan of care for R6.

The written plan of care for R49 was not implemented as it identified the following: obtain and monitor lab/diagnostics as ordered. R49's physician orders dated 7/23/15, identified R49 with a prescription for Digoxin (Cardiac medication to regulate heart) 0.25 milligrams (mg) on odd days and 0.125 mg on even days. The physician orders further identified R49 would have an annual Digoxin level completed annually in August. During review of R49's medical record a Digoxin level was unable to be identified.

When interviewed on 8/6/15, at 9:48 a.m. RN-C verified the medical record lacked a Digoxin level. RN-C stated there was an order from the physician in September 2014 for the level to be drawn but it had been missed. RN-C stated the last Digoxin level was completed in August 2013 (2 years ago) and should have been performed in August 2014. RN-C verified the annual Digoxin lab had been missed by the physician and nursing staff.

During interview with the consultant pharmacist on 8/6/14, at approximately 10:30 a.m. the pharmacy consultant reviewed R49's medical

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2 565	Continued From page 11 record and verified the Digoxin level had not been completed as ordered. The pharmacy consultant confirmed the Digoxin lab value test should be monitored annually as identified by the physician. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee (s)could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee (s)could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 895	Corrected	9/15/15

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2 895	Continued From page 12	2 895		

review the facility failed to provide the necessary services to maintain range of motion (ROM) for 1 of 1 resident (R6) in the sample identified with a ROM deficit.

Findings include:

During observation on 8/3/15, at 11:41 a.m. R6 was noted to have the middle finger of her left hand folded/curled into her palm. When questioned whether she was able to move the finger, R6 attempted and then responded, "No". R6 was observed to grab the left middle finger with her right fingers and attempt to extend the finger but was unable. R6 was then observed to wince and state, "Ouch" when attempting to manipulate/extend the left middle finger.
During a subsequent observation on 8/5/15, at 11:31 a.m. R6 was seated in the dining room with her left hand middle finger pressing against her palm. When R6 was questioned whether she could bend this finger, she responded, "No". R6 indicated it hurt when she attempted to extend the finger. R6 was noted to have no protection to palm on the left hand nor any device applied to correct the contracture.
During review of R6's medical record there was a progress note dated 2/18/15, at 2:41 p.m. which indicated that R6 had an appointment at the clinic with a provider to examine her (L) [left] hand middle finger that was locked in curled position - "trigger finger". The physician recommended a pulley release of finger to straighten it out and relieve the pain. The physician noted that contact would be made with the responsible party for R6 and a decision for what plan of treatment would be made.
During review of R6's care plan, dated 6/6/15, the care plan identified R6 with limited physical mobility related to arthritis in knees/legs. The care

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plan identified R6 would maintain range of motion (ROM) through interventions including:
1. Ambulate with assist of one staff with the support of a gait belt and four wheeled walker twice daily.
2. Active ROM exercises 5 minutes twice a day with cares seven days per week.
3. Small group exercises 5 days per week.

During review of R6's quarterly Minimum Data Set (MDS) assessments, dated 3/6/15 and 6/5/15, the identification of the functional limitation of ROM to R6's left middle finger was lacking.

When interviewed on 8/6/15, at 10:20 a.m. the activity director (AD) stated the facility used to have daily exercises which were implemented via the activities program but they had not routinely been offered for a while. The AD was unaware of the care plan for R6 included the small group exercises 5 days a week and stated R6 usually slept in during the day and generally would not be out of bed at the time the small group exercises were conducted, if they were conducted.

During interview on 8/6/15, at 11:05 a.m. nursing assistant (NA)-D stated R6 was supposed to get exercises daily with cares but stated they were usually not completed related to time constraints.

When interviewed on 8/6/15, at 11:10 a.m. registered nurse (RN)-A, RN-C and the AD verified R6's ROM program was not being thoroughly implemented. The staff were unsure who was responsible for which part of the ROM program.

SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all

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2 895	Continued From page 14 residents at risk for limited range of motion to assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk of a decline in range of motion. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide repositioning services based on a comprehensive assessment to reduce the risk of further skin breakdown for 1	2 900	Corrected	9/15/15

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of 2 residents (R61) reviewed who currently had pressure ulcers.

Findings include:
R61 was admitted on 6/11/15 with diagnoses which included: right heel ulcer, right foot ulcers on the 4th and 5th digits, morbid obesity, sepsis, cellulitis, depression, atrial fibrillation and chronic kidney disease.

R61's admission Minimum Data Set (MDS) assessment dated 6/18/15, identified R61 with one (1) stage two pressure ulcer and one (1) unstageable pressure ulcer, both were present upon admission. The admission MDS assessment failed to include any Care Area Assessment (CAA) related to the identified skin issues/pressure ulcers.

When the medical record was reviewed, it lacked any comprehensive assessment of R61's skin since admission. R61's medical record contained a Braden Scale (assessment to identify pressure ulcer risk) in the assessment section but lacked any documentation (blank). A Pressure Ulcer Risk assessment was identified to be conducted along with the Braden scale, but was not completed. There was no evidence in the medical record to identify R61 was assessed for any risk factors.

R61's physician orders dated 8/3/15, identified R61 with pressure ulcers located on his right toes on the 4th and 5th digits. R61 was further identified with a right heel pressure ulcer.

R61's plan of care plan dated 7/1/15, for skin, identified R61 with three (3) pressure ulcers and potential for pressure ulcer development related to history of ulcers and immobility. The goal listed

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on the plan of care included that the pressure ulcers would show signs of healing and remain free from infection by/through review date.

Interventions that were included on the care plan were:
1. Administer treatments as ordered and monitor for effectiveness.
2. Assess/record/monitor wound healing weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the wound nurse or physician.
3. Assistance to turn/reposition at least every 2 hours, more often as needed or requested.
4. Apply moisturizer daily to skin. Do not massage over bony prominence's and use mild cleansers for peri-care/washing.
5. Pressure relieving/reducing device 1) on bed - has air mattress; and 2) on Right foot - boot on right foot at all times, please assure that heel is properly placed to offload pressure
6. Follow facility policies/protocols for the prevention/treatment of skin breakdown.
7. Monitor dressing daily to ensure it is intact and adhering. Report lose dressing to Treatment nurse.

During observation of morning cares on 8/5/15, at 6:30 a.m. R61 was observed lying supine (on back) in bed with a pillow under his lower right leg to keep the right heel off the bed. The lower bed also had a bed cradle on it to keep R61's blankets off his feet. At 7:15 a.m. R61 remained in the same position (supine).

On 8/5/15, at 7:40 a.m. nursing assistant (NA)-I entered the resident room and stated R61 did not have the boot applied to the right foot as the

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urinary catheter had leaked during the night and the boot was sent to laundry to be washed. NA-I acknowledged R61 but performed no cares nor repositioning. R61 remained in the supine position until 8:50 a.m. at which time NA-M entered R61's room and elevated the head of the bed to approximately 130 degrees so R61 could eat breakfast in bed. NA-M delivered toast, coffee and juice on the tray table and left the room without any repositioning. R61 remained on his back in bed through 9:28 a.m. (3 hrs) when NA-I re-entered the room to assist R61 to get up for the day. After entering the room on 8/5/15, at 9:28 a.m. NA-I was questioned about the last time R61 was last repositioned. NA-I indicated it had about 6:00 a.m. NA-I stated she had not repositioned R61 yet and was unsure when the staff from night shift had last repositioned R61. NA-I began to perform morning cares at 9:30 a.m. At 9:45 a.m. (3 hours and 45 minutes later) NA-I and NA-E assisted R61 to sit up in bed and pivoted him to a seated position with his legs over the side of the bed. RN-D then entered the room to perform wound cares.

During observation of morning cares on 8/5/15 at 9:55 a.m. registered nurse (RN)-D performed a wound treatment to the right heel. RN-C removed the gauze wrap from around R61's right heel and then removed a 4 x 4 gauze dressing. The dressing adhered to the wound and was moistened prior to removal. After the dressing was removed, R61 was noted to have a baseball circumference area covered with black scab which encompassed the entire heel region. RN-D redressed the wound after cleansing it with wound cleaner. After the heel was treated, RN-D treated the toes. R61 was noted to have pressure ulcers on the fourth and fifth digits of his right foot, which were approximately the size of a

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2 900	Continued From page 18 pencil eraser. The wounds were noted to be red in color and open. RN-D cleansed the wounds with wound cleaner and then replaced a sleeve between the toes to keep them separated after placing a fibrocol dressing over both open areas. During interview on 8/6/15, at 9:37 a.m. RN-A stated a wound nurse visited weekly to review the wounds on R61's right foot and toes. After reviewing R61's medical record RN-A verified there is was no Braden Scale assessment, no Pressure Ulcer Risk assessment nor tissue perfusion assessment as expected per policy. The skin assessment should include an evaluation of the skin integrity & tissue tolerance (ability of the skin & its supporting structures to endure the effects of pressure without adverse effects) after pressure to that area has been reduced or redistributed. RN-A stated the facility typically conducted a tissue perfusion assessment to identify the lying and seating repositioning needs of the resident and was unsure how the determination of a two (2) hour reposition schedule was identified since no assessment had yet been completed. RN-A further stated that rolling R61 up in the bed while he remained on his back and buttock did not relieve pressure to the skin and therefore would not meet the definition of repositioning. After reviewing the skin monitoring sheets with RN-A, it was noted the identified wound had remained stable for R61. R61 failed to receive repositioning as directed by the plan of care which identified a repositioning schedule indicating at least every two (2) hours. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure	2 900		

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2 900	Continued From page 19 they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to conduct a comprehensive assessment related to the continued use of an indwelling Foley catheter for	2 910	Corrected	9/15/15

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1 of 2 residents (R61) reviewed for urinary catheter use and failed to provide timely toileting services for 1 of 1 resident (R6) who experienced urinary incontinence and required extensive assistance.

Findings include:

R61 failed to conduct a comprehensive urinary assessment related to the continued use of a Foley catheter.

R61 was admitted on 6/11/15, with diagnoses including: right heel ulcer, right foot ulcers on the 4th and 5th digits, morbid obesity, sepsis, cellulitis, depression, atrial fibrillation and chronic kidney disease. R61 was admitted with an indwelling Foley catheter and the rationale for it's continued use was identified on the physician orders as chronic urinary incontinence related to immobility.

R61's admission Minimum Data Set (MDS) assessment dated 6/18/15, identified R61 with an indwelling Foley catheter. The MDS lacked a Care Area Assessment (CAA) related to urinary status which included the continued use of the Foley catheter. During review of R61's medical record an assessment for urinary status could not be located. An assessment was lacking which included consideration of the risks & benefits of an indwelling catheter; the potential for removal of the catheter and consideration of complications resulting from the use of the indwelling catheter.

The admission physician orders dated 8/3/15, identified that R61's Foley Catheter, #16 French (Fr) should be changed monthly or as needed. The physician orders identified the rationale for the catheter as chronic urinary incontinence

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related to immobility.

During review of R61's written plan of care dated 7/1/15, it was lacking any documentation which included the risks, goals, and/or interventions related to the indwelling Foley catheter.

When interviewed on 8/6/15, at 9:37 a.m. registered nurse (RN)-A confirmed R61's medical record lacked an urinary assessment and also verified a CAA had not been completed with the admission MDS assessment. RN-A further stated there had been communication with R61's physician related to the rationale for continued use of the Foley catheter. The physician identified R6 with diagnosis of chronic incontinence related to immobility as the primary reason for the use of the catheter. The medical record lacked justification for an attempt to discontinue the catheter and/or rationale for it's continued use.

Staff failed to provide timely assistance with toileting for R6 to maintain as much urinary function as possible. R6 had current diagnoses identified on the diagnosis list as: Osteoarthrosis, glaucoma, hypertonic bladder, dementia, anxiety and depression.

During observation on 8/5/15, at 6:55 a.m. R6 was noted to be lying supine in bed with her eyes closed and remained in bed in this same position until 10:22 a.m. (3 1/2 hrs. later). At this time nursing assistant (NA)-D entered room to provide morning cares. At 10:25 a.m. NA-D and NA-H assisted R6 to transfer from her bed to the bathroom with the use of a walker and assisted R6 onto the toilet. It was noted the incontinent brief was urine soaked when removed and that R6 voided once on the toilet. At approximately 10:30 a.m. NA-D was interviewed about the last

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2 910	Continued From page 22	2 910		

time R6 was assisted with any toileting needs. NA-D stated she was unsure when R6 was last toileted and/or was offered toileting.

During review of R6's bladder assessment dated 9/4/14, it identified R6 as incontinent of bladder related to impaired mobility/ambulation. Contributing factors included abnormal labs, Alzheimer's disease/dementia, arthritis, and fall history. The assessment further identified R6 was able to verbalize the need to toilet and should be offered toilet every 2 hours. The type of incontinence was identified as urge incontinence.

R6's care plan dated 6/6/15, identified R6 as frequently incontinent. The care plan identified the following interventions for management of urinary status:
1. Will be clean, dry and odor free with no skin breakdown or signs of urinary tract infection (UTI).
2. Assist resident with toileting, transfers, changing pad, pericare and clothes adjustment.
3. Offer toilet every 2 hours.
4. Notify nurse if res. complains of urinary problems such as burning, frequency or pain.
5. Uses Tena day regular daytime and Tena brief medium. at night for incontinence product.

During interview on 8/6/15, at 9:14 a.m. NA-F indicated that R6 required assistance with transferring to toilet and needed staff to stay with her when on toilet.

During interview with registered nurse (RN)-C on 8/6/15, at 9:48 a.m. it was verified R6 should be offered to toilet at least every two hours and agreed the necessary care was not provided.

SUGGESTED METHOD OF CORRECTION:

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2 910	Continued From page 23 The director of nursing or designee, could review all residents at risk for incontinence to assure they are receiving the necessary treatment/services to reduce incontinence and the unnecessary use of catheters. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for further issues with incontinence and unnecessary use of catheters. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to routinely clean, monitor and sanitize dietary equipment which had the potential to affect all 56 residents residing in the facility. Findings include: During observation of the kitchen on 8/3/15, at 9:07 a.m. the following was noted: (1) One electric can opener located on a stainless steel table near the steam table was noted to have a thick, black build up on the surface of the cutting blade and also on the area surrounding	21015	Corrected	9/15/15

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21015	Continued From page 24	21015		

the blade. The dietary manager (DM) verified the food residue came off in chucks when touched and could potentially contaminate food when utilized to open canned items without the proper cleaning. The DM further verified she was not certain when the electric can opener had last been used but thought it was this morning.
(2) A manual can opener was also located on the stainless table and had evidence of thick, black residue surrounding the cutting edge surface which broke/flaked off when touched. The DM verified this particular can opener had been utilized that morning (8/3/15) without cleaning after use. The DM further confirmed a cleaning schedule had not been implemented nor had the equipment been consistently sanitized/cleaned between uses.

Three stainless steel carts were observed being utilized for breakfast service on 8/3/15 and 8/6/15. The surface, drawers and tracks of the drawers on the carts contained large amounts of crumbs, spills and food particle build up. Each of the carts contained oatmeal, bread for toast, 1/2 gallon milk cartons, yogurt and various juices. Nursing assistants were observed to prepare breakfast items located on the carts and place the food items onto Styrofoam plates and/or bowls.

When interviewed on 8/5/15, at 7:34 a.m. nursing assistant (NA)-B verified the dietary carts were frequently transported down resident hallways soiled with crumbs, spills and food residue from previous usage. She further indicated she had requested the carts be cleaned and they had returned in the same condition. NA-B indicated the appearance of the dietary cart this morning had crumbs and soil on the surface and tract of the cart. She indicated the cart had been in this

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21015	Continued From page 25 condition for a "long time". NA-B stated, " there used to be a procedure in which the carts were cleaned after each use and then thoroughly cleansed weekly", but stated she was not aware of this schedule at the present time. During an interview on 8/05/15, at 7:53 a.m. NA-C indicated she was not aware of a cleaning schedule for the carts and confirmed the carts had crumbs, food residue on the cart surfaces and in the tracks of the drawers; in addition, food routinely spilled into the drawers of the cart when used to prepare resident breakfasts and sometimes spilled under/onto the condiments stored in these dietary carts. The DM was interviewed on 8/5/15, at 8:19 a.m. and verified there was no cleaning schedule for the carts utilized daily to transport, store and prepare food items for residents who routinely ate breakfast in their rooms. The DM indicated the carts are restocked daily with food items, Styrofoam plates/bowls and plastic silverware and dietary staff were expected to wipe down as necessary. Review of the documentation provided from a computer generated listing of cleaning duties confirmed documentation was lacking to indicate this tool had been completed by staff to ensure proper cleaning of the equipment. This tool had been developed by the facility to ensure the completion of the required cleaning duties in the dietary department. Temperature logs located in the dietary area were available/posted near the dishwashing (wash/rinse), refrigerators and freezer equipment. The temperatures logs were noted to have multiple areas left blank, indicating the required temperatures had not been recorded per facility policy. Documentation was lacking to indicate the	21015		

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equipment remained in safe operating condition to maintain dietary sanitization. The DM confirmed the equipment had not been monitored appropriately during the times that were noted to be left blank.

When interviewed on 8/6/15, at 12:30 p.m. the dishwasher/dietary aide (DA)-A confirmed the wash/rinse temperatures on the dishwasher had not been monitored on 8/5/15 and 8/6/15.

Facility Policies Reviewed: Policy and Procedure Manual Section: Dietary
Last revision date: 05/15,
Subject: Breakfast Cart
2.1.5 Dietary & Activity staff work together to clean up plates/silverware/glasses/cups and condiments
3.1.7 All serving utensils may not be left in food. They must be taken out of the food and put on a plate
3.1.9 Dietary Staff once all items are off cart are to wipe down cart & restock cart for morning,
3.1.10 Once a week all items are taken off cart and a assigned dietary aide takes all items out of cart and wash inside and out of cart and restocks cart

Subject: Dietary Weekly Cleaning Effective: 07/15
Policy: The Dietary Kitchen will be cleaned on a weekly basis by Dietary Staff as assigned to each shift.
Procedure:
2.1 weekly the dietary manager puts out a clean list in the kitchen. This list has all shifts that work in a 24 hour period. Along with what needs to be cleaned.
2.2 dietary staff are responsible to look at clean sheet for days duties.

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21015	Continued From page 27 2.3 once cleaning duty is done staff are to initial that job has been completed. 2.4 at the end of the week the dietary manager picks up cleaning list for week and files in the office. SUGGESTED METHOD OF CORRECTION: The dietary manager could develop a schedule to ensure that all dietary equipment is cleaned and sanitized. A system for cleaning the carts used to deliver food could also be developed and staff could be inserviced. Random audits could be conducted by the dietary manager and reported to the quality assurance committee to ensure the proper cleaning. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of	21390		9/15/15

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21390	Continued From page 28 employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to change gloves and/or use proper handwashing during wound care for 1 of 1 resident (R61) reviewed during dressing changes to pressure ulcers located on the foot and failed to establish an infection control program which included comprehensive surveillance of resident symptoms, analysis of the surveillance and investigation of patterns identified. This had the potential to affect all 56 residents who resided in the facility. Findings include: During observation of wound cares on 8/5/15, at 9:55 a.m. registered nurse (RN)-D was noted to provide treatments to R61's right heel pressure ulcer and the ulcers located between the forth and fifth digits on the right foot. After staff assisted R61 to be seated on the edge of the bed, RN-D donned gloves and removed the old gauze dressing from around R61's heel and ankle. After the gauze was removed from the heel, it was noted that some of the gauze remained attached/stuck to the scab tissue of the wound. RN-D applied a wound cleanser with	21390	Corrected	

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spray to saturate the area and detach the gauze from the wound. After RN-D removed the gauze which had visible drainage, clean wound dressing supplies were removed from the resident's drawer with the same gloved hands used to remove the soiled gauze. RN-D proceeded to apply a clean 4 x 4 dressing and wrap with the same gloved hands. RN-D failed to remove the soiled gloves and apply new gloves prior to re-dressing the wound.

After the heel wound had been treated and new dressings applied, RN-D applied a clean dressing to the wounds located on R61's forth and fifth digits with the same gloved hands. No handwashing nor a change in gloves was noted throughout the entire procedure when both wounds were treated.

When interviewed on 8/6/15, at 8:31 a.m. RN-D verified she had not changed her gloves, stating, "I should have changed gloves".

Review of the Hand Hygiene policy dated 8/2011, indicated the procedure for hand antisepsis if hands are not visibly soiled use the system approved alcohol-based hand rub for routinely decontaminating hands in all other clinical situations including after removing gloves.

The facility's Infection Control Logs were reviewed from 1/1/2015 through 8/2/2015. The logs identified the facility tracked only the name of the resident, source of the infection, date of onset and was not done every month for the entire building. The facility's surveillance processes also lacked identification of the following: location of the resident within the facility, specific symptoms that were present, cultures performed/ organism identified, and the

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date the infection resolved. Furthermore, the logs lacked analysis and/or investigation of patterns identified.

When interviewed on 8/6/15, at 11:28 a.m. the infection control officer (ICO) confirmed a current infection control program which included tracking and trending infections in the nursing home had not been implemented on a monthly basis. The ICO stated she had responsibility for the infection control policies and procedures both in the attached hospital and the nursing home. The ICO indicated they were in the process of addressing this at the quality assurance committee as infection control issues had not been reported in recent months.

During an interview with the director of nursing (DON) on 8/6/15, at 11:38 a.m. it was confirmed the infection control program was in need of some improvement.

Review of the facility policy titled, Infection Prevention and Control Program, revised on 11/13, indicated the facility would maintain surveillance of the healthcare facility infection potentials, identify and analyze the incidents and caution of healthcare associated infections. To develop and implement a preventive and/or corrective program to minimize infection hazards. The infection control registered nurse will act as the liaison for all committee members, collecting and correlating data, reporting information on infection control to the proper personnel and teaching and reinforcing infection control policy and procedures,

SUGGESTED METHOD OF CORRECTION: The DON or infection control officer could develop a system to track, trend and implement infection

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21390	Continued From page 31 control policies and procedures. Staff could be educated on the infection control program along with random audits of staff cares to ensure proper techniques are implemented. The infection control program could be integrated with the quality assurance program. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and 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	21426	Corrected	9/15/15

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21426	Continued From page 32 facility failed to ensure all residents (R) and health care workers (HCW's) received baseline tuberculosis (TB) screening for signs and symptoms of TB and also included a 2 step tuberculin skin test (TST), for 5 of 5 residents (R60, R56, R24, R61, R3) in the sample and 4 of 5 newly hired employees (LPN-B, EW-A, RN-D, DA-A). Finding include: The facility lacked all components required for a resident TB screening. R60 had been admitted to the facility on 6/10/2015. After review of the record, no baseline screening was done for signs and symptoms of TB for R60. R56 had been admitted to the facility on 2/16/2015. After review of the record, no baseline screening was done for signs and symptoms of TB for R56. R24 had been admitted to the facility on 4/1/2015. After review of the record, no baseline screening was done for signs and symptoms of TB for R24. R61 had been admitted to the facility on 6/11/2015. After review of the record, no baseline screening was done for signs and symptoms of TB for R61. R3 had been admitted to the facility on 6/2/2015. After review of the record, no baseline screening was done for signs and symptoms of TB for R3. In addition the facility lacked all components required for HCW's TB screening.	21426		

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21426	Continued From page 33 A review of personnel records for five newly hired employees revealed the following: Licensed practical nurse (LPN)-B had been hired on 7/1/15. After review of the record, a baseline screening was done for signs and symptoms of TB on 6/27/15. A tuberculin skin test (TST) was administered to LPN-B on 6/27/15 and second step administered on 3/31/15, however the second step was not administered within 1 to 3 weeks of first step TST. Environmental worker (EW)-A had been hired on 9/18/15. After review of the record, a baseline screening was done for signs and symptoms of TB on 9/9/15. A TST was administered to EW-A on 9/9/15 and second step administered on 10/25/15, however the second step was not administered within 1 to 3 weeks of first TST. Register nurse (RN)-D had been hired on 10/27/15. After review of the record, a baseline screening was done for signs and symptoms of TB on 1/28/15. A TST was administered to RN- D on 10/8/14 and second step administered on 1/28/15, however the second step was not administered within 1 to 3 weeks of first step TST and symptoms screening was not done upon hire. Dietary aid (DA)-A had been hired on 12/8/14. After review of the record, a baseline screening was done for signs and symptoms of TB on 12/2/14. A TST was administered to DW-A on 12/2/14 and second step was never within 1 to 3 weeks of first step TST. During interview on 8/6/15 at 12:10 p.m. the director of nursing (DON) confirmed the facility policy and verified TB screening and two step TST's were not being done right for residents and	21426		

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21426	Continued From page 34 HCW in the facility and stated "we should be following the policy." Review of facility policy titled, Tuberculin Exposure Control Plan, revised on 4/13 indicated all employees are screened upon hire for TB using two-step screening process, the first step TST is administered upon hire followed by second step TST 1-3 weeks later. Baseline TB assessment should be used. Conduct a TB risk assessment. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop a system to ensure the facility is maintaining an accurate system for recording tuberculin skin testing for resident and staff in order to provide appropriate care and services. The Director of Nursing could develop and implement a random audit tool to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change.	21530		9/15/15

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B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician.

C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.

This MN Requirement is not met as evidenced by:
Based on interview and document review the consultant pharmacist failed to report the necessity of monitoring the blood level of a medication when conducting the monthly drug regimen review to identify irregularities for 1 of 5 residents (R49) reviewed for unnecessary medications.

Plan of correction: Corrected

Findings include:

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R49's physician orders dated 7/23/15, identified R49 with a prescription for Digoxin (heart medication to regulate heart) 0.25 milligrams (mg) on odd days and 0.125 mg on even days. The physician orders further identified R49 should have a Digoxin blood level completed annually in August. During review of R49's medical record a Digoxin level was unable to be identified.

When interviewed on 8/6/15, at 9:48 a.m. registered nurse (RN)-C verified the medical record lacked documentation of a Digoxin level. RN-C confirmed that in September 2014 the physician ordered a blood level be drawn but it had been missed. RN-C further stated the last Digoxin level was completed in August 2013 (2 years ago) and should have been done in August 2014. RN-C verified the annual Digoxin lab had been missed by the physician and nursing staff.

During interview with the consultant pharmacist on 8/6/14, at approximately 10:30 a.m. the pharmacy consultant reviewed R49's medical record and verified the Digoxin level had not been completed as ordered. The pharmacy consultant verified the Digoxin level had been missed during his monthly reviews and confirmed the lab test should be monitored annually as identified by the physician.

SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance.

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21530	Continued From page 37 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to monitor lab values to assess medication effectiveness for 1 of 5 residents (R49) reviewed for unnecessary medications. Findings include: R49's physician orders dated 7/23/15, identified	21540	Corrected	9/15/15

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Continued From page 38

R49 with a prescription for Digoxin (Cardiac medication to regulate heart) 0.25 milligrams (mg) on odd days and 0.125 mg on even days. The physician orders further identified R49 would have an annual Digoxin level completed annually in August. During review of R49's medical record a Digoxin level was unable to be identified.

When interviewed on 8/6/15, at 9:48 a.m. registered nurse RN-C verified the medical record lacked a Digoxin level. RN-C stated there was an order from the physician in September 2014 for the level to be drawn but it had been missed. RN-C stated the last Digoxin level was completed in August 2013 (2 years ago) and should have been performed in August 2014. RN-C verified the annual Digoxin lab had been missed by the physician and nursing staff.

During interview with the consultant pharmacist on 8/6/14, at approximately 10:30 a.m. the pharmacy consultant reviewed R49's medical record and verified the Digoxin level had not been completed as ordered. The pharmacy consultant confirmed the Digoxin lab value test should be monitored annually as identified by the physician.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or desigee could work with the medical director and consultant pharmacist to ensure medications were reviewed for appropriate interventions and monitoring. The DON could ensure the staff were educated on the importance of monitoring for unnecessary medications.The DON or designee could randomly audit resident records to ensure adequate monitoring and documentation was in place.

TIME PERIOD FOR CORRECTION: Twenty-one

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21540	Continued From page 39 (21) days. .	21540		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to assess the ability to self administer medications for 5 of 11 residents (R4, R5, R9, R51, R52) observed to self administer medications. Findings include: It was observed on 8/3/15, at 11:25 a.m. while	21565	Corrected	9/15/15

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21565	Continued From page 40 interviewing R52 in a room shared with his spouse (R51) that two medication cups were left sitting on a small table in between two recliners occupied by R51 and R52. One medication cup had two large white oblong tablets along with a few smaller tablets in it and the other medication cup contained pudding with a spoon sticking out of it. R52 stated his wife R51 likes to take the pills right before dinner and she takes them with pudding. While interviewing R52, it was noted that R51 took the medication in the cup mixed with the pudding. During the supper meal on 8/4/15, at 5:52 p.m. it was noted that both R51 and R52 were seated at a dining room table. It was noted that registered nurse (RN)-D placed a plastic medication cup next to R51 and another plastic medication cup next to R52. Both cups had medication mixed with applesauce. It was observed that RN-D left the table to dish up more medications from the medication cart located in the hallway outside of the dining room. She left prior to either R51 or R52 taking their respective medications. RN-D had her back to both residents as they consumed their medications. When interviewed on 8/3/15, at 11:58 a.m. RN-C stated there are some residents they routinely leave medications with so they can take them after the nurse has set them up into the medication cup. RN-C stated R51 and R52 eat breakfast in their room so their medications are left with them. RN-C added some residents request to have their medications left with them and staff will accommodate them as long as the resident is trustworthy and there is no cognitive impairment or history of refusing mediations. RN-C further stated they consider medication self administration when the resident can identify their	21565		

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own medication and demonstrate the ability to set up their medication. They also require a self administration assessment and physician's order. Both an assessment and physician order was lacking in the records for R51 and R52.

It was observed during the evening meal on 8/4/15, at 5:45 p.m. that RN-D delivered liquid potassium mixed with juice to the table where R4 was seated. R4 was seated at the table with 3 other residents. R4 left the table area at 6:36 p.m. and the medication had not yet been consumed. The medication remained at the table during the entire evening meal until 6:55 p.m. when the dietary aide cleared the table, dumped the contents of the juice glass into a bucket of remaining juices left on the tables and not consumed.

When interviewed on 8/4/15, at 7:32 p.m. RN-D confirmed she had mixed the liquid potassium in a smaller plastic cup with juice.

When interviewed on 8/6/15, at 11:54 a.m. RN-C stated the nurses know that they need to make sure R4 receives her medication as she doesn't always want to take her medication and this has been a problem. RN-C reiterated the nurses should know better than this.

R5 failed to have an assessment conducted to identify her ability to safely self administer medications.

During observation of the noon meal on 8/3/15, at 11:52 a.m. R5 was observed seated at the dining room table with a plastic medication cup located on the table in front of her which contained crushed medication mixed in applesauce. There were three other residents seated at the table.

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The medication cup remained at the table throughout the noon meal until R5 self administered the medications at 12:10 p.m. Licensed practical nurse (LPN)-A was noted to leave the dining room area at the time of the observation and was in a location where she unable to visualize R5.

During observation of the evening meal on 8/4/15, at 5:15 p.m. R5 was again observed to have a plastic medication cup located on the table in the dining room table where she was seated. It contained crushed medication in applesauce. There were three other residents seated at the table with her. R5 self administered the medications at 5:32 p.m. Registered nurse (RN)-G, who left the medications placed on the table, left the dining room area multiple times and was unable to monitor and/or continuously visualize R5 during the observation.

When the medical record was reviewed, it lacked any assessment related to R5's ability to self administer medications.

R9 failed to have an assessment conducted to identify her ability to safely self administer medications.

During observation of the supper meal on 8/4/15, at 5:27 p.m. R9 was observed seated in her wheelchair at the dining room table with a white paper medication cup on the table in front of her that contained medication while R9 was sleeping with her chin resting against her chest. There were three other residents seated at the table with her. R9 was observed to have the medications sitting on the table until her supper meal came at 5:53 p.m. Staff proceeded to wake R9 up to eat and then R9 proceeded to self

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administered her medications independently prior to eating supper. RN-G, who left the medications placed on the table, left the dining room area multiple times and did not have R9 within view during the observation.

During review of R9's medical record it was noted R9 lacked an assessment to identify her ability to self administer medications.

When physician orders were reviewed, they indicated R9 may self administer AM (morning) oral medications after set up by nurse.

During interview on 8/6/15 at 2:13 p.m. RN-C confirmed R9 lacked a self administration assessment and only had physician orders to: self administer AM oral meds after set up by nurse. RN-C verified the medications should not be left on the table for self administration unless there was an assessment to identify the resident was safe and when the resident was sleeping and stated "this is unsafe practice and the medication should not have been left with the resident."

The facility had developed a Medication Administration Orientation worksheet, undated, which was used to train staff on the facility standard for medication administration. Item 8. d. on the orientation sheet identified staff were to observe residents during the administration to ensure the medication was taking appropriately.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing (DON) or desigee ensure the appropriate assessments are conducted to ensure the safe administration of medications. The DON could ensure the staff were educated on the importance of the assessment process. The DON or designee could randomly audit

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21565	Continued From page 44 resident records to ensure adequate monitoring and documentation was in place. The DON could could random audits to ensure medication is not left with residents unless deemed safe by the interdisciplinary team. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure resident rooms were kept in good repair for 4 of 56 resident (R18, R35, R8 and R48) rooms who were reviewed during the environmental tour. Findings include: On 8/5/15, at 1:15 p.m. an environmental tour of the facility was conducted with the director of nursing (DON) and maintenance supervisor (MS) present. The DON and MS confirmed the following findings: (1) It was noted when entering R18's room that an area located on the left wall above the base	21695	Corrected	9/15/15

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21695	Continued From page 45 board had several areas of missing paint and exposed sheet rock, which approximately measured two and half feet long by 6 inches wide (2 1/2 ft x 6 in). (2) It was also noted when entering R35's room that several large scuff marks with paint missing were observed on the wall above the bed and located near the bed side rail. Sheet rock was exposed and measured approximately two feet by one foot (2 ft x 1 ft). (3) There was a large area measuring 3 feet long by 1 foot wide (3 ft x 1 ft) above the base board located next to the TV stand in R8's room. The wall was noted to have black, scuffed areas with gouges. Sheet rock was exposed on the entire noted area. (4) In R48's room, several large areas were observed on the wall above the bed measuring approximately five feet long by 2 feet wide (5 ft x 2 ft). The wall had multiple tears in the wall paper, which was peeling and missing from the wall and exposing the sheet rock. On 8/5/15 at 1:15 p.m. the maintenance staff (MS) confirmed he fixes issues which are written and reported by either staff and/or housekeeping. MS indicated he was unaware of the areas noted during the tour, he does not keep a work log and currently is not conducting routine environmental tours. MS stated "I should know about this and they should be fixed; I don't feel the system is working and we need to come up with something different." On 8/5/15, at 1:15 p.m. the director of nursing (DON) confirmed the findings and was not aware of the noted areas, but stated "there is always	21695		

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21695	Continued From page 46 room for improvement." A facility maintenance policy was requested on 8/6/15, and the DON indicated the facility did not have a policy which addressed routine maintenance in the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to promote a dignified dining experience by serving breakfast on Styrofoam plates and bowls and using plastic utensils for 24 of 24 residents (R4, R5, R6, R7, R8, R9, R11, R13, R16, R22, R23, R25, R27, R28, R31, R34, R41, R44, R45, R47, R51, R52,	21805	Corrected	9/15/15

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R56 and R61) observed being served breakfast in their rooms.

Findings include:

During observation on 8/3/15, at 9:30 a.m. three stainless steel carts containing breakfast items were located in the dining room and at the end of the East and West hallways. Each of the carts contained oatmeal, bread for toast, 1/2 gallon milk cartons, yogurt and various juices. Nursing assistants were observed to prepare breakfast items located on the carts and place the food items onto Styrofoam plates and/or bowls. Thin, white plastic silverware was retrieved from the cart with the food item and delivered to each resident located on the east and west halls and who preferred to eat in their room for the breakfast meal;(R4, R5, R6, R7, R8, R9, R11, R13, R16, R22, R23, R25, R27, R28, R31, R34, R41, R44, R45, R47, R51, R52, R56 and R61)

During observation on 8/5/15, at 7:30 a.m. breakfast items were delivered to residents via the carts in the dining room and East and West halls. Styrofoam plates/bowls and the thin, white plastic silverware were available on the east and west hall carts as part of the breakfast meal service. At 7:34 a.m. nursing assistant (NA)-B, located on the west wing prepared breakfast items from the cart and served the residents with the Styrofoam dishes.

The cart utilized to take items into the dining room contained regular ceramic dishes and metal reusable silverware that were utilized for serving breakfast food to the residents who were eating their meal in the dining room.

On 8/5/15, at 7:53 a.m. NA-C prepared food from

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the cart and served breakfast items to residents located on the east wing. NA-C served toast, hot and/or cold cereals, milk, juice and coffee. The food items were served on the Styrofoam plates and bowls and plastic silverware was provided with the meal.

The following morning, on 8/6/15, at 8:30 a.m. the breakfast meal was again prepared from the carts and served on the disposable dishes to residents located on the east and west halls. NA's on both East and West Wings verified that had been the practice to serve breakfast on Styrofoam plates/bowls and use plastic silverware for as long as they could recall. When questioned if there was a reason for this practice, replied, "that is just the way it is".

When interviewed on 8/5/15, at 9:00 a.m. NA-B verified that residents were served breakfast on Styrofoam dishes and thin, white plastic silverware was utilized on a daily basis as that was the practice. NA-B indicated she felt there was an issue with using Styrofoam and plastic, but didn't have any say in the matter.

During an interview on 8/5/15, at 9:30 a.m. NA-C also verified that Styrofoam dishes and plastic silverware were used to serve breakfast to residents located in their rooms on a daily basis. NA-C indicated she was not aware of a reason for using disposable verses reusable dishware. NA-C further indicated she thought it would be nice if they used regular dishes related to safety for the residents handling the plates.

When interviewed on 8/05/15, at 8:19 a.m. the dietary manager (DM) indicated the use of the Styrofoam disposable dishes and plastic spoons had been used on carts as "that is what the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00340	A. BUILDING: ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDRICKS COMMUNITY HOSPITAL	**503 E LINCOLN STREET HENDRICKS, MN 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) COMPLETE DATE
21805	Continued From page 49	21805		

process has been since July 2014" when she started in her position. The DM further indicated she didn't feel the practice of using Styrofoam and plastic was dignified.

On 8/06/15, at 10:32 a.m. the director of nursing (DON) stated she was not aware of resident's concerns regarding the use of Styrofoam dishes and plastic silverware but further indicated she didn't think it was appropriate. She also added that she has a family member living in facility and didn't feel it was appropriate. She stated that Styrofoam dishes presented a safety concern (flimsy) related to the risk of spills.

When interviewed on 8/06/15, at 10:42 a.m. R50 indicated she didn't have an issue with the use of plastic silverware because she knew staff were busy but stated she would never use paper/Styrofoam plates/bowls at home and would prefer to have glass or ceramic dishes. R50 further indicated she had noticed the silverware used was of poor quality as it was very thin and would easily break when used.

Review of the facility policy: Policy and Procedure Manual Hendricks Community Hospital Association Subject: Breakfast Cart Section Dietary Policy No: 8711.145.01 effective 7/03, Revised 01/09 05/15
Procedure:
3.1.1 Breakfast carts are stocked by dietary with plates/silverware/glasses/cups and condiments
3.1.7 D. Staff are to pick up dirty dishes & put in dirty bus tubs once resident is done with breakfast. The facility policy makes no reference to use of disposable dishes or utensils.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could

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21805	Continued From page 50 review/revise policies and procedures related to the provision of dignified care and services. Employees could be re-educated on these policies. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		