DEPARTMENT OF	HEALTH AND HUMA	N SERVICES		CENTERS FOR MED	ICARE & MEDICAID SERVICES
	-	ARE/MEDICAID CERTI			ID: 4TBH
	PART I -	TO BE COMPLETED B	Y THE STAT	TE SURVEY AGENCY	Facility ID: 00340
1. MEDICARE/MEDICAI	D PROVIDER NO.	3. NAME AND ADDRESS OF (L3) HENDRICKS COMM		ITAL	4. TYPE OF ACTION: $\underline{7}$ (L8)
(L1) <b>245467</b> 2.STATE VENDOR OR ME	EDICAID NO	(L4) 503 E LINCOLN STR			1. Initial 2. Recertification
(L2) <b>204342400</b>		(L5) HENDRICKS, MN		(L6) <b>56136</b>	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHA	ANGE OF OWNERSHIP	7. PROVIDER/SUPPLIER CA	TEGORY	<u>02</u> (L7)	7. On-Site Visit 9. Other 8. Full Survey After Complaint
(L9)		01 Hospital 05 HHA	09 ESRD	13 PTIP 22 CLIA	
6. DATE OF SURVEY	<b>09/24/2015</b> (L34)	02 SNF/NF/Dual 06 PRTF 03 SNF/NF/Distinct 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING DATE: (L35)
<ol> <li>ACCREDITATION STA 0 Unaccredited</li> </ol>	TUS: (L10)	04 SNF 08 OPT/S		16 HOSPICE	09/30
2 AOA	3 Other				
11LTC PERIOD OF CERT	TIFICATION	10.THE FACILITY IS CERTIF	IED AS:		
From (a):		X A. In Compliance With		And/Or Approved Waivers Of	
To (b):		Program Requirements Compliance Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12. Total Facility Beds	<b>58</b> (L18)	1. Acceptable PO	DC	4. 7-Day RN (Rural SN	
		<ul> <li>B. Not in Compliance with</li> </ul>	Program	5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	<b>58</b> (L17)	Requirements and/or A		* Code: A	(L12)
14. LTC CERTIFIED BED I	BREAKDOWN			15. FACILITY MEETS	
18 SNF 1	8/19 SNF 19 SNF	ICF II	D	1861 (e) (1) or 1861 (j) (1):	(L15)
(L37)	58 (L38) (L39)	(L42) (L4	43)		
16. STATE SURVEY AGE	NCY REMARKS (IF APPLICA	BLE SHOW LTC CANCELLATI	ON DATE):		
17. SURVEYOR SIGNATU	JRE	Date :		18. STATE SURVEY AGENCY	APPROVAL Date:
Kathryn Serie, U	Init Supervisor	09/25/2015	(L19) K	amala Fiske-Downing, F	Enforcement Specialist 09/25/2015 (L20)
	PART II - TO BE	COMPLETED BY HCFA	REGIONAL	OFFICE OR SINGLE S	<b>FATE AGENCY</b>
19. DETERMINATION OF	FELIGIBILITY	20. COMPLIANCE	WITH CIVIL		cial Solvency (HCFA-2572)
1. Facility is I	Eligible to Participate	RIGHTS ACT:		<ol> <li>Ownership/Contro</li> <li>Both of the Above</li> </ol>	l Interest Disclosure Stmt (HCFA-1513) :
2. Facility is	not Eligible (L21)				
	(L21)				
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24. LTC AGR	REEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	DATE ENDING	DATE	VOLUNTARY 00	
04/01/1987				01-Merger, Closure 02-Dissatisfaction W/ Reimburse	05-Fail to Meet Health/Safety
(L24)	(L41)	(L25)		03-Risk of Involuntary Termination	n
25. LTC EXTENSION DA		VE SANCTIONS 1 of Admissions:		04-Other Reason for Withdrawal	
	A. Suspension	(L44)			00-Active
	(L27) B. Rescind Su	spension Date:			
		(L45)			
28. TERMINATION DATE	3: 29	. INTERMEDIARY/CARRIER	NO.	30. REMARKS	
		03001			
	(L28)		(L31)		
31. RO RECEIPT OF CMS-	-1539 32	. DETERMINATION OF APPRO	VAL DATE		
	(L32)		(L33)	DETERMINATION APPR	ROVAL



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,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> 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,

Kumala Fiske Downing

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

#### **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 245467	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/24/2015
Name	e of Facility		Street Address, City, State, Zip Code	
HE	NDRICKS 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
0	F0176 483.10(n)	C	Correction Completed 9/15/2015		F0241 483.15(a)		Correction Completed 09/15/2015		0	F0272 483.20(b)(1)		Correction Completed 09/15/2015
LSC				LSC					LSC			_
ID Prefix Reg. # LSC	F0278 483.20(a) - (	C 0	Correction Completed 9/10/2015	ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)		Correction Completed 09/10/2015		ID Prefix Reg. # LSC	F0314 483.25(c)		Correction Completed 09/15/2015
ID Prefix Reg. # LSC	483.25(d)	C	Correction Completed 9/15/2015	ID Prefix Reg. # LSC	F0318 483.25(e)(2)		Correction Completed 09/15/2015		ID Prefix Reg. # LSC	483.25(I)		Correction Completed 09/15/2015
ID Prefix Reg. # LSC	F0371 483.35(i)	C	Correction Completed 9/15/2015	ID Prefix Reg. # LSC	F0425 483.60(a).(b)		Correction Completed 09/15/2015		ID Prefix Reg. # LSC	F0428 483.60(c)		Correction Completed 09/15/2015
ID Prefix Reg. # LSC	F0441 483.65	C	Correction Completed 9/15/2015	ID Prefix Reg. # LSC	F0465 483.70(h)		Correction Completed 09/11/2015		ID Prefix Reg. # LSC			
Reviewed I State Agen Reviewed I CMS RO	cy	Reviewed E KS/kfd Reviewed E	•	Date: 09/25/20 Date:	Signature 15 Signature		03	3048			Date: C Date:	9/24/2015
Followup t		mpleted on: 2015			Check for any Uncorrected					Summary of the Facility?	YES	NO

#### **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 245467	(Y2) Multiple Construction A. Building B. Wing 01 - MA	IN BUILDING 01	(Y3) Date of Revisit 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
			Correction				Correction					Correction
ID Prefix			Completed 08/18/2015	ID Prefix			Completed 08/20/2015		ID Prefix			Completed 08/12/2015
-	NFPA 101			-	NFPA 101				-	NFPA 101		
LSC	K0029			LSC	K0047				LSC	K0056		
ID Prefix			Correction Completed	ID Prefix			Correction Completed		ID Prefix			Correction Completed
Reg. # LSC				Reg. #					Reg. # LSC			
ID Prefix Reg. # LSC			Correction Completed	Reg. #			Correction Completed		Reg. #			Correction Completed
ID Prefix Reg. # LSC			Correction Completed	Reg. #			Correction Completed		Reg. #			
ID Prefix Reg. # LSC			Correction Completed	Reg. #								
Reviewed E	By Revie	wed	Ву	Date:	Signatur	e of Sur	veyor:				Date:	
State Agen	cy GS/k	fd		09/25/20	15			35	482		09/	08/2015
Reviewed E CMS RO			Ву	Date:	Signatur	e of Sur	veyor:				Date:	
Followup t	o Survey Complete 8/4/2015	d on	:							Summary of the Facility?	YES	NO

DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			<b>CENTERS FOR MEI</b>	DICARE & MED	ICAID SERVICES
	MEDICA	ARE/MEDICAL	D CERTIFIC	CATION A	AND TRANSMITTAL		ID: 4TBH
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY		Facility ID: 00340
1. MEDICARE/MEDICAID PROVIDI (L1) <b>245467</b> 2.STATE VENDOR OR MEDICAID N		3. NAME AND AI (L3) <b>HENDRICK</b> (L4) <b>503 E LINC</b>	S COMMUN	ITY HOSP	ITAL	4. TYPE OF ACT	2. Recertification
(L2) <b>204342400</b>		(L5) HENDRICK			(L6) <b>56136</b>	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF ( (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey A	9. Other fter Complaint
<ul> <li>6. DATE OF SURVEY 08/0</li> <li>8. ACCREDITATION STATUS:</li> <li>0 Unaccredited 1 TJC 2 AOA 3 Other</li> </ul>	6/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 0 15 ASC 16 HOSPICE	FISCAL YEAR EN 09/30	DING DATE: (L35)
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requir	ements:
To (b):			equirements		2. Technical Personnel		Services Limit
12.Total Facility Beds	<b>58</b> (L18)	-	e Based On: cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN	7. Medical NF)8. Patient R	
13.Total Certified Beds	<b>58</b> (L17)	X B. Not in Con Requirem	npliance with Prog ents and/or Appli		5. Life Safety Code * Code: <b>B</b>	9. Beds/Ro (L12)	om
14. LTC CERTIFIED BED BREAKDO	WN			1	15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
58 (L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION 2	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
<u>Pamela Hovdet, HFE N</u>	JE II	0	8/31/2015	(L19) K	Kamala Fiske-Downing, I	Enforcement Spe	ecialist 09/21/2015 (L20)
PAL	RT II - TO BE	COMPLETED I	BY HCFA RH	EGIONAI	<b>COFFICE OR SINGLE S</b>	STATE AGENCY	
19. DETERMINATION OF ELIGIBIL  1. Facility is Eligible to F  2. Facility is estimized for the set of the set	Participate		IPLIANCE WITI ITS ACT:	H CIVIL	<ol> <li>Statement of Fina</li> <li>Ownership/Contr</li> <li>Both of the Above</li> </ol>	ol Interest Disclosure St	
2. Facility is not Eligible	(L21)						
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION <b>04/01/1987</b>	BEGINNINC	6 DATE	ENDING DA	ΓE	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure		<u>UNTARY</u> to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	OTHE	<u>R</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-10	vider Status Change
(L27)	B. Rescind Su	spension Date:	(L44)			00-Act	ive
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



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:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - 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 <u>Kathryn.serie@state.mn.us</u> 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. Hendricks Community Hospital August 20, 2015 Page 4

### 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

Hendricks Community Hospital August 20, 2015 Page 5

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Hendricks Community Hospital August 20, 2015 Page 6

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			RM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		OMB 1	IO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OATE SURVEY COMPLETED
		245467	B. WING		08/06/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HENDRIC	CKS COMMUNITY HO	SPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC 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 COMMENT	S	F 000		
F 176 SS=E	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substa regulations has beet your verification. 483.10(n) RESIDEN DRUGS IF DEEME An individual reside the interdisciplinary	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with NT SELF-ADMINISTER	F 176		9/15/15
	by: Based on observat review the facility fa self administer med (R4, R5, R9, R51, F administer medicati Findings include: It was observed on interviewing R52 in spouse (R51) that t sitting on a small ta	NT is not met as evidenced ion, interview and document iled to assess the ability to lications for 5 of 11 residents R52) observed to self ons. 8/3/15, at 11:25 a.m. while a room shared with his wo medication cups were left ble in between two recliners ad R52. One medication cup		Resident assessments will be complete 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 too has been updated. Education to nursin and TMA staff will be conducted by 9/10/15. Monitoring of staff compliance assure medication administration practices are followed will be implemented. Three medication passe will be monitored/week for a minimum of	g to
		ER/SUPPLIER REPRESENTATIVE'S SIGI		TITLE	(X6) DATE

**Electronically Signed** 

08/28/2015

PRINTED: 08/31/2015

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.

		& MEDICAID SERVICES				0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · /	E SURVEY PLETED		
		245467	B. WING		08/	06/2015		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE			
HENDRI	CKS COMMUNITY HO	DSPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 176	had two large white few smaller tablets cup contained pudd of it. R52 stated hi pills right before dir pudding. While inte that R51 took the n with the pudding. During the supper n was noted that both a dining room table nurse (RN)-D place next to R51 and an next to R52. Both with applesauce. If the table to dish up medication cart loc the dining room. S R52 taking their res had her back to bo their medications. When interviewed stated there are so leave medications a after the nurse has medication cup. R breakfast in their ro left with them. RN- request to have the and staff will accon resident is trustwor impairment or histo RN-C further stated administration whe	age 1 e oblong tablets along with a in it and the other medication ding with a spoon sticking out s wife R51 likes to take the nner and she takes them with erviewing R52, it was noted nedication in the cup mixed meal on 8/4/15, at 5:52 p.m. it n R51 and R52 were seated at e. It was noted that registered ed a plastic medication cup other plastic medication cup outher plastic medication mixed t was observed that RN-D left o more medications from the ated in the hallway outside of he left prior to either R51 or spective medications. RN-D th residents as they consumed on 8/3/15, at 11:58 a.m. RN-C me residents they routinely with so they can take them set them up into the N-C stated R51 and R52 eat borm so their medications are -C added some residents air medications left with them nmodate them as long as the thy and there is no cognitive ory of refusing mediations. d they consider medication self n the resident can identify their d demonstrate the ability to set	F 176	residents per medication pass Director of Nursing or designe monitor effectiveness of corre outcomes and will be evaluate Assurance.	e will ection. Audit			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/31/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245467	B. WING			08/	06/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO	SPITAL			03 E LINCOLN STREET IENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 176	Both an assessmer lacking in the record It was observed due 8/4/15, at 5:45 p.m. potassium mixed w was seated. R4 was other residents. R4 and the medication The medication rene entire evening mea dietary aide cleared contents of the juice remaining juices lef consumed. When interviewed of stated the nurses k sure R4 receives he always want to take been a problem. R should know better R5 failed to have an identify her ability to medications. During observation 11:52 a.m. R5 was room table with a p on the table in front crushed medication were three other rea The medication cup throughout the noor	And the physician order was ds for R51 and R52. The evening meal on that RN-D delivered liquid ith juice to the table where R4 as seated at the table during the l until 6:55 p.m. when the l the table, dumped the e glass into a bucket of t on the tables and not on 8/4/15, at 7:32 p.m. RN-D mixed the liquid potassium in p with juice. on 8/6/15, at 11:54 a.m. RN-C now that they need to make er medication as she doesn't e her medication and this has N-C reiterated the nurses than this. In assessment conducted to o safely self administer of the noon meal on 8/3/15, at observed seated at the dining lastic medication cup located of her which contained mixed in applesauce. There sidents seated at the table.	F	176			

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		AND HUMAN SERVICES			FORM	08/31/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245467	B. WING		08/	06/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
HENDRIC	CKS COMMUNITY HO	SPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 176	Licensed practical r leave the dining roc observation and wa unable to visualize During observation 8/4/15, at 5:15 p.m. have a plastic medi table in the dining r seated. It contained applesauce. There seated at the table the medications at 4 (RN)-G, who left the table, left the dining was unable to monivisualize R5 during When the medical n any assessment rel administer medication verified R5 lacked a medication assessr orders from the phy to safely self admin RN-C verified the m on the table for self was an assessmen safe to do so and th administration of m R9 failed to have an identify her ability to medications. During observation at 5:27 p.m. R9 was	nurse (LPN)-A was noted to om area at the time of the as in a location where she R5. of the evening meal on . R5 was again observed to ication cup located on the oom table where she was d crushed medication in were three other residents with her. R5 self administered 5:32 p.m. Registered nurse e medications placed on the g room area multiple times and itor and/or continuously the observation. record was reviewed, it lacked lated to R5's ability to self ions. a 8/5/15, at 12:43 p.m. RN-C a self administration of ment. There also were no ysician identifying R5 as able hister her own medications. nedications should not be left administration unless there at to identify the resident was hen a physician order for self edications would be required. n assessment conducted to b safely self administer of the supper meal on 8/4/15, s observed seated in her	F 176			
	at 5:27 p.m. R9 was					

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		AND HUMAN SERVICES			FORM	08/31/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	245467				08/	06/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO	SPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 176	paper medication c that contained med with her chin resting were three other re- with her. R9 was of medications sitting meal came at 5:53 R9 up to eat and th administer her med eating supper. RN- placed on the table multiple times and c during the observat During review of R9 R9 lacked an asses self administer med oral medications aff During interview on confirmed R9 may s oral medications aff During interview on confirmed R9 lacke assessment and or self administer AM nurse. RN-C verifie be left on the table there was an asses was safe and when stated "this is unsaf should not have bee The facility had dev Administration Orie which was used to f standard for medica on the orientation s	up on the table in front of her ication while R9 was sleeping g against her chest. There sidents seated at the table bserved to have the on the table until her supper p.m. Staff proceeded to wake en R9 proceeded to self lications independently prior to -G, who left the medications , left the dining room area did not have R9 within view ion. D's medical record it was noted asment to identify her ability to dications. ders were reviewed, they elf administer AM (morning)	F 176			

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ATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (		E SURVEY PLETED
		245467	B. WING		08/0	06/2015
NAME OF I	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	00/0	00/2010
IENDRI	CKS COMMUNITY HO	DSPITAL		03 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETIC DATE
F 176	Continued From pa	age 5	F 176			
F 241 SS=E		tion was taking appropriately. ⁄ AND RESPECT OF	F 241			9/15/15
	manner and in an e enhances each res	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.				
	by: Based on observa review the facility fa dining experience to Styrofoam plates a utensils for 24 of 24 R8, R9, R11, R13, R28, R31, R34, R4 R56 and R61) obset their rooms. Findings include: During observation stainless steel carts were located in the the East and West contained oatmeal, milk cartons, yogur assistants were ob items located on the items onto Styrofoa white plastic silver cart with the food it resident located on who preferred to ea	NT is not met as evidenced tion, interview and document ailed to promote a dignified by serving breakfast on nd bowls and using plastic 4 residents (R4, R5, R6, R7, R16, R22, R23, R25, R27, 1, R44, R45, R47, R51, R52, erved being served breakfast in on 8/3/15, at 9:30 a.m. three s containing breakfast items dining room and at the end of hallways. Each of the carts bread for toast, 1/2 gallon t and various juices. Nursing served to prepare breakfast e carts and place the food am plates and/or bowls. Thin, ware was retrieved from the em and delivered to each the east and west halls and at in their room for the c, R5, R6, R7, R8, R9, R11,		Regular ceramic dishes and metal reusable silverware replaced utilizati Styrofoam or plastic 8/11/2015. Breakfast cart policy was updated to that real silverware, plates and bowls be used in the dining room. Styrofoa and plastic plates/silverware were removed from all locations in the Nu Home and replaced with reusable ut and dishware. Staff meeting 9/10/15 go over correct tableware and utensi utilization for meals. Dietary manage designee will audit bi-weekly to assu policy compliance.	o state s will m rsing censils 5 to il er or	

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		AND HUMAN SERVICES				FORM	08/31/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245467	B. WING			08/	06/2015
NAME OF	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	SPITAL		-	03 E LINCOLN STREET IENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	R13, R16, R22, R2 R41, R44, R45, R4 During observation breakfast items were the carts in the mai West halls. Styrofor white plastic silverwa and west hall carts service. At 7:34 a.r located on the west items from the cart the Styrofoam dishe The cart designated contained regular c reusable silverware breakfast food to the their meal in the mat On 8/5/15, at 7:53 at the cart and served located on the east and/or cold cereals food items were set and bowls and plas with the meal. The following morn breakfast meal was carts and served or residents located of NA's on both East at had been the practi Styrofoam plates/bo for as long as they of	3, R25, R27, R28, R31, R34, 7, R51, R52, R56 and R61) on 8/5/15, at 7:30 a.m. re delivered to residents via in dining room, the East and oam plates/bowls and thin, vare were available on the east as part of the breakfast meal m. nursing assistant (NA)-B, t wing prepared breakfast and served the residents with es. d for the main dining room ceramic dishes and metal that were utilized for serving he residents who were eating ain dining room. a.m. NA-C prepared food from d breakfast items to residents twing. NA-C served toast, hot , milk, juice and coffee. The rved on the Styrofoam plates stic silverware was provided ing, on 8/6/15, at 8:30 a.m. the s again prepared from the n the disposable dishes to n the east and west halls. and West Wings verified this ice to serve breakfast on owls and use plastic silverware could recall. When was a reason for this practice,	F 2	241			

Facility ID: 00340

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		AND HUMAN SERVICES			FORM	08/31/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245467	B. WING		08/	06/2015
NAME OF	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
HENDRI	CKS COMMUNITY HO	SPITAL	-	503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 241	verified that resider Styrofoam dishes a silverware was utiliz was the practice. N was an issue with u but didn't have any During an interview also verified that St silverware were use residents located in NA-C indicated she using disposable ve NA-C further indica nice if they used reg for the residents ha When interviewed of dietary manager (D Styrofoam disposable had been used on of process has been s started in her positi she didn't feel the p and plastic was dig When interviewed of indicated she didn't plastic silverware b busy but stated she paper/Styrofoam pl prefer to have glass further indicated sh used was of poor q would easily break On 8/06/15, at 10:3	on 8/5/15, at 9:00 a.m. NA-B hts were served breakfast on and thin, white plastic zed on a daily basis as that IA-B indicated she felt there using Styrofoam and plastic, say in the matter. on 8/5/15, at 9:30 a.m. NA-C tyrofoam dishes and plastic ed to serve breakfast to a their rooms on a daily basis. e was not aware of a reason for erses reusable dishware. Ited she thought it would be gular dishes related to safety andling the plates. on 8/05/15, at 8:19 a.m. the DM) indicated the use of the ble dishes and plastic spoons carts as "that is what the since July 2014" when she on. The DM further indicated oractice of using Styrofoam nified. on 8/06/15, at 10:42 a.m. R50 t have an issue with the use of ecause she knew staff were e would never use ates/bowls at home and would s or ceramic dishes. R50 he had noticed the silverware uality as it was very thin and	F 241			

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TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED	
		245467	B. WING _		08/	/06/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
HENDRI	CKS COMMUNITY HO	SPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE	
F 241 F 272 SS=D	and plastic silverwa didn't think it was a that she has a fami didn't feel it was ap Styrofoam dishes p (flimsy) related to th Review of the facilit Manual Hendricks ( Association Subjec Dietary Policy No: Revised 01/09 05/1 Procedure: 3.1.1 Breakfast car plates/silverware/gl 3.1.7 D. Staff are to dirty bus tubs once breakfast. The faci to use of disposable 483.20(b)(1) COMP ASSESSMENTS The facility must co a comprehensive, a reproducible assess functional capacity. A facility must make assessment of a re resident assessment by the State. The a least the following:	the use of Styrofoam dishes are but further indicated she ppropriate. She also added ly member living in facility and propriate. She stated that presented a safety concern he risk of spills. Ty policy: Policy and Procedure Community Hospital t: Breakfast Cart Section 8711.145.01 effective 7/03, 5 ts are stocked by dietary with asses/cups and condiments o pick up dirty dishes & put in resident is done with ility policy makes no reference e dishes or utensils. PREHENSIVE anduct initially and periodically accurate, standardized sment of each resident's e a comprehensive sident's needs, using the nt instrument (RAI) specified assessment must include at emographic information;	F 24			9/15/15	

Facility ID: 00340

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		AND HUMAN SERVICES	PRINTED: FORM OMB NO.				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY IPLETED
		245467	B. WING	i		08/	06/2015
	PROVIDER OR SUPPLIER	SPITAL		5	STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 272	Continence; Disease diagnosis a Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potential Documentation of s the additional asses areas triggered by t Data Set (MDS); ar	and procedures; ; summary information regarding ssment performed on the care the completion of the Minimum	F	272			
	by: Based on observat review the facility fa comprehensive ass ulcer risks to preve of 2 residents (R61 ulcers and failed to comprehensive ass indwelling Foley cat (R61) reviewed for Findings include: R61 was admitted of which included: rig	NT is not met as evidenced tion, interview and document ailed to conduct an initial sessment related to pressure nt further skin breakdown for 1 ) identified with pressure conduct an initial sessment for the use of an theter for 1 of 2 residents urinary catheter use.			Bowel and Bladder and Skin as for R61 completed 8/27/15. All residents with pressure ulcer Foley catheters were reviewed a evaluated for completion of asse Education relevant to the Reside Assessment Instrument (RAI)wi conducted with Nurse Managers and WOCN by September 10, 2 An audit of thoroughness and co of comprehensive assessments done on 2 residents per week.	s and and essments. ent II be s, RNs 015 ompletion will be	

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TATEMEN	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION		E SURVEY
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COMPLETE	
		245467	B. WING _		08/	06/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	DSPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 272	cellulitis, depressio kidney disease. R61's admission M assessment dated one (1) stage two p unstageable pressi upon admission. T assessment failed Assessment (CAA) issues/pressure uk When the medical any comprehensive since admission. F a Braden Scale (as ulcer risk) in the as any documentation Risk assessment v along with the Brac completed. There medical record to it any risk factors. R61's physician ord R61 with pressure on the 4th and 5th identified with a rig During observation 9:55 a.m. registere room to perform w heel. RN-C remove R61's right heel an dressing. The dres was moistened prid dressing was remo	in, atrial fibrillation and chronic linimum Data Set (MDS) 6/18/15, identified R61 with pressure ulcer and one (1) ure ulcer, both were present The admission MDS to include any Care Area prelated to the identified skin	F 27	72 or designee will monitor effective correction. Audit outcomes will b evaluated by Quality Assurance.		

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	08/31/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245467	B. WING		08/	06/2015
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
HENDRI	CKS COMMUNITY HO	SPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 272	wound cleaner. Aft treated the toes. R pressure ulcers on right foot, which we pencil eraser. The in color and open. with wound cleaner between the toes to placing a fibrocol du During interview on stated a wound nur wounds on R61's ri reviewing R61's me there is was no Bra Pressure Ulcer Rist perfusion assessme RN-A stated the fact tissue perfusion ass and seating reposit The skin assessme evaluation of the skin & endure the effects of effects) after press reduced or redistrib R61 was admitted v catheter and the ra was identified on th urinary incontinence R61's admission M assessment dated indwelling Foley cat Care Area Assessm status which include Foley catheter. Du	ter the heel was treated, RN-D ter the heel was treated, RN-D the fourth and fifth digits of his ere approximately the size of a wounds were noted to be red RN-D cleansed the wounds r and then replaced a sleeve b keep them separated after ressing over both open areas. A 8/6/15, at 9:37 a.m. RN-A rese visited weekly to review the tight foot and toes. After edical record RN-A verified aden Scale assessment, no k assessment nor tissue ent as expected per policy. cility typically conducted a sessment to identify the lying tioning needs of the resident. ent should include an kin integrity & tissue tolerance a its supporting structures to of pressure without adverse ure to that area has been	F 272			

Facility ID: 00340

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	KEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING	3	COIV	IFLETED
		245467	B. WING		08/	06/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRI	CKS COMMUNITY H	OSPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 272 F 278 SS=D	be located. An ass included considera an indwelling cathe the catheter and ca resulting from the The admission phy identified that R61 (Fr) should be cha The physician orde the catheter as cha related to immobili When interviewed registered nurse (F record lacked a un verified a CAA had admission MDS as 483.20(g) - (j) ASS ACCURACY/COO The assessment no resident's status. A registered nurse each assessment participation of hea A registered nurse assessment is con Each individual wha assessment must that portion of the Under Medicare an willfully and knowin	sessment was lacking which the of the risks & benefits of eter; the potential for removal of onsideration of complications use of the indwelling catheter. //sician orders dated 8/3/15, /s Foley Catheter, #16 French nged monthly or as needed. ers identified the rationale for ronic urinary incontinence ty. on 8/6/15, at 9:37 a.m. RN)-A confirmed R61's medical inary assessment and also not been completed with the sessment. ESSMENT RDINATION/CERTIFIED nust accurately reflect the must conduct or coordinate with the appropriate alth professionals. must sign and certify that the npleted. o completes a portion of the sign and certify the accuracy of	F 272	2		9/10/15

If continuation sheet Page 13 of 46

		& MEDICAID SERVICES			OMB NO.			
-	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED		
		245467	B. WING		08/0	06/2015		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
HENDRI	CKS COMMUNITY HO	SPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIOI DATE		
F 278	subject to a civil mo \$1,000 for each ass willfully and knowing to certify a material resident assessmen penalty of not more assessment. Clinical disagreeme material and false s This REQUIREMEN by: Based on observat review the facility fa limitation in range o Minimum Data Set resident (R6) review finger on the left mi Findings include: During observation was noted to have the hand folded/curled questioned whether finger, R6 attempte R6 was observed to with her right finger finger but was unab wince and state, "O manipulate/extend to During a subsequen 11:31 a.m. R6 was her left hand middle palm. When R6 was could bend this fing	oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money than \$5,000 for each ent does not constitute a statement. NT is not met as evidenced tion, interview and document ailed to accurately reflect of motion status on the (MDS) assessment for 1 of 1 wed who experienced a trigger	F 27	<ul> <li>RN assessment and OT evaluatic completed 8/17/2015 for R6. The treatment plan initiated and continue relevant to residents left hand fing functional limitations.</li> <li>Correction Plan: Education to nut staff to assure thoroughness and accuracy of resident functional assessments are completed and planned with the multidisciplinary be conducted by 9/10/15. An auximplemented to track accuracy at thoroughness of MDS quarterly F assessments via a random select resident reviews bi-monthly. The designee will be responsible for monitoring outcomes and reporting Quality Assurance.</li> </ul>	erapy nues ger's rsing care team will dit will be nd ROM tion of DON or			

If continuation sheet Page 14 of 46

		AND HUMAN SERVICES & MEDICAID SERVICES				FOF	D: 08/31/2015 M APPROVED O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION		ATE SURVEY OMPLETED
		245467	B. WING	i		C	8/06/2015
NAME OF F	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP	CODE	
HENDRIC	CKS COMMUNITY HO	SPITAL			503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 278	palm on the left har correct the contract During review of Re progress note dated indicated that R6 ha with a provider to ex- finger that was lock finger". The physic release of finger to the pain. The physic release of finger to the pain. The physic for what plan of treat During review of Re care plan identified mobility related to a plan identified R6 w (ROM) through inte 1. Ambulate with as support of a gait be twice daily. 2. Active ROM exer with cares seven da 3. Small group exer During review of Re Set (MDS) assess 6/5/15, the identifica limitation of ROM to lacking. During interview on registered nurse (R limitation in R6's lef last two (2) quarter	noted to have no protection to ad nor any device applied to ure. 5's medical record there was a d 2/18/15, at 2:41 p.m. which ad an appointment at the clinic kamine her (L) hand middle ed in curled position - "trigger ian recommended a pulley straighten it out and relieve ician noted contact would be e party for R6 and a decision atment would be made. 5's care plan, dated 6/6/15, the R6 with limited physical rthritis in knees/legs. The care yould maintain range of motion rventions including: asist of one staff with the It and four wheeled walker	F	278			
F 282	this limitation. 483.20(k)(3)(ii) SEF	RVICES BY QUALIFIED	Fź	282			9/10/15

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		AND HUMAN SERVICES				PRINTED: 08/31/2015 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED
		245467	B. WING	i		08/06/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•
HENDRI	CKS COMMUNITY HO	SPITAL			03 E LINCOLN STREET IENDRICKS, MN 56136	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLÉTION
F 282 SS=D	Continued From pa	-	F	282		
	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.					
	<ul> <li>Care.</li> <li>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.</li> <li>Findings include:</li> <li>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.</li> <li>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:</li> <li>1. Will be clean, dry and odor free with no skin breakdown or signs of urinary tract infection (UTI).</li> <li>2. Assist resident with toileting, transfers, changing pad, pericare and clothes adjustment.</li> <li>3. Offer toilet every 2 hours.</li> <li>4. Notify nurse if res. complains of urinary</li> </ul>				Reviewed R6 care plan. Staff in care plan and CNA assignment s current relevant for resident's toil needs. August 27, 2015. Staff education on responsivener following resident care plans as a CNA work sheets will be conduct September 10, 2015. An audit o care plan follow through will be implemented via a random select residents and observation of toil frequency and documentation of during selected time in a given st will be conducted on a weekly ba Audit outcomes will be monitored DON or designee and evaluated Quality Assurance. R49 digoxin level was drawn on a Physician notified. An audit of all residents on digox assure they have had care plann work drawn will be implemented. Thereafter, a monthly audit will b assure routine lab work is compl random audit of 10 residents/mo DON or designee will be respons monitoring outcomes and reporti	sheets as leting ss to noted on ted by f resident tion of eting care hift. This isis. d by the by 8/6/2015. in to ied lab e done to eted via a nth. The sible for

Facility ID: 00340

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		AND HUMAN SERVICES				FORM	APPROVED
	TOF DEFICIENCIES		(X2) MUL	TIPL	LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245467	B. WING			08/0	06/2015
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	SPITAL			03 E LINCOLN STREET		
			<u> </u>	H	IENDRICKS, MN 56136		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	uge 16	F 2	282			
	medium. at night fo	r incontinence product.			Quality Assurance.		
	was noted to be lyir closed and remaine until 10:22 a.m. (3 nursing assistant (N morning cares. At assisted R6 to trans bathroom with the u R6 onto the toilet. It brief was urine soal R6 voided once ass approximately 10:3 about the last time toileting needs. NA- when R6 was last to toileting.	on 8/5/15, at 6:55 a.m. R6 ng supine in bed with her eyes ed in bed in this same position 1/2 hrs. later). At this time NA)-D entered room to provide 10:25 a.m. NA-D and NA-H sfer from her bed to the use of a walker and assisted t was noted the incontinent ked when removed and that sisted on the toilet. At 0 a.m. NA-D was interviewed R6 was assisted with any -D stated she was unsure oileted and/or was offered					
	9/4/14, it identified I related to impaired Contributing factors Alzheimer's disease history. The assess able to verbalize the offered toilet every incontinence was ic During interview on indicated that R6 re	6's bladder assessment dated R6 as incontinent of bladder mobility/ambulation. s included abnormal labs, e/dementia, arthritis, and fall sment further identified R6 was e need to toilet and should be 2 hours. The type of dentified as urge incontinence. b 8/6/15, at 9:14 a.m. NA-F equired assistance with t and needed staff to stay with					
	8/6/15, at 9:48 a.m. offered to toilet at le staff waited longer t	th registered nurse (RN)-C on . it was verified R6 should be east every two hours and if than two hours they were not n plan of care for R6.					

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	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245467	B. WING			08/	06/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO	SPITAL			03 E LINCOLN STREET IENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 17	F 2	82			
	implemented as it id and monitor lab/dia physician orders da with a prescription f medication to regula (mg) on odd days a The physician order have an annual Dig in August. During r a Digoxin level was When interviewed of verified the medical RN-C stated there w physician in Septen drawn but it had be last Digoxin level was (2 years ago) and s August 2014. RN-C	care for R49 was not dentified the following: obtain gnostics as ordered. R49's ated 7/23/15, identified R49 for Digoxin (Cardiac ate heart) 0.25 milligrams and 0.125 mg on even days. rs further identified R49 would joxin level completed annually eview of R49's medical record unable to be identified. on 8/6/15, at 9:48 a.m. RN-C I record lacked a Digoxin level. was an order from the nber 2014 for the level to be en missed. RN-C stated the as completed in August 2013 should have been performed in c verified the annual Digoxin ed by the physician and					
F 314 SS=D	nursing staff. During interview wit on 8/6/14, at approx pharmacy consultar record and verified completed as order confirmed the Digox monitored annually 483.25(c) TREATM PREVENT/HEAL P Based on the comp resident, the facility who enters the facil	th the consultant pharmacist ximately 10:30 a.m. the nt reviewed R49's medical the Digoxin level had not been red. The pharmacy consultant xin lab value test should be as identified by the physician.	F 3	14			9/15/15

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		& MEDICAID SERVICES				0938-039	
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245467	B. WING		08/0	06/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET	)DE		
HENDRICKS COMMUNITY HOSPITAL							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 314	individual's clinical of they were unavoida pressure sores rece services to promote prevent new sores This REQUIREMEN by: Based on observat review the facility fa services based on a to reduce the risk o of 2 residents (R61 pressure ulcers. Findings include: R61 was admitted of which included: rig on the 4th and 5th of cellulitis, depression kidney disease. R61's admission M assessment dated one (1) stage two p unstageable pressu upon admission. T assessment failed t Assessment (CAA) issues/pressure ulce When the medical n any comprehensive since admission. F a Braden Scale (as ulcer risk) in the ast any documentation	condition demonstrates that ble; and a resident having eives necessary treatment and a healing, prevent infection and from developing. NT is not met as evidenced tion, interview and document illed to provide repositioning a comprehensive assessment f further skin breakdown for 1 reviewed who currently had on 6/11/15 with diagnoses ht heel ulcer, right foot ulcers digits, morbid obesity, sepsis, n, atrial fibrillation and chronic inimum Data Set (MDS) 6/18/15, identified R61 with ressure ulcer and one (1) are ulcer, both were present he admission MDS to include any Care Area related to the identified skin	F 314	A comprehensive assessment an plan was completed on 8/27/2015 R61. Policy and procedure for skin integrity was reviewed and is currer residents with pressure ulcers will reviewed to assure thoroughness accuracy of comprehensive asses Staff education on accountability t following resident care plans as no CNA work sheets will be conducted September 10, 2015. An audit of plan follow through will be implem via a random selection of resident observation of repositioning freque and documentation of care during selected time in a given shift. This conducted on a weekly basis. Auto outcomes will be monitored by the or designee and evaluated by Qua Assurance.	for ent. All be and sments. o bted on d by resident ented s and ency s will be dit b DON		

Facility ID: 00340

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		AND HUMAN SERVICES				FORM	08/31/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY
		245467	B. WING	i		08/	06/2015
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
HENDRIG	CKS COMMUNITY HO	SPITAL		-			
					-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION SHOULD	) BE	(X5) COMPLETION DATE
F 314	Continued From pa	ae 19	LLER/CLIA NUMBER:       (X2) MULTIPLE CONSTRUCTION A.BUILDING       (X3) DATE SURVEY COMPLETED         A.BUILDING       08/06/2015         B.WING       STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56136       08/06/2015         DES VES       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETION DATE         Destroin       F 314       F 314         not is right toes rther cer.       F 314         for skin, ulcers and ent related e goal listed pressure di remain date.       F 314         e care plan and monitor       I         ling weekly. re possible. d perimeter, port und nurse       I				
	-	en scale, but was not	1.	714			
		was no evidence in the					
		dentify R61 was assessed for					
	P61's physician are	lers dated 8/3/15, identified					
		ulcers located on his right toes					
		digits. R61 was further					
	identified with a right heel pressure ulcer.						
	R61's plan of carou	olan dated 7/1/15, for skin,					
		three (3) pressure ulcers and					
		re ulcer development related					
		and immobility. The goal listed					
		included that the pressure					
		signs of healing and remain by/through review date.					
	Interventions that w were:	vere included on the care plan					
		ments as ordered and monitor					
		nonitor wound healing weekly.					
		dth and depth where possible.					
		ent status of wound perimeter,					
		aling progress. Report declines to the wound nurse					
	or physician.						
		rn/reposition at least every 2					
		as needed or requested.					
		er daily to skin. Do not					
	cleansers for peri-c	/ prominence's and use mild					
		ng/reducing device 1) on bed -					
		nd 2) on Right foot - boot on					
		s, please assure that heel is					
	properly placed to c	offload pressure plicies/protocols for the					
		nt of skin breakdown.					

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED		
		245467	B. WING		08/06/2015		
NAME OF	PROVIDER OR SUPPLIER	2.0.00		STREET ADDRESS, CITY, STATE, ZIP CODE	00/	00/2015	
	CKS COMMUNITY HO	OSPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
F 314	adhering. Report lo nurse. During observation 6:30 a.m. R61 was back) in bed with a to keep the right he also had a bed crac blankets off his fee in the same position On 8/5/15, at 7:40 a entered the resider have the boot appli urinary catheter have the boot was sent to acknowledged R61 reposition until 8:50 a entered R61's room bed to approximate eat breakfast in bed and juice on the tra without any repositi back in bed through re-entered the room the day. After enter 9:28 a.m. NA-I was time R61 was last r had about 6:00 a.m. repositioned R61 ye staff from night shift NA-I began to perfor a.m. At 9:45 a.m. ( NA-I and NA-E ass pivoted him to a se	of morning cares on 8/5/15, at observed lying supine (on pillow under his lower right leg tel off the bed. The lower bed dle on it to keep R61's t. At 7:15 a.m. R61 remained in (supine). a.m. nursing assistant (NA)-I troom and stated R61 did not ed to the right foot as the d leaked during the night and o laundry to be washed. NA-I but performed no cares nor remained in the supine t.m. at which time NA-M in and elevated the head of the ely 130 degrees so R61 could d. NA-M delivered toast, coffee y table and left the room oning. R61 remained on his in 9:28 a.m. (3 hrs) when NA-I in to assist R61 to get up for ing the room on 8/5/15, at questioned about the last repositioned. NA-I indicated it to the tast repositioned R61. orm morning cares at 9:30 3 hours and 45 minutes later) isted R61 to sit up in bed and ated position with his legs over RN-D then entered the room	F 3				

Facility ID: 00340

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		AND HUMAN SERVICES				FORM	08/31/2015 APPROVED		
STATEMENT	TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	0938-0391 E SURVEY PLETED		
		245467	B. WING _			08/	06/2015		
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-			
				50	3 E LINCOLN STREET				
HENDRIG	CKS COMMUNITY HO	SPITAL	HENDRICKS, MN 56136						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE		
F 314	Continued From pa	ige 21	F 3 <sup>-</sup>	814					
	<ul> <li>9:55 a.m. registered wound treatment to removed the gauze heel and then remo The dressing adher moistened prior to r was removed, R61 circumference area which encompasse redressed the wour wound cleaner. Aft treated the toes. R pressure ulcers on right foot, which we pencil eraser. The in color and open. with wound cleaner between the toes to placing a fibrocol du</li> <li>During interview on stated a wound nur wounds on R61's ri reviewing R61's me there is was no Bra Pressure Ulcer Rist perfusion assessme the skin assessme evaluation of the skin &amp; endure the effects of effects) after presso reduced or redistrib typically conducted assessment to iden repositioning needs</li> </ul>	of morning cares on 8/5/15 at d nurse (RN)-D performed a of the right heel. RN-C e wrap from around R61's right oved a 4 x 4 gauze dressing. red to the wound and was removal. After the dressing was noted to have a baseball a covered with black scab of the entire heel region. RN-D nd after cleansing it with the rethe heel was treated, RN-D 61 was noted to have the fourth and fifth digits of his ere approximately the size of a wounds were noted to be red RN-D cleansed the wounds and then replaced a sleeve of keep them separated after ressing over both open areas. 8/6/15, at 9:37 a.m. RN-A se visited weekly to review the ght foot and toes. After edical record RN-A verified iden Scale assessment, no k assessment nor tissue ent as expected per policy. ent should include an an in integrity & tissue tolerance a its supporting structures to of pressure without adverse ure to that area has been outed. RN-A stated the facility a tissue perfusion ntify the lying and seating s of the resident and was termination of a two (2) hour							

Facility ID: 00340

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MILL TI	PLE CONSTRUCTION	X3) DATE SURV	-039 /=v	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		G	COMPLETED		
		245467	B. WING		08/06/20	15	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
HENDRI	CKS COMMUNITY HO	SPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMP	(5) LETIO ATE	
F 314 F 315 SS=D	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. 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER		F 314 F 315		9/15/	15	
	assessment, the far resident who enters indwelling catheter resident's clinical co catheterization was who is incontinent of treatment and servi	ent's comprehensive cility must ensure that a s the facility without an is not catheterized unless the ondition demonstrates that necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder e.					
	by: Based on observat review the facility fa comprehensive ass continued use of ar 1 of 2 residents (Re catheter use and fa services for 1 of 1 r	NT is not met as evidenced tion, interview and document ailed to conduct a sessment related to the indwelling Foley catheter for 61) reviewed for urinary iled to provide timely toileting resident (R6) who experienced e and required extensive		Reviewed R6 care plan. Staff inform care plan and CNA assignment sheet current relevant to resident's toileting needs. August 27, 2015. Staff education on responsiveness to following resident care plans as note CNA work sheets will be conducted	ets as g o ed on		

Facility ID: 00340

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		AND HUMAN SERVICES				FORM	08/31/2015 APPROVED 0938-0391		
	STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245467	B. WING			08/	06/2015		
NAME OF P	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	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE		
F 315	Continued From pa	ige 23	FS	315	Sentember 10, 2015 An oudit of r	aaidaat			
	assistance. Findings include:				September 10, 2015. An audit of r care plan follow through will be implemented via a random selection				
	A comprehensive u	prehensive urinary assessment related to ontinued use of a Foley catheter was not			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				
	R61 was admitted of including: right hee	admitted on 6/11/15, with diagnoses : right heel ulcer, right foot ulcers on the 5th digits, morbid obesity, sepsis,			monitored by the DON or designee evaluated by Quality Assurance.	N or designee and			
	cellulitis, depression kidney disease. R6 indwelling Foley ca	n, atrial fibrillation and chronic 1 was admitted with an theter and the rationale for it's			Bowel and bladder assessment for completed 8/27/15.				
		identified on the physician rinary incontinence related to			All residents with Foley catheters w reviewed and evaluated for comple assessments. Policy for Indwelling Catheter Use reviewed and current	tion of			
	assessment dated indwelling Foley cat	inimum Data Set (MDS) 6/18/15, identified R61 with an theter. The MDS lacked a			education relevant to the policy will provided by 9/10/15.	be			
	status which include Foley catheter. Du record an assessm be located. An ass included considerat an indwelling cathe the catheter and co	nent (CAA) related to urinary ed the continued use of the ring review of R61's medical ent for urinary status could not ressment was lacking which tion of the risks & benefits of ter; the potential for removal of posideration of complications use of the indwelling catheter.			An audit of thoroughness and com of comprehensive assessments wi done on 5 residents/month. The D designee will monitor effectiveness correction. Audit outcomes will be evaluated by Quality Assurance.	ll be ON or			
	identified that R61's (Fr) should be char The physician orde	sician orders dated 8/3/15, s Foley Catheter, #16 French nged monthly or as needed. rs identified the rationale for onic urinary incontinence y.							
	During review of Re	61's written plan of care dated							

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		AND HUMAN SERVICES			FORM	08/31/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245467	B. WING		08/	06/2015
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
HENDRIG	CKS COMMUNITY HO	SPITAL		03 E LINCOLN STREET IENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 315	Continued From pa 7/1/15, it was lackin included the risks, g related to the indwe When interviewed of registered nurse (R record lacked a urin verified a CAA had admission MDS assistated there had be physician related to use of the Foley ca documented a diag related to immobility use of the catheter. justification for an a catheter and/or ratio Staff failed to provid toileting for R6 to m function as possible identified on the dia glaucoma, hypertor and depression. During observation was noted to be lyin closed and remained until 10:22 a.m. (3 nursing assistant (N morning cares. At assisted R6 to transi bathroom with the u R6 onto the toilet. In		F 315			
	approximately 10:3 about the last time	sisted on the toilet. At 0 a.m. NA-D was interviewed R6 was assisted with any -D stated she was unsure				

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		AND HUMAN SERVICES				FORM	08/31/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE	E SURVEY PLETED
		245467	B. WING	i		08/(	06/2015
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
HENDRIC	CKS COMMUNITY HO	SPITAL		-	503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	Continued From pa	ıge 25	- F:	315	;		
	when R6 was last to toileting.	oileted and/or was offered					
	9/4/14, it identified I related to impaired Contributing factors Alzheimer's disease history. The assess able to verbalize the offered toilet every	6's bladder assessment dated R6 as incontinent of bladder mobility/ambulation. s included abnormal labs, e/dementia, arthritis, and fall sment further identified R6 was e need to toilet and should be 2 hours. The type of dentified as urge incontinence.					
	frequently incontine following intervention status: 1. Will be clean, dry breakdown or signs (UTI). 2. Assist resident w changing pad, perion 3. Offer toilet every 4. Notify nurse if res problems such as b 5. Uses Tena day res	ed 6/6/15, identified R6 as ent. The care plan identified the ons for management of urinary y and odor free with no skin s of urinary tract infection with toileting, transfers, care and clothes adjustment. 2 hours. s. complains of urinary purning, frequency or pain. egular daytime and Tena brief or incontinence product.					
	indicated that R6 re	8/6/15, at 9:14 a.m. NA-F equired assistance with t and needed staff to stay with					
F 318	8/6/15, at 9:48 a.m. offered to toilet at le agreed the necessa	th registered nurse (RN)-C on . it was verified R6 should be east every two hours and ary care was not provided. EASE/PREVENT DECREASE	F (	318	3		9/15/15

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/31/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION (		E SURVEY PLETED
		245467	B. WING			08/0	06/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO	SPITAL			03 E LINCOLN STREET IENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318 SS=D	Continued From pa	-	FS	318			
	resident, the facility with a limited range appropriate treatme	ent and services to increase d/or to prevent further					
	by: Based on observat review the facility fa services to maintain of 1 resident (R6) in ROM deficit. Findings include: During observation was noted to have t hand folded/curled questioned whether finger, R6 attempte R6 was observed to with her right finger finger but was unab wince and state, "O manipulate/extend to During a subsequen 11:31 a.m. R6 was her left hand middle palm. When R6 was could bend this fing indicated it hurt whe	NT is not met as evidenced ion, interview and document iled to provide the necessary nange of motion (ROM) for 1 the sample identified with a on 8/3/15, at 11:41 a.m. R6 he middle finger of her left into her palm. When she was able to move the d and then responded, "No". o grab the left middle finger s and attempt to extend the ble. R6 was then observed to uch" when attempting to the left middle finger. nt observation on 8/5/15, at seated in the dining room with e finger pressing against her as questioned whether she er, she responded, "No". R6 en she attempted to extend noted to have no protection to			RN Assessment and OT evaluation completed 8/17/2015 for R6. Thera treatment plan initiated and continue relevant to resident's left hand finger functional limitation. Correction Plan: All residents at risk be assessed for limited range of mo assure they are referred and/or rece appropriate treatment/services to pr further functional decline. Staff education to assure thoroughn and accuracy of resident functional assessments are completed and ca planned with the multidisciplinary tea be conducted 9/10/15. An audit will be implemented via ran selection of 5 residents/month to as appropriate assessment and referra treatment. Audit outcomes will be monitored by the DON or designee a evaluated by Quality Assurance.	py es r's will otion to eiving event ess re am will ndom sure I for	

Facility ID: 00340

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		AND HUMAN SERVICES				FORM	: 08/31/2015 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245467	B. WING	ì		08/	06/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	SPITAL			503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 318	correct the contract During review of Re progress note dated indicated that R6 ha with a provider to e- middle finger that w "trigger finger". The pulley release of fin relieve the pain. The would be made with and a decision for w be made. During review of Re care plan identified mobility related to a plan identified R6 w (ROM) through inte 1. Ambulate with as support of a gait be twice daily. 2. Active ROM exer with cares seven da 3. Small group exer During review of Re Set (MDS) assess 6/5/15, the identificat limitation of ROM to lacking. When interviewed of activity director (AD have daily exercises the activities progra been offered for a w the care plan for Re exercises 5 days a slept in during the of	ture. 6's medical record there was a d 2/18/15, at 2:41 p.m. which ad an appointment at the clinic xamine her (L) [left] hand vas locked in curled position - e physician recommended a nger to straighten it out and ne physician noted that contact h the responsible party for R6 what plan of treatment would 6's care plan, dated 6/6/15, the R6 with limited physical arthritis in knees/legs. The care would maintain range of motion erventions including: ssist of one staff with the eft and four wheeled walker	F	318			

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		AND HUMAN SERVICES			FORM	08/31/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245467	B. WING		08/	06/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO	SPITAL		HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 318 F 329 SS=D	Continued From pa were conducted; if the During interview on assistant (NA)-D state exercises daily with usually not completed When interviewed of registered nurse (R verified R6's ROM p implemented. The state responsible for white 483.25(I) DRUG RE UNNECESSARY D Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and of record; and residen drugs receive gradu behavioral intervent	age 28 they were conducted. 8/6/15, at 11:05 a.m. nursing ated R6 was supposed to get a cares but stated they were ted related to time constraints. on 8/6/15, at 11:10 a.m. N)-A, RN-C and the AD program was not being staff were unsure who was ch part of the ROM program. EGIMEN IS FREE FROM PRUGS or for excessive duration; or nonitoring; or without adequate se; or in the presence of nces which indicate the dose or discontinued; or any	F 318	DEFICIENCY)	RIATE	9/15/15

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/31/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY PLETED
		245467	B. WING		08/0	06/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	SPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 29	F 329			
	by: Based on interview facility failed to mor medication effective (R49) reviewed for Findings include: R49's physician orce R49 with a prescrip medication to regul (mg) on odd days a The physician orde have an annual Dig in August. During r a Digoxin level was When interviewed or registered nurse RN lacked a Digoxin level or order from the physic the level to be draw RN-C stated the lass in August 2013 (2 y been performed in A the annual Digoxin physician and nursi During interview wit on 8/6/14, at approxi- pharmacy consultation record and verified completed as order confirmed the Digoxin	NT is not met as evidenced y and document review the hitor lab values to assess eness for 1 of 5 residents unnecessary medications. lers dated 7/23/15, identified tion for Digoxin (Cardiac ate heart) 0.25 milligrams and 0.125 mg on even days. rs further identified R49 would oxin level completed annually eview of R49's medical record unable to be identified. on 8/6/15, at 9:48 a.m. N-C verified the medical record vel. RN-C stated there was an sician in September 2014 for rn but it had been missed. at Digoxin level was completed ears ago) and should have August 2014. RN-C verified lab had been missed by the ng staff. th the consultant pharmacist kimately 10:30 a.m. the nt reviewed R49's medical the Digoxin level had not been red. The pharmacy consultant xin lab value test should be as identified by the physician.		R49 digoxin level was drawn on 8/ Physician notified. The policy of Unnecessary Medicat was reviewed and is current. Staff education will include policy review September 10, 2015. An audit of all residents on digoxin assure they have had care planned work drawn will be implemented. Thereafter, a monthly audit will be of assure routine lab work is complete random audit of 10 residents/month DON or designee will be responsibl monitoring outcomes and reporting Quality Assurance.	ions by to l lab done to ed via a n. The le for	

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES			FOR	D: 08/31/2015 MAPPROVED D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		245467	B. WING		08	8/06/2015
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE	
HENDRIG	CKS COMMUNITY HO	OSPITAL			03 E LINCOLN STREET IENDRICKS, MN 56136	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From pa	uge 30	F3	329		
F 371 SS=F	483.35(i) FOOD PF STORE/PREPARE	ROCURE, /SERVE - SANITARY	F۵	371		9/15/15
	considered satisfact authorities; and	om sources approved or story by Federal, State or local distribute and serve food ditions				
	by: Based on observative review the facility factorial and sanitize dietary potential to affect a facility. Findings include: During observation 9:07 a.m. the follow (1) One electric car steel table near the have a thick, black cutting blade and a the blade. The diet food residue came and could potential utilized to open can cleaning. The DM f	NT is not met as evidenced tion, interview and document ailed to routinely clean, monitor requipment which had the II 56 residents residing in the of the kitchen on 8/3/15, at ving was noted: n opener located on a stainless e steam table was noted to build up on the surface of the lso on the area surrounding tary manager (DM) verified the off in chucks when touched ly contaminate food when aned items without the proper urther verified she was not ectric can opener had last aght it was this morning.			Electric can opener was disposed of on 8/5/2015 Manual can opener was replaces on 8/11/2015 Thorough cleaning of stainless steel care was completed 8/5/2015 Since 8/6/2015 the temperature logs hav 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

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STATEMEN	F OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		E SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COM	PLETED
		245467	B. WING _			06/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	Ξ	
HENDRI	CKS COMMUNITY HO	SPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 371	stainless table and residue surrounding which broke/flaked verified this particul utilized that morning after use. The DM f schedule had not b equipment been co between uses. Three stainless ste- utilized for breakfas 8/6/15. The surface drawers on the cart crumbs, spills and f the carts contained gallon milk cartons, Nursing assistants breakfast items loc the food items onto bowls. When interviewed of assistant (NA)-B ve frequently transport soiled with crumbs, previous usage. Sf requested the carts returned in the sam the appearance of thad crumbs and so the cart. She indica condition for a "long used to be a proceo cleaned after each	pener was also located on the had evidence of thick, black g the cutting edge surface off when touched. The DM ar can opener had been g (8/3/15) without cleaning turther confirmed a cleaning een implemented nor had the nsistently sanitized/cleaned el carts were observed being et service on 8/3/15 and e, drawers and tracks of the s contained large amounts of ood particle build up. Each of oatmeal, bread for toast, 1/2 yogurt and various juices. were observed to prepare ated on the carts and place Styrofoam plates and/or on 8/5/15, at 7:34 a.m. nursing erified the dietary carts were ted down resident hallways spills and food residue from ne further indicated she had be cleaned and they had he condition. NA-B indicated the dietary cart this morning il on the surface and tract of ated the cart had been in this g time". NA-B stated, "there dure in which the carts were use and then thoroughly out stated she was not aware	F 37	71 Temperature list audited 4 time by CDM or designee	es per week	

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		AND HUMAN SERVICES				FORM	08/31/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245467	B. WING	i		08/	06/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
HENDRI	CKS COMMUNITY HO	SPITAL			03 E LINCOLN STREET IENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	NA-C indicated she schedule for the ca had crumbs, food re and in the tracks of routinely spilled into used to prepare res sometimes spilled us stored in these diet. The DM was intervi and verified there we the carts utilized da prepare food items breakfast in their ro carts are restocked Styrofoam plates/be dietary staff were ex necessary. Review provided from a cor cleaning duties con lacking to indicate t by staff to ensure p equipment. This to facility to ensure the cleaning duties in the Temperature logs to available/posted ne (wash/rinse), refrige The temperatures had r policy. Documenta equipment remaine to maintain dietary s	on 8/05/15, at 7:53 a.m. was not aware of a cleaning rts and confirmed the carts esidue on the cart surfaces the drawers; in addition, food the drawers of the cart when sident breakfasts and under/onto the condiments ary carts. weed on 8/5/15, at 8:19 a.m. vas no cleaning schedule for illy to transport, store and for residents who routinely ate ooms. The DM indicated the daily with food items, owls and plastic silverware and xpected to wipe down as of the documentation mputer generated listing of firmed documentation was his tool had been completed roper cleaning of the ol had been developed by the e completion of the required he dietary department.	F	371			

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		AND HUMAN SERVICES				FORM	08/31/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245467	B. WING			08/	06/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO	SPITAL			03 E LINCOLN STREET IENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 371	Continued From pa	ge 33	F 3	71			
	dishwasher/dietary wash/rinse tempera not been monitored Facility Policies Rev Manual Section: D Last revision date: 0 Subject: Breakfast 2.1.5 Dietary & Act clean up plates/silve condiments 3.1.7 All serving ut They must be taker plate 3.1.9 Dietary Staff to wipe down cart & 3.1.10 Once a wee and a assigned diet	05/15,					
	07/15 Policy: The Dietary weekly basis by Die shift. Procedure: 2.1 weekly the diet list in the kitchen. T in a 24 hour period. cleaned. 2.2 dietary staff are sheet for days dutie 2.3 once cleaning of that job has been c 2.4 at the end of th	duty is done staff are to initial					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/31/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245467	B. WING _			08/0	06/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO	SPITAL			3 E LINCOLN STREET ENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Continued From pa	ge 34	F 3	71			
F 425 SS=E	( ) / /	RMACEUTICAL SVC - EDURES, RPH	F 4	25			9/15/15
	drugs and biologica them under an agre §483.75(h) of this p unlicensed personn law permits, but onl supervision of a lice A facility must provi (including procedur acquiring, receiving administering of all the needs of each r The facility must en a licensed pharmac	de pharmaceutical services es that assure the accurate , dispensing, and drugs and biologicals) to meet esident. nploy or obtain the services of cist who provides consultation e provision of pharmacy					
	by: Based on observat review the facility fa administration of m (R4, R5, R9, R51 a medications left with	NT is not met as evidenced tion, interview and document tiled to ensure the safe edications for 5 of 11 residents nd R52) observed to have hout observation of ingesting, t asleep and/or left while other te area.			Resident assessments will be comp to determine ability to safely self administer medication. If assessed a capable, a physician order will be secured. Policy has been reviewed updated. The resident assessment has been updated. The Medication Administration and Orientation work has been updated to include training Self Administration of Medications p	as and tool sheet g of	

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PRINTED: 08/31/2015

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	( )	E SURVEY
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	СОМ	PLETED
		245467	B. WING			06/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
HENDRI	CKS COMMUNITY HO	OSPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 425	interviewing R52 in spouse (R51) that is sitting on a small ta occupied by R51 at had two large white few smaller tablets cup contained pudd of it. R52 stated hi pills right before dir pudding. While inter that R51 took the n with the pudding. During the supper n was noted that both a dining room table nurse (RN)-D place next to R51 and an next to R52. Both with applesauce. If the table to dish up medication cart loc the dining room. S R52 taking their res had her back to both their medications. When interviewed of stated there are so leave medications after the nurse has medication cup. R breakfast in their ro left with them. RN- request to have the and staff will accon-	age 35 8/3/15, at 11:25 a.m. while a room shared with his wo medication cups were left ble in between two recliners and R52. One medication cup e oblong tablets along with a in it and the other medication ding with a spoon sticking out s wife R51 likes to take the mer and she takes them with erviewing R52, it was noted hedication in the cup mixed meal on 8/4/15, at 5:52 p.m. it n R51 and R52 were seated at a plastic medication cup other plastic medication cup other plastic medication mixed t was observed that RN-D left more medications from the ated in the hallway outside of he left prior to either R51 or spective medications. RN-D th residents as they consumed	F 4		and TMA staff will be . Monitoring of staff medication es are followed will ee medication red/week for a its per medication Nursing or designee ess of correction.	

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		AND HUMAN SERVICES			FORM	08/31/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245467	B. WING		08/	06/2015
NAME OF P	ROVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRIC	KS COMMUNITY HO	SPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 425	Continued From pa	ige 36	F 425	5		
	<ul> <li>8/4/15, at 5:45 p.m. potassium mixed w was seated. R4 was other residents. R4 and the medication by R4. The resider within reach of the resident within reach of the resider within reach of the resident within reach of the juice contained the remarkand not consumed.</li> <li>When interviewed of confirmed she had a smaller plastic cutable.</li> <li>When interviewed of stated the nurses k sure R4 receives he always want to take been a problem. During observation at 5:27 p.m. R9 was wheelchair at the dipaper medication c that contained med with her chin resting were three other result her and within was observed to hat the table until her si (25 minutes later). up to eat and then I</li> </ul>	ring the evening meal on that RN-D delivered liquid th juice to the table where R4 as seated at the table with 3 left the table area at 6:36 p.m. had not yet been consumed ths seated at the table were medication mixed in the juice n remained at the table during meal until 6:55 p.m. when a d the table and dumped the e glass into a bucket which tining juices left on the tables by the residents. on 8/4/15, at 7:32 p.m. RN-D mixed the liquid potassium in p with juice and left on the on 8/6/15, at 11:54 a.m. RN-C now that they need to make er medication as she doesn't the medication and this has of the supper meal on 8/4/15, s observed seated in her ining room table with a white up on the table in front of her lication while R9 was sleeping g against her chest. There sidents seated at the table reach of the medication. R9 ave the medications sitting on upper meal came at 5:53 p.m. Staff proceeded to wake R9 R9 proceeded to take the endently prior to eating supper.				

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		AND HUMAN SERVICES				FORM	08/31/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245467	B. WING			08/(	06/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO	SPITAL		-	03 E LINCOLN STREET IENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	RN-G, who left the itable, left the dining did not have R9 with observation. When interviewed of verified the medicat table unless there with resident could s confirmed that when "this is unsafe pract not have been left within gobservation 11:52 a.m. R5 was room table with a pl on the table in front crushed medication were three other reswithin reach of the medication cup remains the noon meal until medications at 12:1 nurse (LPN)-A was room area at the tim in a location where During observation 8/4/15, at 5:15 p.m. have a plastic medi table in the dining reseated. It contained applesauce. There is seated at the table medications at 5:32 (RN)-G, who left the table, left the dining reseated.	medications placed on the groom area multiple times and hin view during the on 8/6/15, at 2:13 p.m. RN-C tions should not be left on the was an assessment to identify safely administer and also in the resident was sleeping tice and the medication should with the resident." of the noon meal on 8/3/15, at observed seated at the dining lastic medication cup located of her which contained mixed in applesauce. There sidents seated at the table and mediation cup. The nained at the table throughout R5 self administered the 10 p.m. Licensed practical noted to leave the dining ne of the observation and was she unable to visualize R5. of the evening meal on . R5 was again observed to ication cup located on the oom table where she was d crushed medication in were three other residents with her. R5 took the 2 p.m. Registered nurse e medications placed on the groom area multiple times and itor and/or continuously	F 4	125			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/31/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245467	B. WING		08/	06/2015
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRIC	CKS COMMUNITY HO	SPITAL		03 E LINCOLN STREET IENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 425 F 428 SS=D	<ul> <li>p.m. it was verified left on the table for not safe practice an</li> <li>The facility had dev Administration Oriel which was used to the standard for medication on the orientation sho observe residents of ensure the medication 483.60(c) DRUG RI IRREGULAR, ACT</li> <li>The drug regimen of reviewed at least or pharmacist.</li> <li>The pharmacist mut the attending physic nursing, and these the by:</li> <li>Based on interview consultant pharmacion medication when cor regimen review to id</li> </ul>	th RN-C on 8/5/15, at 12:43 the medications should not be self-administration as it was not was not facility policy. The loped a Medication ntation worksheet, undated, train staff on the facility ation administration. Item 8.d. heet identified staff were to during the administration to ion was taking appropriately. EGIMEN REVIEW, REPORT	F 425	R49 digoxin level was drawn on 8 Physician notified. The policy of Unnecessary Medica was reviewed and is current. Pha will review policy as well as physic standing orders. The Pharmacist review checklist will be updated to digoxin level monitoring.	ations rmacist ian monthly	

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Facility ID: 00340

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245467	B. WING		08/	06/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRIC	CKS COMMUNITY HO	SPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	Continued From pa	ge 39	F 428	8		
	R49 with a prescrip medication to regula (mg) on odd days a The physician order have a Digoxin bloc August. During rev	lers dated 7/23/15, identified tion for Digoxin (heart ate heart) 0.25 milligrams nd 0.125 mg on even days. rs further identified R49 should od level completed annually in iew of R49's medical record a nable to be identified.		An audit of monthly pharmacy revie 5 residents will be done to assure t pharmacist has referred residents f appropriate lab work. The DON or designee will be responsible for monitoring outcomes and reporting Quality Assurance.	he for	
	registered nurse (R record lacked docu RN-C confirmed tha physician ordered a had been missed. Digoxin level was c years ago) and sho 2014. RN-C verifie	on 8/6/15, at 9:48 a.m. N)-C verified the medical mentation of a Digoxin level. at in September 2014 the blood level be drawn but it RN-C further stated the last ompleted in August 2013 (2 uld have been done in August d the annual Digoxin lab had physician and nursing staff.				
F 441 SS=F	on 8/6/14, at approx pharmacy consultar record and verified completed as order verified the Digoxin his monthly reviews should be monitore physician.	h the consultant pharmacist kimately 10:30 a.m. the nt reviewed R49's medical the Digoxin level had not been ed. The pharmacy consultant level had been missed during and confirmed the lab test d annually as identified by the I CONTROL, PREVENT	F 441			9/15/15
	Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.				

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		AND HUMAN SERVICES				FORM	08/31/2015 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245467	B. WING			08/0	06/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
HENDRIG	CKS COMMUNITY HO	OSPITAL			03 E LINCOLN STREET IENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 441	Continued From pa	uge 40	F4	41			
	Program under whi (1) Investigates, co in the facility; (2) Decides what po should be applied t (3) Maintains a reco actions related to in (b) Preventing Spre (1) When the Infect determines that a r prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each di hand washing is ind professional practic (c) Linens Personnel must ha transport linens so infection.	stablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective ifections. ead of Infection tion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. t require staff to wash their irect resident contact for which dicated by accepted					
	review the facility fa use proper handwa of 1 resident (R61)	tion, interview and document ailed to change gloves and/or ishing during wound care for 1 reviewed who required o pressure ulcers located on			August 6, 2015: Nurse involved w cares verbalized to Director recogr her breach in Infection Control star while changing residents dressing. reviewed proper standards on prop	nition of ndards Nurse	

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	· · /	E SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COM	PLETED	
		245467	B. WING _		08/	06/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
HENDRI	CKS COMMUNITY HO	OSPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136			
(X4) ID PREFIX TAG	(EACH DEFICIENC)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
F 441	PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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		F 44	<ul> <li>hand hygiene and glove utiliz Director.</li> <li>Hand Hygiene policy reviewe current. Hand Hygiene policy all staff 8/27/2015. Staff educ hand hygiene standards of pr reviewed by September 10, 2</li> <li>An audit of 5 dressing change be implemented to focus on h standards of practice complia outcomes will be monitored b or designee and evaluated by Assurance.</li> <li>Infection Prevention and Con reviewed and is current. An e system for Nursing Home star resident infections will be dev Staff will be educated by Sep 2015 on infection reporting an management of residents. In Control Nurse will track and t Home infections. Medical Sta</li> </ul>	d and is posted for ation on actice will be 015. es/month will and hygiene ince. Audit y the DON v Quality trol Program updated log ff to report eloped. tember 10, nd fection rend Nursing aff oversees		
				the Infection Control program An audit of staff logging of re- infections and completion of a trend report will be implemen outcomes will be monitored b or designee and evaluated by Assurance.	sident a monthly ted. Audit y the DON		
	handwashing nor a	e gloved hands. No change in gloves was noted re procedure when both ed.					

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		AND HUMAN SERVICES				FORM	08/31/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245467	B. WING			08/	06/2015
NAME OF	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	SPITAL			03 E LINCOLN STREET ENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 441	verified she had no "I should have char Review of the Hand indicated the proce hands are not visibl approved alcohol-b decontaminating has situations including The facility's Infecti- reviewed from 1/1/2 logs identified the fa- the resident, source onset and was not entire building. The processes also lack following: location of facility, specific sym cultures performed/ date the infection re- lacked analysis and identified. When interviewed of infection control off infection control off and trending infecti- not been implement ICO stated she had control policies and attached hospital an- indicated they were this at the quality as infection control iss recent months. During an interviewed	on 8/6/15, at 8:31 a.m. RN-D t changed her gloves, stating,	F 4	141			

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		AND HUMAN SERVICES & MEDICAID SERVICES		F	NTED: 08/31/2015 FORM APPROVED B NO. 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(3) DATE SURVEY COMPLETED
		245467	B. WING		08/06/2015
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
HENDRIC	CKS COMMUNITY HO	SPITAL		03 E LINCOLN STREET IENDRICKS, MN 56136	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 441 F 465 SS=B	some improvement Review of the facilit Prevention and Cor 11/13, indicated the surveillance of the h potentials, identify a caution of healthcar develop and implem corrective program The infection control the liaison for all col and correlating data infection control to t teaching and reinfor and procedures. 483.70(h) SAFE/FUNCTIONA E ENVIRON The facility must pro sanitary, and comfor residents, staff and This REQUIREMEN by: Based on observat failed to ensure resi	program was in need of y policy titled, Infection atrol Program, revised on facility would maintain nealthcare facility infection and analyze the incidents and re associated infections. To nent a preventive and/or to minimize infection hazards. I registered nurse will act as mmittee members, collecting a, reporting information on the proper personnel and rcing infection control policy AL/SANITARY/COMFORTABL	F 441 F 465	The four identified resident room rep are being addressed by maintenance staff. A policy to define procedure for	;
	R48) rooms who we environmental tour. Findings include: On 8/5/15, at 1:15 p	ere reviewed during the		notification of Nursing Home environmental repairs to Maintenance being developed. Maintenance staff on call 24/7. Maintenance is notified staff for any significant environment s or repair issues. A log is being develo to be completed by staff to report any	e is are by safety oped

Event ID:4TBH11

Facility ID: 00340

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	OF DEFICIENCIES	& MEDICAID SERVICES	( <b>X</b> 2) MUI	тірі	E CONSTRUCTION		0938-039	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:				· · /	PLETED	
		245467	B. WING			08/0	06/2015	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
HENDRI	CKS COMMUNITY HO	DSPITAL			03 E LINCOLN STREET IENDRICKS, MN 56136			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIC DATE	
F 465	Continued From pa	age 44	F 4	65				
	nursing (DON) and present.	I maintenance supervisor (MS)			non-immediate needs. This is to b reviewed by maintenance staff we Documentation of repair completio	əkly.		
	<ul> <li>The DON and MS confirmed the following findings:</li> <li>(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).</li> <li>(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</li> </ul>				be noted on the log. Staff education include but not limited to maintena staff, nursing staff, activity staff and environmental service staff will be completed by September 10. An a be implemented to monitor effective of staff reporting, documentation o environmental repair issues and timeliness of repairs. Maintenance developing a facility round template monthly rounding of the environment	on to nce d uudit will reness f is e for		
	located near the be	the bed side rail. Sheet rock was I measured approximately two feet by						
	by 1 foot wide (3 ft located next to the wall was noted to h	ge area measuring 3 feet long x 1 ft) above the base board TV stand in R8's room. The have black, scuffed areas with k was exposed on the entire						
	observed on the wa approximately five 2 ft). The wall had	several large areas were all above the bed measuring feet long by 2 feet wide (5 ft x multiple tears in the wall paper, and missing from the wall and c rock.						
	(MS) confirmed he and reported by eit MS indicated he wa during the tour; he	b.m. the maintenance staff fixes issues which are written her staff and/or housekeeping. as unaware of the areas noted does not keep a work log and ducting routine environmental						

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		AND HUMAN SERVICES				FORM	: 08/31/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	TE SURVEY IPLETED
		245467	B. WING		·····	08/	/06/2015
NAME OF I	PROVIDER OR SUPPLIER	·			TREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO	SPITAL			03 E LINCOLN STREET IENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 465	they should be fixed working and we need different." On 8/5/15, at 1:15 p (DON) confirmed th of the noted areas, room for improvem A facility maintenant	should know about this and d; I don't feel the system is ed to come up with something o.m. the director of nursing he findings and was not aware but stated "there is always ent." Ince policy was requested on N indicated the facility did not a addressed routine	F	465			

Facility ID: 00340

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		AND HUMAN SERVICES & MEDICAID SERVICES	7	5467024	F	NTED: 08/31/2015 FORM APPROVED B NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(3) DATE SURVEY COMPLETED
		245467	B. WING			08/04/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,		
HENDRIG	CKS COMMUNITY HO	SPITAL		503 E LINCOLN STREE HENDRICKS, MN 56		
				and the second se	PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD BUILD TO THE APPROPRIA	E COMPLETION
K 000	INITIAL COMMENT	ſS	КO	00		
	FIRE SAFETY					
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.				
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
×	Minnesota Departm Fire Marshal Divisio time of this survey, Hospital Nursing Ho substantial complia participation in Mec Subpart 483.70(a), 2000 edition of Nati Association (NFPA)	Survey was conducted by the nent of Public Safety, State on, on August 4, 2015. At the Hendricks Community ome was found not to be in nce with the requirements for licare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection Standard 101, Life Safety ter 19 Existing Health Care				
	Occupancies. PLEASE RETURN	THE PLAN OF R THE FIRE SAFETY TAGS) TO: spections Division pet, Suite 145			<b>0C</b>	
LABORATORY	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
Electron	ically 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.

State State

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		AND HUMAN SERVICES				FORM	08/31/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245467	B. WING			08/0	04/2015
NAME OF I	PROVIDER OR SUPPLIER		L	9	STREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO	SPITAL			503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	ĸ	000			
	Angela.Kappenmar <mailto:angela.kap THE PLAN OF COI DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pro 3. The name and/or responsible for corr prevent a reoccurre Hendricks Commun was constructed as The original building one-story, has no b protected and was II(111) construction The first addition was one-story, has no b protected and was II(111) construction The second additio one-story, has no b protected and was II(111) construction</mailto:angela.kap 	itney@state.mn.us> and n@state.mn.us ppenman@state.mn.us> RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. In title of the person rection and monitoring to ence of the deficiency. hity Hospital Nursing Home follows: g was constructed in 1969, is asement, is fully fire sprinkler determined to be of Type as constructed in 1987, is asement, is fully fire sprinkler determined to be of Type in was constructed in 1993, is asement, is fully fire sprinkler determined to be of Type					
	access hospital by opening protective	s separated from a critical a two-hour fire wall, and the consisted of a labeled, e latching, 90-minute fire rated					

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If continuation sheet Page 2 of 6

PRINTED:	08/31/2015
FORM	APPROVED
OMB NO	0938-0391

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVE COMPLETED
		245467 B. WING			08/04/201
	PROVIDER OR SUPPLIER	DSPITAL		STREET ADDRESS, CITY, STATE, ZIP CC 503 E LINCOLN STREET HENDRICKS, MN 56136	DDE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLE
K 000 K 029 SS=E	detection in the cor corridors which is r department notifica protected with auto are interconnected control panel [FACI of 58 beds and had survey. The requirement at NOT MET as evide NFPA 101 LIFE SA One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved autor option is used, the other spaces by sr doors. Doors are s field-applied protect 48 inches from the permitted. 19.3.2 This STANDARD in Based on observa facility failed to mail	re alarm system with smoke ridors and spaces open to the nonitored for automatic fire ation. Resident Rooms are matic smoke detectors which to the building fire alarm P]. The facility has a capacity I a census of 56 at time of the 42 CFR, Subpart 483.70(a) is enced by: FETY CODE STANDARD construction (with ¾ hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from noke resisting partitions and self-closing and non-rated or tive plates that do not exceed bottom of the door are	KO		all

		AND HUMAN SERVICES		F	TED: 08/31/2015 ORM APPROVED NO: 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X: 01 - MAIN BUILDING 01	3) DATE SURVEY COMPLETED
		245467	B. WING		08/04/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HENDRI	CKS COMMUNITY HO	SPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION TE DATE
K 029	Findings include: On 8/4/15 between observation reveale Unapproved door h the doors to the Sto	9:30 AM and 12:30 PM, ed: old open devices observed on prage Room Door (over 50 sq	K 029		
K 047 SS=D	over doors within th Area Doors need to unapproved hold or These findings was Building Engineer ( NFPA 101 LIFE SA Exit and directional accordance with se	be be checked to ensure all be checked to ensure all be devices are removed. Confirmed with the Chief JB) at the time of discovery. FETY CODE STANDARD signs are displayed in ction 7.10 with continuous rved by the emergency lighting 1	K 047		8/20/15
	Based on observat provide several ope the means of egres NFPA Life Safety C 7.10.5.2. The defici- residents, staff and illuminated exit sign from being utilized i emergency situation	s not met as evidenced by: ion, the facility has failed to erational exit signs that marks s path in accordance with ode 101 (2000 edition), Sec. ent practice could affect visitors, if the lack of properly n prevented a means of egress n a timely manner in an n.		The exit signs in Physical Therapy, Chapel, Main Entrance and through of the Nursing Home have been fixed by maintenance department. Monthly checks will be done to make sure the working.	y the
	Findings include:				
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 4TBH2:	 1 Fa	acility ID: 00340 If continuati	on sheet Page 4 of 6

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PRINTED:	08/31/2015
FORM	APPROVED
OMB NO.	0938-0391

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

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2)					OMB NO.	SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		PLETED
	245467 B. WI		B. WING		08/0	)4/2015
	PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         CKS COMMUNITY HOSPITAL       503 E LINCOLN STREET         BUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE
K 047	on 08/04/2015, it w illuminated exit sigr physical therapy ar building entrance a	ige 4 veen 9:30 AM and 12:30 PM as observed that the is that are located in the ea, chapel and at the main nd exit were in-operative due ulbs that are located within the	κc	)47		
K 056 SS=D	Maintenance Super NFPA 101 LIFE SA If there is an autom installed in accorda for the Installation of provide complete c building. The syste accordance with NI Inspection, Testing Water-Based Fire F supervised. There supply for the syste systems are equipp	FETY CODE STANDARD atic sprinkler system, it is ince with NFPA 13, Standard of Sprinkler Systems, to overage for all portions of the em is properly maintained in FPA 25, Standard for the and Maintenance of Protection Systems. It is fully is a reliable, adequate water em. Required sprinkler bed with water flow and tamper e electrically connected to the	KC	956		8/12/15
	Based on observar system is not instal accordance with NI Installation of Sprin to maintain the spri	s not met as evidenced by: tions, the automatic sprinkler led and maintained in PA 13 the Standard for the kler Systems (99). The failure nkler system in compliance could allow fire development		The sprinkler head that did r rest of the sprinklers was rep Building Sprinkle INC. All sp are uniform throughout the N Home.	laced by prinkler heads	

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED:	08/31/2015
FORM	APPROVED
OMB NO	0038_0301

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01       (X3) DATE SUF COMPLET         NAME OF PROVIDER OR SUPPLIER HENDRICKS COMMUNITY HOSPITAL       245467       B. WING       08/04/2         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE MONTHURD DE DESCEDED BY FULL       ID       PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE       COMPLET	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					. 0938-039
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         HENDRICKS COMMUNITY HOSPITAL       503 E LINCOLN STREET         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)       PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM         K 056       Continued From page 5 that would reduce the egress conditions affecting all residents, staff and visitors of the facility.       K 056         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.       Nite sas confirmed by Maintenance Supervisor	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					
HENDRICKS COMMUNITY HOSPITAL       503 E LINCOLN STREET         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX       PROVIDER'S PLAN OF CORRECTION (EACH OCRRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       Con         K 056       Continued From page 5 that would reduce the egress conditions affecting all residents, staff and visitors of the facility.       K 056         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.       Only one types of fire sprinkler head is allowed within a fire compartment.			245467	B. WING				/04/2015
HENDRICKS COMMUNITY HOSPITAL       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 ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM         K 056       Continued From page 5 that would reduce the egress conditions affecting all residents, staff and visitors of the facility.       K 056         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.       On facility Maintenance Supervisor	NAME OF I	PROVIDER OR SUPPLIER			E C		<u></u>	
(X4) ID PREFIX TAG       PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM         K 056       Continued From page 5 that would reduce the egress conditions affecting all residents, staff and visitors of the facility.       K 056         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.       Only one style of fire sprinkler head is allowed within a fire compartment.	HENDRI	CKS COMMUNITY HO	DSPITAL					
<ul> <li>that would reduce the egress conditions affecting all residents, staff and visitors of the facility.</li> <li>Findings include:</li> <li>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.</li> <li>This was confirmed by Maintenance Supervisor</li> </ul>	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	OULD BE	(X5) COMPLETION DATE
	K 056	that would reduce t all residents, staff a Findings include: On facility tour betw on 8/4/2015, it was types of fire sprinkl bulb) within the Ma style of fire sprinkle	the egress conditions affecting and visitors of the facility. ween 09:30 AM and 12:30 PM s observed that there were two ers (fusible link and glass ain Nurses Station. Only one	K	056	3		
			d by Maintenance Supervisor					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00340



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 <u>only a suggestion</u> 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

Hendricks Community Hospital August 20, 2015 Page 2

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,

Kumala Fiske Downing

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

Minnesc	ta Department of He	alth			-	_
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00340	B. WING		08/0	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO		COLN STREI KS, MN 5613			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depart	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess					
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 08/28/15

If continuation sheet 1 of 51

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00340 B. WING			08/	06/2015
IAME OF I	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, ST	TATE, ZIP CODE	•	
IENDRI	CKS COMMUNITY HO	OSPITAL	LINCOLN STREE RICKS, MN 5613			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 000		-	2 000			
	you electronically. is necessary for St enter the word "cor text. You must ther State licensure pro completion date, th	Alth orders being submitted t Although no plan of correcti ate Statutes/Rules, please rrected" in the box available in indicate in the electronic cess, under the heading be date your orders will be electronically submitting to the nent of Health.	for			
	surveyors of this D above provider and orders are issued. electronic plan of c	, 5th and August 6th, 2015 epartment's staff, visited the d the following correction Please indicate in your correction that you have lers, and identify the date wheted.				
	the State Licensing federal software.	nent of Health is documentin Correction Orders using ag numbers have been sota state statutes/rules for	ng			
	column entitled "IE statute/rule out of o "Summary Stateme and replaces the "T correction order. T findings which are after the statement evidence by." Follo	number appears in the far le D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statu t, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.	9			
	FOURTH COLUMI "PROVIDER'S PLA	ARD THE HEADING OF TH N WHICH STATES, AN OF CORRECTION." TH ERAL DEFICIENCIES ONLY	IS			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY IPLETED
		00340	B. WING		08/	06/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
IENDRI	CKS COMMUNITY HO	ISPITAL	ICOLN STREE KS, MN 5613			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ige 2	2 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 540	MN Rule 4658.0400 Resident Assessme	0 Subp. 1 & 2 Comprehensive ent	2 540			9/15/15
	conduct a compreh resident's needs, w capability to perform significant impairment nursing assessment Minnesota Statutes 15, may be used as resident assessment comprehensive res used to develop, re comprehensive plat 4658.0405. Subp. 2. Informat comprehensive ress include at least the A. medically der medical history; B. medical statt C. physical and D. sensory and E. nutritional stats F. special treat	ion; ential; n potential; itus;				

STATE FORM

6899

4TBH11

If continuation sheet 3 of 51

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED	
		00340	B. WING		08/	08/06/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DRESS, CITY,	STATE, ZIP CODE	1		
HENDRI	CKS COMMUNITY HO	SDITAL	NCOLN STRE CKS, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 540	Continued From pa	age 3	2 540				
	N. resident pre	eferences.					
	by: Based on observat	ient is not met as evidenced		Corrected			
	comprehensive as ulcer risks to preve of 2 residents (R61 ulcers and failed to comprehensive as indwelling Foley ca	ailed to conduct an initial sessment related to pressure ent further skin breakdown for ) identified with pressure o conduct an initial sessment for the use of an atheter for 1 of 2 residents urinary catheter use.	1				
	which included: rig on the 4th and 5th cellulitis, depression kidney disease. R61's admission M assessment dated one (1) stage two p unstageable press upon admission. T assessment failed	on 6/11/15 with diagnoses ght heel ulcer, right foot ulcers digits, morbid obesity, sepsis, on, atrial fibrillation and chronic linimum Data Set (MDS) 6/18/15, identified R61 with pressure ulcer and one (1) ure ulcer, both were present The admission MDS to include any Care Area ) related to the identified skin cers.					
	any comprehensive since admission. If a Braden Scale (as ulcer risk) in the as any documentation Risk assessment v along with the Brad completed. There	record was reviewed, it lacked e assessment of R61's skin R61's medical record contained seessment to identify pressure seessment section but lacked n (blank). A Pressure Ulcer vas identified to be conducted den scale, but was not was no evidence in the dentify R61 was assessed for	d				

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00340	B. WING		08/	06/2015
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
ENDRIG	CKS COMMUNITY HO	OSPITAL	NCOLN STREE CKS, MN 5613			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 540	Continued From pa	age 4	2 540			
	R61 with pressure on the 4th and 5th identified with a rig During observation 9:55 a.m. registere room to perform we heel. RN-C remove R61's right heel an dressing. The dres was moistened prid dressing was remo baseball circumfere scab which encom RN-D redressed th wound cleaner. Af treated the toes. F pressure ulcers on right foot, which we pencil eraser. The in color and open.	ders dated 8/3/15, identified ulcers located on his right toes digits. R61 was further ht heel pressure ulcer. of morning cares on 8/5/15 at d nurse (RN)-D entered R61's ound treatment to the right ed the gauze wrap from around d then removed a 4 x 4 gauze sing adhered to the wound and or to removal. After the oved, R61 was noted to have a ence area covered with black passed the entire heel region. e wound after cleansing it with ter the heel was treated, RN-E 861 was noted to have the fourth and fifth digits of his ere approximately the size of a wounds were noted to be red RN-D cleansed the wounds				
	between the toes to placing a fibrocol d	r and then replaced a sleeve o keep them separated after ressing over both open areas. n 8/6/15, at 9:37 a.m. RN-A				
	stated a wound nur wounds on R61's ri reviewing R61's me there is was no Bra	rse visited weekly to review the ight foot and toes. After edical record RN-A verified aden Scale assessment, no k assessment nor tissue				
	perfusion assessm RN-A stated the fac tissue perfusion as	ent as expected per policy. cility typically conducted a sessment to identify the lying				
	The skin assessme evaluation of the sk	tioning needs of the resident. ent should include an kin integrity & tissue tolerance & its supporting structures to				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 08/06/2015	
		00340				
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO	<b>NSDITAI</b>	NCOLN STREE CKS, MN 5613			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ON SHOULD BE COMPLE HE APPROPRIATE DATE	
2 540	Continued From page 5		2 540			
	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.					
	assessment dated indwelling Foley ca Care Area Assess status which includ Foley catheter. Du record an assess be located. An ass included considera an indwelling cather the catheter and co	linimum Data Set (MDS) 6/18/15, identified R61 with an theter. The MDS lacked a nent (CAA) related to urinary led the continued use of the uring review of R61's medical nent for urinary status could no sessment was lacking which tion of the risks & benefits of eter; the potential for removal o posideration of complications use of the indwelling catheter.	t			
	identified that R61 (Fr) should be chai The physician orde	vsician orders dated 8/3/15, s Foley Catheter, #16 French nged monthly or as needed. ers identified the rationale for onic urinary incontinence ty.				
	registered nurse (F record lacked an u	on 8/6/15, at 9:37 a.m. RN)-A confirmed R61's medica rinary assessment and also not been completed with the sessment.				
	The director of nur- related to the nece for incontinence an	THOD OF CORRECTION: sing could inservice staff ssary assessments required of pressure ulcers. A system d to track the completion of the	,			
STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT COM	e survey IPleted
--------------------------	--	---	---------------------------------------	---	------------------------------	-------------------------
		00340	B. WING		08/06/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	ISPITAT	NCOLN STRI CKS, MN 56 <sup>-</sup>			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 540	Continued From pa	ige 6	2 540			
		ss and an audit could be lity assurance committee.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 550	MN Rule 4658.040 Resident Assessme	0 Subp. 4 Comprehensive ent; Review	2 550			9/10/15
	home must examin quarterly and must comprehensive ass	f assessments. A nursing le each resident at least revise the resident's sessment to ensure the y of the assessment.				
	by: Based on observati review the facility fa limitation in range of Minimum Data Set	ent is not met as evidenced ion, interview and document ailed to accurately reflect of motion status on the (MDS) assessment for 1 of 1 wed who experienced a trigger iddle finger.		Corrected		
	Findings include:					
	was noted to have hand folded/curled questioned whethe finger, R6 attempte R6 was observed to with her right finger finger but was unab wince and state, "C manipulate/extend During a subseque	on 8/3/15, at 11:41 a.m. R6 the middle finger of her left into her palm. When r she was able to move the ed and then responded, "No". o grab the left middle finger rs and attempt to extend the ole. R6 was then observed to ouch" when attempting to the left middle finger. nt observation on 8/5/15, at seated in the dining room with				

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED		
		00340	B. WING		08/	06/2015		
NAME OF	PROVIDER OR SUPPLIER	STREET AI	T ADDRESS, CITY, STATE, ZIP CODE					
HENDRI	CKS COMMUNITY HO	OSPITAL	NCOLN STREE CKS, MN 5613					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
2 550	Continued From pa	age 7	2 550					
	palm. When R6 was could bend this fing indicated it hurt whe the finger. R6 was palm on the left han correct the contract During review of R6 progress note date indicated that R6 h with a provider to e finger that was lock finger". The physic release of finger to the pain. The physic release of finger to the pain. The physic for what plan of tree During review of R6 care plan identified mobility related to a plan identified R6 v (ROM) through inter 1. Ambulate with as support of a gait be twice daily. 2. Active ROM exe with cares seven da 3. Small group exe During review of R6 Set (MDS) assess 6/5/15, the identific limitation of ROM to lacking. During interview on registered nurse (F limitation in R6's lei last two (2) quarter	6's medical record there was a d 2/18/15, at 2:41 p.m. which ad an appointment at the clinic examine her (L) hand middle ked in curled position - "trigger cian recommended a pulley straighten it out and relieve cician noted contact would be e party for R6 and a decision atment would be made. 6's care plan, dated 6/6/15, the R6 with limited physical arthritis in knees/legs. The care vould maintain range of motion erventions including: ssist of one staff with the elt and four wheeled walker						

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00340	B. WING		08/	06/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	)SPITAI	NCOLN STRE CKS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 550	Continued From pa	age 8	2 550			
	this limitation.					
	The director of nurs track the accuracy after providing inse nurses'. An audit c	THOD OF CORRECTION: sing could develop a system to of the quarterly assessments rvice to the assessment could be developed, tracked the quality assurance	5			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one	•			
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			9/10/15
		omprehensive plan of care I personnel involved in the t.				
	by: Based on observat review the facility fa services as directed 1 of 1 resident (R6) incontinence and fa monitor lab results	ent is not met as evidenced ion, interview and document ailed to provide toileting d by the written plan of care fo ) reviewed with urinary ailed to follow the care plan to for 1 of 5 residents (R49) essary medications.	r	Corrected		
	Findings include:					
	written plan of care diagnoses identifie	de toileting as directed on the for R6. R6 had current d on the diagnosis list as: ucoma, hypertonic bladder,				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00340	B. WING	B. WING		08/06/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
HENDRIG	CKS COMMUNITY HO	ISDITAL	NCOLN STREE CKS, MN 5613				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 9	2 565				
	dementia, anxiety a	and depression.					
	frequently incontine following intervention status: 1. Will be clean, dr breakdown or signs (UTI). 2. Assist resident w changing pad, perion 3. Offer toilet every 4. Notify nurse if re problems such as 1 5. Uses Tena day r	ed 6/6/15, identified R6 as ent. The care plan identified the ons for management of urinary y and odor free with no skin s of urinary tract infection with toileting, transfers, care and clothes adjustment. 2 hours. s. complains of urinary purning, frequency or pain. egular daytime and Tena brief or incontinence product.	/				
	was noted to be lyi closed and remain until 10:22 a.m. (3 nursing assistant (1 morning cares. At assisted R6 to tran bathroom with the R6 onto the toilet. I brief was urine soa R6 voided once on 10:30 a.m. NA-D w time R6 was assist	on 8/5/15, at 6:55 a.m. R6 ng supine in bed with her eyes ed in bed in this same position 1/2 hrs. later). At this time NA)-D entered room to provide 10:25 a.m. NA-D and NA-H sfer from her bed to the use of a walker and assisted t was noted the incontinent ked when removed and that the toilet. At approximately vas interviewed about the last ed with any toileting needs. as unsure when R6 was last offered toileting.					
	9/4/14, it identified related to impaired Contributing factors Alzheimer's diseas history. The assess	6's bladder assessment dated R6 as incontinent of bladder mobility/ambulation. s included abnormal labs, e/dementia, arthritis, and fall sment further identified R6 was e need to toilet and should be	5				

TATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00340	B. WING		08/	08/06/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE				
IENDRIG	СКЅ СОММИНІТУ НО	OSPITAL	NCOLN STREE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 10	2 565				
		2 hours. The type of dentified as urge incontinence					
	indicated that R6 re	a 8/6/15, at 9:14 a.m. NA-F equired assistance with t and needed staff to stay with					
	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.						
	implemented as it i and monitor lab/dia physician orders da with a prescription medication to regul (mg) on odd days a The physician orde have an annual Dig in August. During r	care for R49 was not dentified the following: obtain ignostics as ordered. R49's ated 7/23/15, identified R49 for Digoxin (Cardiac late heart) 0.25 milligrams and 0.125 mg on even days. rs further identified R49 would goxin level completed annually review of R49's medical record a unable to be identified.	,				
	verified the medica RN-C stated there physician in Septer drawn but it had be last Digoxin level w (2 years ago) and s August 2014. RN-C	on 8/6/15, at 9:48 a.m. RN-C I record lacked a Digoxin leve was an order from the nber 2014 for the level to be een missed. RN-C stated the ras completed in August 2013 should have been performed in C verified the annual Digoxin ed by the physician and					
	on 8/6/14, at appro	th the consultant pharmacist ximately 10:30 a.m. the nt reviewed R49's medical					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00340	B. WING		08/06/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IENDRIG	CKS COMMUNITY HO	)SPITAI	NCOLN STREE CKS, MN 5613			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 11	2 565			
	completed as order confirmed the Digo	the Digoxin level had not beer red. The pharmacy consultant xin lab value test should be as identified by the physician.				
	The director of nurs (s)could review and procedures related each individual res of nursing or design to educate staff and	THOD OF CORRECTION: sing (DON) or designee d revise policies and to ensuring the care plan for ident is followed. The director nee (s)could develop a system d develop a monitoring system providing care as directed by care.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
2 895	MN Rule 4658.052 Motion	5 Subp. 2.B Rehab - Range of	2 895			9/15/15
	that is directed tow through positioning implemented and r comprehensive res of nursing services	motion. A supportive program ard prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the nursing care plan which				
	receives appropriat	th a limited range of motion te treatment and services to notion and to prevent further of motion.				
	by:	ent is not met as evidenced				
	Based on observat	ion, interview and document		Corrected		

STATE FORM

4TBH11

If continuation sheet 12 of 51

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00340	B. WING		08/	08/06/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
HENDRIG	CKS COMMUNITY HO	OSPITAL	NCOLN STREE CKS, MN 5613				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
2 895	Continued From pa	age 12	2 895				
	services to maintai	ailed to provide the necessary n range of motion (ROM) for 1 n the sample identified with a					
	Findings include:						
	was noted to have hand folded/curled questioned whethe finger, R6 attempte R6 was observed to with her right finger finger but was unab wince and state, "C manipulate/extend During a subseque 11:31 a.m. R6 was her left hand middle palm. When R6 was could bend this fing indicated it hurt wh the finger. R6 was palm on the left han correct the contract During review of R6 progress note date indicated that R6 h with a provider to e middle finger that w "trigger finger". Th pulley release of fir relieve the pain. Th	on 8/3/15, at 11:41 a.m. R6 the middle finger of her left into her palm. When r she was able to move the ed and then responded, "No". o grab the left middle finger rs and attempt to extend the ole. R6 was then observed to Ouch" when attempting to the left middle finger. nt observation on 8/5/15, at seated in the dining room with e finger pressing against her as questioned whether she ger, she responded, "No". R6 en she attempted to extend noted to have no protection to nd nor any device applied to ture. 6's medical record there was a d 2/18/15, at 2:41 p.m. which ad an appointment at the clinic examine her (L) [left] hand vas locked in curled position - e physician noted that contact h the responsible party for R6					
	and a decision for the made. During review of Recare plan identified	what plan of treatment would 6's care plan, dated 6/6/15, the R6 with limited physical arthritis in knees/legs. The care					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED		
		00340	B. WING	B. WING		08/06/2015		
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	DDRESS, CITY, STATE, ZIP CODE				
IENDRIC	CKS COMMUNITY HO	)SPITAI	INCOLN STREE					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE		
2 895	Continued From pa	age 13	2 895					
	<ul> <li>(ROM) through international (ROM) through international (ROM) through international (ROM) through the support of a gait betwice daily.</li> <li>2. Active ROM exemption (ROM) and (ROM) and</li></ul>	vould maintain range of motio erventions including: ssist of one staff with the elt and four wheeled walker rcises 5 minutes twice a day ays per week. rcises 5 days per week. 6's quarterly Minimum Data ments, dated 3/6/15 and ation of the functional o R6's left middle finger was						
	activity director (AE have daily exercise the activities progra been offered for a the care plan for R exercises 5 days a slept in during the out of bed at the tir were conducted, if During interview or	on 8/6/15, at 10:20 a.m. the D) stated the facility used to as which were implemented vi am but they had not routinely while. The AD was unaware o 6 included the small group week and stated R6 usually day and generally would not b ne the small group exercises they were conducted. n 8/6/15, at 11:05 a.m. nursing tated R6 was supposed to get	f					
	exercises daily with usually not comple When interviewed registered nurse (F verified R6's ROM thoroughly implement	ated No was supposed to get ted related to time constraints on 8/6/15, at 11:10 a.m. RN)-A, RN-C and the AD program was not being ented. The staff were unsure ole for which part of the ROM						
	program. SUGGESTED ME	THOD OF CORRECTION: Th or designee, could review all	e					

ND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00340	B. WING		08/	06/2015
IAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IENDRI	CKS COMMUNITY HO	ISPITAL	NCOLN STREE CKS, MN 5613			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 895	residents at risk for assure they are rec treatment/services range of motion. Th designee, could con delivery of care; to services are impler decline in range of	I limited range of motion to eiving the necessary to prevent further limitation in ne director of nursing or nduct random audits of the ensure appropriate care and nented; to reduce the risk of a				
2 900	Ulcers Subp. 3. Pressure comprehensive res of nursing services development of a n provides that: A. a resident wh without pressure s pressure sores unle condition demonstr authenticates, that B. a resident w receives necessary promote healing, pr new sores from dev This MN Requirement by: Based on observation	5 Subp. 3 Rehab - Pressure sores. Based on the ident assessment, the director must coordinate the ursing care plan which o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and tho has pressure sores y treatment and services to revent infection, and prevent veloping. ent is not met as evidenced ion, interview and document ailed to provide repositioning		Corrected		9/15/15

	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00340	B. WING	B. WING		08/06/2015	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
IENDRI	CKS COMMUNITY HO	SDITAL	NCOLN STREE CKS, MN 5613				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	age 15	2 900				
	of 2 residents (R6 pressure ulcers.	1) reviewed who currently had					
	which included: rig on the 4th and 5th	on 6/11/15 with diagnoses ght heel ulcer, right foot ulcers digits, morbid obesity, sepsis, on, atrial fibrillation and chronic					
	assessment dated one (1) stage two p unstageable press upon admission. T assessment failed	linimum Data Set (MDS) 6/18/15, identified R61 with pressure ulcer and one (1) ure ulcer, both were present The admission MDS to include any Care Area ) related to the identified skin cers.					
	any comprehensive since admission. F a Braden Scale (as ulcer risk) in the as any documentation Risk assessment v along with the Brac completed. There	record was reviewed, it lacked e assessment of R61's skin R61's medical record containe ssessment to identify pressure sessment section but lacked n (blank). A Pressure Ulcer vas identified to be conducted den scale, but was not was no evidence in the dentify R61 was assessed for	d				
	R61 with pressure on the 4th and 5th	ders dated 8/3/15, identified ulcers located on his right toes digits. R61 was further ht heel pressure ulcer.	5				
	identified R61 with potential for pressu	plan dated 7/1/15, for skin, three (3) pressure ulcers and ure ulcer development related and immobility. The goal listed	Ŀ				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00340	B. WING	B. WING		08/06/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
IENDRIC	CKS COMMUNITY HO	OSPITAL	NCOLN STREE				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE	
2 900	Continued From pa	age 16	2 900				
	ulcers would show	included that the pressure signs of healing and remain by/through review date.					
	<ul> <li>were:</li> <li>1. Administer treat for effectiveness.</li> <li>2. Assess/record/r Measure length, wi Assess and docum wound bed and he improvements and or physician.</li> <li>3. Assistance to tu hours, more often a</li> <li>4. Apply moisturized massage over bon cleansers for peri-c</li> <li>5. Pressure relievi has air mattress; a right foot at all time properly placed to 6. Follow facility per prevention/treatme</li> <li>7. Monitor dressin adhering. Report loo nurse.</li> </ul>	ing/reducing device 1) on bed ind 2) on Right foot - boot on es, please assure that heel is offload pressure olicies/protocols for the ent of skin breakdown. g daily to ensure it is intact and ose dressing to Treatment	r				
	6:30 a.m. R61 was back) in bed with a to keep the right he also had a bed cra blankets off his fee in the same positio		g				
	entered the resider	a.m. nursing assistant (NA)-I nt room and stated R61 did no ied to the right foot as the	t				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00340	B. WING		08/	06/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
HENDRIC	CKS COMMUNITY HO		ICOLN STREE CKS, MN 5613			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	age 17	2 900			
	acknowledged R61 repositioning. R61 position until 8:50 a entered R61's roor bed to approximate eat breakfast in be and juice on the tra without any reposit back in bed throug re-entered the roor the day. After ente 9:28 a.m. NA-I was time R61 was last had about 6:00 a.m repositioned R61 y staff from night shi NA-I began to perf a.m. At 9:45 a.m. NA-I and NA-E ass pivoted him to a set the side of the bed to perform wound of During observation	o of morning cares on 8/5/15 at				
	wound treatment to removed the gauze heel and then remo The dressing adhe moistened prior to	ed nurse (RN)-D performed a o the right heel. RN-C e wrap from around R61's right oved a $4 \times 4$ gauze dressing. ored to the wound and was removal. After the dressing				
	circumference area which encompasse redressed the wou wound cleaner. Af treated the toes. F	was noted to have a baseball a covered with black scab ed the entire heel region. RN-D nd after cleansing it with iter the heel was treated, RN-D R61 was noted to have				
		the fourth and fifth digits of his ere approximately the size of a				

ND PLAN OF CORRECTION		A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		PLETED		
		00340	B. WING		08/	08/06/2015	
IAME OF PI	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, S	TATE, ZIP CODE			
IENDRIC	KS COMMUNITY HO	ISPITAL	LINCOLN STREE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 900	Continued From pa	ige 18	2 900				
	in color and open. with wound cleaner between the toes to placing a fibrocol du During interview on stated a wound nur wounds on R61's ri reviewing R61's me there is was no Bra Pressure Ulcer Rish perfusion assessme evaluation of the skin & endure the effects of effects) after pressur reduced or redistrib typically conducted assessment to iden repositioning needs unsure how the det reposition schedule assessment had ye further stated that r he remained on his relieve pressure to not meet the definit reviewing the skin r it was noted the ide stable for R61. R61 failed to receiv the plan of care wh schedule indicating SUGGESTED MET	ntify the lying and seating s of the resident and was thermination of a two (2) hour e was identified since no et been completed. RN-A olling R61 up in the bed wh b back and buttock did not the skin and therefore wou ion of repositioning. After monitoring sheets with RN-A entified wound had remained re repositioning as directed ich identified a repositioning at least every two (2) hours	s er as. the ce b ility r ile ild A, d by cs.				
	The director of nurs all residents at risk	sing or designee, could revie					

	NT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00340	B. WING		08/	06/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	OSPITAL	NCOLN STREE CKS, MN 5613			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 19	2 900			
	from developing an pressure ulcers. T designee, could co delivery of care; to services are impler pressure ulcer deve TIME PERIOD FOI (21) days.	to prevent pressure ulcers ad to promote healing of he director of nursing or nduct random audits of the ensure appropriate care and nented; to reduce the risk for elopment. R CORRECTION: Twenty-one	2 910			
	Incontinence Subp. 5. Incontine have a continuous management to rec unnecessary use o comprehensive res home must ensure A. a resident w without an indwellir unless the resident that catheterization B. a resident w receives appropriat prevent urinary trac	5 Subp. 5 A.B Rehab - nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the sident assessment, a nursing that: who enters a nursing home ng catheter is not catheterized 's clinical condition indicates was necessary; and ho is incontinent of bladder te treatment and services to ct infections and to restore as ler function as possible.				9/15/15
	by: Based on observat review the facility fa comprehensive ass	ent is not met as evidenced ion, interview and document ailed to conduct a sessment related to the n indwelling Foley catheter for		Corrected		

STATE FORM

4TBH11

If continuation sheet 20 of 51

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00340	B. WING		08/	06/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
IENDRI	CKS COMMUNITY HO	OSPITAL	NCOLN STREE CKS, MN 5613			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	age 20	2 910			
	catheter use and fa	61) reviewed for urinary ailed to provide timely toileting resident (R6) who experienced e and required extensive	ł			
	Findings include:					
		uct a comprehensive urinary d to the continued use of a				
	including: right hee 4th and 5th digits, r cellulitis, depressio kidney disease. R6 indwelling Foley ca continued use was	on 6/11/15, with diagnoses el ulcer, right foot ulcers on the morbid obesity, sepsis, in, atrial fibrillation and chronic it was admitted with an theter and the rationale for it's identified on the physician urinary incontinence related to				
	assessment dated indwelling Foley ca Care Area Assessm status which includ Foley catheter. Du record an assessm be located. An ass included considera an indwelling cather the catheter and co	linimum Data Set (MDS) 6/18/15, identified R61 with ar theter. The MDS lacked a nent (CAA) related to urinary led the continued use of the uring review of R61's medical nent for urinary status could no sessment was lacking which tion of the risks & benefits of eter; the potential for removal consideration of complications use of the indwelling catheter.	t			
	identified that R61's (Fr) should be char The physician orde	sician orders dated 8/3/15, s Foley Catheter, #16 French nged monthly or as needed. ers identified the rationale for onic urinary incontinence				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00340	B. WING	B. WING		08/06/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
	CKS COMMUNITY HO	503 E LIN	ICOLN STREE	ET			
		HENDRIC	CKS, MN 5613	36			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 910	Continued From pa	ige 21	2 910				
	related to immobilit	у.					
	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.						
	toileting for R6 to m function as possible identified on the dia	de timely assistance with naintain as much urinary e. R6 had current diagnoses agnosis list as: Osteoarthrosis, nic bladder, dementia, anxiety					
	was noted to be lyir closed and remaine until 10:22 a.m. (3 nursing assistant (N morning cares. At assisted R6 to trans bathroom with the u	on 8/5/15, at 6:55 a.m. R6 ng supine in bed with her eyes ed in bed in this same position 1/2 hrs. later). At this time NA)-D entered room to provide 10:25 a.m. NA-D and NA-H sfer from her bed to the use of a walker and assisted t was noted the incontinent					
	brief was urine soa R6 voided once on	ked when removed and that the toilet. At approximately as interviewed about the last					

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00340	B. WING		08/	08/06/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
IENDRIC	CKS COMMUNITY HO	ISPITAT	INCOLN STREE				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 910	Continued From pa	age 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.						
	9/4/14, it identified related to impaired Contributing factor Alzheimer's diseas history. The assess able to verbalize th offered toilet every	6's bladder assessment dated R6 as incontinent of bladder mobility/ambulation. s included abnormal labs, e/dementia, arthritis, and fall sment further identified R6 wa ie need to toilet and should be 2 hours. The type of dentified as urge incontinence	S				
	frequently incontine following interventi status: 1. Will be clean, dr breakdown or sign (UTI). 2. Assist resident v changing pad, peri 3. Offer toilet every 4. Notify nurse if re problems such as 5. Uses Tena day r	ed 6/6/15, identified R6 as ent. The care plan identified th ons for management of urinary y and odor free with no skin s of urinary tract infection with toileting, transfers, care and clothes adjustment. y 2 hours. es. complains of urinary burning, frequency or pain. regular daytime and Tena brief or incontinence product.	y				
	indicated that R6 re	n 8/6/15, at 9:14 a.m. NA-F equired assistance with t and needed staff to stay with					
	8/6/15, at 9:48 a.m offered to toilet at l	ith registered nurse (RN)-C on . it was verified R6 should be east every two hours and ary care was not provided.					
	SUGGESTED ME	THOD OF CORRECTION:					

Minnesc	ta Department of He	alth			FUNI	APPROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00340	B. WING		08/06/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	SDITAL	ICOLN STRE KS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 23	2 910			
21015	all residents at risk they are receiving the treatment/services the unnecessary us nursing or designed audits of the delive appropriate care and to reduce the risk for incontinence and un TIME PERIOD FOR (21) days.	sing or designee, could review for incontinence to assure he necessary to reduce incontinence and se of catheters. The director of e, could conduct random ary of care; to ensure ad services are implemented; or further issues with nnecessary use of catheters. R CORRECTION: Twenty-one	21015			9/15/15
21010	Requirements- Sai Subp. 7. Sanitary procedures and cor					0,10,10
	by: Based on observati review the facility fa and sanitize dietary	ent is not met as evidenced on, interview and document illed to routinely clean, monitor equipment which had the II 56 residents residing in the		Corrected		
	Findings include:					
	9:07 a.m. the follow (1) One electric car steel table near the have a thick, black	of the kitchen on 8/3/15, at ving was noted: n opener located on a stainless steam table was noted to build up on the surface of the lso on the area surrounding				

	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/06/2015	
		00340	B. WING			
AME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
IENDRI	CKS COMMUNITY HO	SPITAL	ICOLN STREE CKS, MN 5613			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
TAG 21015	Continued From particular the blade. The diet food residue came and could potential utilized to open came cleaning. The DM from the elebeen used but thou (2) A manual can or stainless table and residue surrounding which broke/flaked verified this particul utilized that morning after use. The DM from the elebeen uses. Three stainless steries at the carts contained gallon milk cartons, Nursing assistants breakfast items loc the food items onto bowls. When interviewed cassistant (NA)-B ver frequently transport soiled with crumbs, previous usage. Si requested the carts cart	,	21015			

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00340	B. WING	B. WING		06/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO	OSPITAL	INCOLN STREE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21015	Continued From pa	age 25	21015			
	used to be a proce cleaned after each	g time". NA-B stated, " there dure in which the carts were use and then thoroughly but stated she was not aware the present time.				
	NA-C indicated she schedule for the ca had crumbs, food r and in the tracks of routinely spilled inte used to prepare res	y on 8/05/15, at 7:53 a.m. e was not aware of a cleaning arts and confirmed the carts residue on the cart surfaces f the drawers; in addition, foo o the drawers of the cart wher sident breakfasts and under/onto the condiments tary carts.	d			
	and verified there we the carts utilized dat prepare food items breakfast in their re- carts are restocked Styrofoam plates/bd dietary staff were en necessary. Review provided from a co- cleaning duties cor- lacking to indicate by staff to ensure pre- equipment. This to facility to ensure th	iewed on 8/5/15, at 8:19 a.m. was no cleaning schedule for aily to transport, store and for residents who routinely at boms. The DM indicated the d daily with food items, owls and plastic silverware an expected to wipe down as v of the documentation mputer generated listing of nfirmed documentation was this tool had been completed proper cleaning of the bol had been developed by the e completion of the required he dietary department.	nd			
	available/posted ne (wash/rinse), refrig The temperatures multiple areas left temperatures had	ocated in the dietary area wer ear the dishwashing erators and freezer equipmen logs were noted to have blank, indicating the required not been recorded per facility ation was lacking to indicate th	t.			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER		CONSTRUCTION		E SURVEY PLETED		
		00340	B. WING		08/	08/06/2015		
NAME OF F	PROVIDER OR SUPPLIER	STR	EET ADDRESS, CITY, ST	DDRESS, CITY, STATE, ZIP CODE				
IENDRIG	СКЅ СОММИНІТУ НС	ISPITAL	E LINCOLN STREE NDRICKS, MN 5613					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
21015	Continued From pa	uge 26	21015					
	to maintain dietary confirmed the equi	ed in safe operating condit sanitization. The DM oment had not been moni g the times that were note	tored					
	dishwasher/dietary wash/rinse tempera	on 8/6/15, at 12:30 p.m. th aide (DA)-A confirmed the atures on the dishwasher I on 8/5/15 and 8/6/15.	e					
	Manual Section: Last revision date: Subject: Breakfast 2.1.5 Dietary & Act clean up plates/silv condiments	05/15,	)					
	They must be taken plate 3.1.9 Dietary Staff to wipe down cart & 3.1.10 Once a wee and a assigned die	n out of the food and put of once all items are off car a restock cart for morning a all items are taken off c tary aide takes all items o le and out of cart and rest	on a t are , art ut of					
	07/15 Policy: The Dietary weekly basis by Die	Veekly Cleaning Effective: V Kitchen will be cleaned cetary Staff as assigned to						
	list in the kitchen. in a 24 hour period cleaned.	ary manager puts out a c This list has all shifts that . Along with what needs t e responsible to look at cl	work o be					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00340	B. WING		08/06/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	SPITAL	COLN STREE KS, MN 5613			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
21015	2.3 once cleaning of that job has been c 2.4 at the end of th picks up cleaning lis office. SUGGESTED MET dietary manager co ensure that all dieta sanitized. A system deliver food could a could be inserviced	duty is done staff are to initial	21015			
21390	proper cleaning. TIME PERIOD FOF (21) days.	A CORRECTION: Twenty-one O Subp. 4 A-I Infection Control	21390			9/15/15
	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service ed prevention and con E. a resident he immunization progr defined in part 465 procedures of resid the prevention and	and procedures. The infection ist include policies and provide for the following: based on systematic data r nosocomial infections in detection, investigation, and s of infectious diseases; d precautions systems to mission of infectious agents; ducation in infection				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00340	B. WING		08/06/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HENDRI	СКЅ СОММИНІТУ НС	)SPITAI	ICOLN STRE KS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLET DATE
21390	Continued From pa	28	21390	DEFICIENCY)		
21000	employee health po practices, including defined in part 4656 G. a system fo H. a system fo products which affe disinfectants, antise incontinence produ I. methods for current standards of	blicies and infection control a tuberculosis program as 8.0815; r reviewing antibiotic use; r review and evaluation of ect infection control, such as eptics, gloves, and				
	by: Based on observat review the facility fa use proper handwa of 1 resident (R61) changes to pressur and failed to estab program which incl surveillance of resid surveillance and inv	ion, interview and document ailed to change gloves and/or ashing during wound care for 1 reviewed during dressing re ulcers located on the foot lish an infection control uded comprehensive dent symptoms, analysis of the vestigation of patterns the potential to affect all 56		Corrected		
	9:55 a.m. registered provide treatments ulcer and the ulcers and fifth digits on the assisted R61 to be bed, RN-D donned gauze dressing from ankle. After the gau heel, it was noted the remained attached	of wound cares on 8/5/15, at d nurse (RN)-D was noted to to R61's right heel pressure s located between the forth he right foot. After staff seated on the edge of the d gloves and removed the old m around R61's heel and uze was removed from the hat some of the gauze /stuck to the scab tissue of the ied a wound cleanser with				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00340	B. WING		08/	08/06/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
HENDRI	CKS COMMUNITY HO	503 E LI	NCOLN STREE	ET			
			CKS, MN 5613	PROVIDER'S PLAN OF		(145)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21390	Continued From pa	age 29	21390				
	from the wound. A which had visible d supplies were remo drawer with the sam remove the soiled apply a clean 4 x 4 same gloved hands soiled gloves and a re-dressing the wound After the heel wound dressings applied, to the wounds loca digits with the sam handwashing nor a throughout the enti	nd had been treated and new RN-D applied a clean dressing ted on R61's forth and fifth e gloved hands. No a change in gloves was noted re procedure when both					
		on 8/6/15, at 8:31 a.m. RN-D ot changed her gloves, stating,					
	indicated the proce hands are not visib approved alcohol-b decontaminating ha	d Hygiene policy dated 8/2011, edure for hand antisepsis if ly soiled use the system based hand rub for routinely ands in all other clinical g after removing gloves.					
	reviewed from 1/1/ logs identified the f the resident, sourc onset and was not entire building. The processes also lac following: location of facility, specific syn	ion Control Logs were 2015 through 8/2/2015. The facility tracked only the name of e of the infection, date of done every month for the e facility's surveillance ked identification of the of the resident within the nptoms that were present, I/ organism identified, and the	f				

Minnesota Department of Health           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED	
		00340	B. WING		08/	06/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
HENDRIG	CKS COMMUNITY HO		NCOLN STREE CKS, MN 5613				
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG	(	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
21390	Continued From pa	age 30	21390				
		esolved. Furthermore, the logs d/or investigation of patterns	3				
	infection control off infection control pro- and trending infect not been implement ICO stated she had control policies and attached hospital a indicated they were this at the quality a	on 8/6/15, at 11:28 a.m. the ficer (ICO) confirmed a current ogram which included tracking ions in the nursing home had hated on a monthly basis. The d responsibility for the infection d procedures both in the and the nursing home. The ICC e in the process of addressing ssurance committee as sues had not been reported in	1 1 2				
	(DON) on 8/6/15, a	with the director of nursing at 11:38 a.m. it was confirmed of program was in need of t.					
	Prevention and Co 11/13, indicated the surveillance of the potentials, identify caution of healthca develop and impler corrective program The infection contr the liaison for all co and correlating dat infection control to	ty policy titled, Infection ntrol Program, revised on e facility would maintain healthcare facility infection and analyze the incidents and ire associated infections. To ment a preventive and/or to minimize infection hazards ol registered nurse will act as committee members, collecting a, reporting information on the proper personnel and prcing infection control policy					
	DON or infection c	THOD OF CORRECTION: The ontrol officer could develop a and and implement infection	e				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00240	B. WING		09/06/2015		
		00340			08/06/2015		
		503 E L IN	DDRESS, CITY, S <sup>-</sup>				
IENDRIG	CKS COMMUNITY HO	DSPITAL HENDRIC	CKS, MN 5613	6			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE	
21390	Continued From pa	age 31	21390				
	educated on the in with random audits techniques are imp control program co quality assurance p	d procedures. Staff could be fection control program along s of staff cares to ensure proper plemented. The infection huld be integrated with the program. R CORRECTION: Twenty-one					
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			9/15/15	
	maintain a compre infection control pro- current tuberculosi issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Mort This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding impleme	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines ed States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). t include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of e technical assistance ntation of the guidelines. ance with this subdivision must he nursing home.					
	by:	ent is not met as evidenced		Coursettad			
	Based on Interview	and document review, the		Corrected			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00340	B. WING		08/	06/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
HENDRI	СКЅ СОММИНІТУ НО	NSDITAI	ICOLN STREE KS, MN 5613			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21426	Continued From pa	age 32	21426			
	care workers (HCW tuberculosis (TB) s symptoms of TB ar tuberculin skin test (R60, R56, R24, R6	ure all residents (R) and health V's) received baseline creening for signs and nd also included a 2 step (TST), for 5 of 5 residents 61, R3) in the sample and 4 of oyees (LPN-B, EW-A, RN-D,				
	Finding include:					
	The facility lacked all components required for a resident TB screening.					
	6/10/2015. After rev	itted to the facility on view of the record, no baseline e for signs and symptoms of				
	2/16/2015. After rev	itted to the facility on view of the record, no baseline e for signs and symptoms of				
	After review of the	itted to the facility on 4/1/2015. record, no baseline screening and symptoms of TB for R24.				
	6/11/2015. After rev	itted to the facility on view of the record, no baseline e for signs and symptoms of				
	After review of the	ted to the facility on 6/2/2015. record, no baseline screening and symptoms of TB for R3.				
	In addition the facili required for HCW's	ity lacked all components TB screening.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00340	B. WING		08/	06/2015	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
IENDRI	CKS COMMUNITY HO	ISPITAT	NCOLN STREE CKS, MN 5613				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21426	Continued From pa	age 33	21426				
	A review of personnel records for five newly hired employees revealed the following:						
	on 7/1/15. After rev screening was don TB on 6/27/15. A tu administered to LP step administered	nurse (LPN)-B had been hired view of the record, a baseline te for signs and symptoms of uberculin skin test (TST) was 'N-B on 6/27/15 and second on 3/31/15, however the ot administered within 1 to 3 TST.					
	9/18/15. After revie screening was don TB on 9/9/15. A TS on 9/9/15 and seco 10/25/15, however	ker (EW)-A had been hired or ew of the record, a baseline the for signs and symptoms of T was administered to EW-A and step administered on the second step was not in 1 to 3 weeks of first TST.					
	10/27/15. After rev screening was don TB on 1/28/15. A T on 10/8/14 and sec 1/28/15, however t administered withir	N)-D had been hired on iew of the record, a baseline te for signs and symptoms of ST was administered to RN- D cond step administered on the second step was not to 3 weeks of first step TST eening was not done upon hire					
	After review of the was done for signs 12/2/14. A TST was	had been hired on 12/8/14. record, a baseline screening and symptoms of TB on s administered to DW-A on d step was never within 1 to 3 TST.					
	director of nursing policy and verified	n 8/6/15 at 12:10 p.m. the (DON) confirmed the facility TB screening and two step ing done right for residents and	4				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00340	B. WING		08/	06/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	NSDITAI	ICOLN STREE KS, MN 5613			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	age 34	21426			
	HCW in the facility following the policy	and stated "we should be ."				
	Exposure Control F all employees are s using two-step scre TST is administere second step TST 1	olicy titled, Tuberculin Plan, revised on 4/13 indicated screened upon hire for TB eening process, the first step d upon hire followed by -3 weeks later. Baseline TB d be used. Conduct a TB risk				
	The Director of Nur develop a system to maintaining an acc tuberculin skin testi order to provide ap The Director of Nur	THOD OF CORRECTION: rsing or designee could o ensure the facility is urate system for recording ing for resident and staff in propriate care and services. rsing could develop and m audit tool to ensure				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21530	MN Rule 4658.131	0 A.B.C Drug Regimen Review	21530			9/15/15
	reviewed at least m currently licensed b This review must b Appendix N of the S Surveyor Procedure Requirements in Lo the Department of Health Care Finand This standard is in available through th	ten of each resident must be nonthly by a pharmacist by the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, cing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan ubject to frequent change.				

	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00340	B. WING		08/	06/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
IENDRI	CKS COMMUNITY HO	OSPITAL	NCOLN STRE CKS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 35	21530			
	irregularities to the and the attending p must be acted upon physician visit, or s pharmacist. For pu- upon" means the a report and the sign of nursing services C. If the attend with the pharmacist not provide adequa pharmacist believe being adversely aff refer the matter to the if the medical direct physician. If the me the attending physic justification for the physician does not must be referred for assessment and as by part 4658.0070. the medical direct must refer the matter	acist must report any director of nursing services obysician, and these reports in by the time of the next ooner, if indicated by the urposes of this part, "acted cceptance or rejection of the ing or initialing by the director and the attending physician. ling physician does not concur t's recommendation, or does ate justification, and the s the resident's quality of life is ected, the pharmacist must the medical director for review tor is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter or review to the quality ssurance committee required If the attending physician is or, the consulting pharmacist ter directly to the quality ssurance committee.				
	by: Based on interview consultant pharmad necessity of monito medication when co regimen review to i	ent is not met as evidenced and document review the cist failed to report the pring the blood level of a onducting the monthly drug dentify irregularities for 1 of 5 viewed for unnecessary		Corrected		
	medications. Findings include:					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00340	B. WING		08/06/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IENDRI	CKS COMMUNITY HO	OSPITAL	NCOLN STREE CKS, MN 5613			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21530	R49's physician orc R49 with a prescrip medication to regul (mg) on odd days a The physician orde have a Digoxin bloc August. During rev Digoxin level was u When interviewed of registered nurse (Fr record lacked docu RN-C confirmed the physician ordered a had been missed. Digoxin level was of years ago) and sho 2014. RN-C verifie been missed by the During interview wi on 8/6/14, at appro pharmacy consulta record and verified completed as order verified the Digoxin his monthly reviews should be monitore physician. SUGGESTED MET administrator, direc consulting pharmac policies and proceo medication usage. educated as neces pharmacist's review with the pharmacist	age 36 ders dated 7/23/15, identified ption for Digoxin (heart late heart) 0.25 milligrams and 0.125 mg on even days. ers further identified R49 should od level completed annually in view of R49's medical record a unable to be identified. on 8/6/15, at 9:48 a.m. RN)-C verified the medical umentation of a Digoxin level. at in September 2014 the a blood level be drawn but it RN-C further stated the last completed in August 2013 (2 build have been done in August ed the annual Digoxin lab had e physician and nursing staff. th the consultant pharmacist ximately 10:30 a.m. the nt reviewed R49's medical the Digoxin level had not beer red. The pharmacy consultant a level had been missed during is and confirmed the lab test ed annually as identified by the CHOD OF CORRECTION: The totor of nursing (DON) and cist could review and revise dures for proper monitoring of Nursing staff could be sary to the importance of the w. The DON or designee, along t, could audit medication ar basis to ensure compliance.				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		e survey IPleted
		00340	B. WING		08/	/06/2015
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
IENDRIC	CKS COMMUNITY HO	)SPITAI	ICOLN STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 37	21530			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring		21540			9/15/15
	monitor each reside unnecessary drug u home's policies and pharmacist must re- resident's attending physician does not home's recommend adequate justification believes the reside adversely affected, matter to the medical director is the medical director is the medical director physician does not the order and if the change the order, t review to the Qualit (QAA) committee r	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the eport any irregularity to the g physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the cal director for review if the not the attending physician. If r determines that the attending have adequate justification for attending physician does not he matter must be referred for ty Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter				
	by: Based on interview facility failed to mor medication effective	ent is not met as evidenced and document review the nitor lab values to assess eness for 1 of 5 residents unnecessary medications.		Corrected		
	B49's physician or	ders dated 7/23/15, identified				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED		
		00340	B. WING	B. WING		08/06/2015		
AME OF F	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, ST	ADDRESS, CITY, STATE, ZIP CODE				
ENDRIG	CKS COMMUNITY HO	SPILAL	E LINCOLN STREE DRICKS, MN 5613					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE		
21540	medication to regu (mg) on odd days a The physician orde have an annual Dig	btion for Digoxin (Cardiac late heart) 0.25 milligrams and 0.125 mg on even days ers further identified R49 wo goxin level completed annu	ould Ially					
	a Digoxin level was When interviewed registered nurse R lacked a Digoxin le order from the physic	review of R49's medical reasonable to be identified. on 8/6/15, at 9:48 a.m. N-C verified the medical reavel. RN-C stated there was sician in September 2014 f	ecord Is an					
	RN-C stated the lat in August 2013 (2 y been performed in	vn but it had been missed. st Digoxin level was compl years ago) and should have August 2014. RN-C verifie lab had been missed by th ing staff.	e d					
	on 8/6/14, at appro pharmacy consulta record and verified completed as orde confirmed the Digo	ith the consultant pharmaci eximately 10:30 a.m. the ant reviewed R49's medical the Digoxin level had not be red. The pharmacy consul- exin lab value test should be $\gamma$ as identified by the physic	been Itant e					
	Director of Nursing with the medical di pharmacist to ensu- for appropriate inte DON could ensure importance of mon medications.The D	THOD OF CORRECTION: (DON) or desigee could w rector and consultant ure medications were review erventions and monitoring. the staff were educated or hitoring for unnecessary DON or designee could ident records to ensure	vork wed The					
	adequate monitorir place.	ng and documentation was						

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00340	B. WING		08/	06/2015
AME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	STATE, ZIP CODE		
IENDRIG	CKS COMMUNITY HO	)SPITAI	INCOLN STRE ICKS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From pa	age 39	21540			
21565	Medications Self Ad Subp. 4. Self-adm self-administer med resident assessme care as required in 4658.0405 indicate is a written order fr This MN Requirem	5 Subp. 4 Administration of dmin hinistration. A resident may dications if the comprehensive ont and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician. ent is not met as evidenced	F			9/15/15
	by: Based on observat review the facility fa self administer med	ion, interview and document ailed to assess the ability to dications for 5 of 11 residents R52) observed to self		Corrected		

STATE FORM

4TBH11

If continuation sheet 40 of 51

STATEMEN	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED		
		00340	B. WING	B. WING		06/2015		
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	DDRESS, CITY, STATE, ZIP CODE				
HENDRI	CKS COMMUNITY HO	ISPITAT	NCOLN STREE CKS, MN 5613					
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	ION SHOULD BE	(X5) COMPLET DATE		
TAG	neddearonn on t		TAG	DEFICIENC		BALL		
21565	Continued From pa	age 40	21565					
	spouse (R51) that sitting on a small ta occupied by R51 a had two large white few smaller tablets cup contained pud- of it. R52 stated hi pills right before dia pudding. While int	a room shared with his two medication cups were left able in between two recliners nd R52. One medication cup e oblong tablets along with a in it and the other medication ding with a spoon sticking out is wife R51 likes to take the nner and she takes them with erviewing R52, it was noted nedication in the cup mixed						
	was noted that both a dining room table nurse (RN)-D place next to R51 and an next to R52. Both with applesauce. I the table to dish up medication cart loo the dining room. S R52 taking their rea	meal on 8/4/15, at 5:52 p.m. it h R51 and R52 were seated at e. It was noted that registered ed a plastic medication cup nother plastic medication cup cups had medication mixed t was observed that RN-D left o more medications from the cated in the hallway outside of the left prior to either R51 or spective medications. RN-D th residents as they consumed	t					
	stated there are so leave medications after the nurse has medication cup. R breakfast in their ro left with them. RN request to have the and staff will accor resident is trustwor impairment or histo RN-C further stated	on 8/3/15, at 11:58 a.m. RN-C ome residents they routinely with so they can take them a set them up into the N-C stated R51 and R52 eat bom so their medications are -C added some residents eir medications left with them nmodate them as long as the rthy and there is no cognitive bory of refusing mediations. d they consider medication sel	f					

	IT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00340		B. WING		08/	08/06/2015	
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, ST	TATE, ZIP CODE	•		
HENDRIG	CKS COMMUNITY HO	OSPITAL		COLN STREE KS, MN 5613				
(X4) ID PREFIX TAG	SUMMARY ST/ (EACH DEFICIENC REGULATORY OR L		FICIENCIES CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21565	Continued From pa	age 41		21565				
	own medication an up their medication administration asse Both an assessme lacking in the record It was observed du 8/4/15, at 5:45 p.m potassium mixed w was seated. R4 was other residents. R4 and the medication The medication rer entire evening mea dietary aide cleared contents of the juic remaining juices le consumed.	h. They also nessment and nt and physic rds for R51 are ring the even that RN-D of with juice to that seated at the left the table of had not yet is mained at the al until 6:55 p. d the table, due glass into a seated at table.	require a self physician's order. ian order was nd R52. ing meal on delivered liquid the table where R4 the table where R4 the table with 3 a area at 6:36 p.m. been consumed. table during the m. when the umped the a bucket of					
	When interviewed confirmed she had a smaller plastic cu	mixed the liq						
	When interviewed stated the nurses k sure R4 receives h always want to take been a problem. F should know better	know that they er medication e her medicat RN-C reiterate	y need to make h as she doesn't tion and this has					
	R5 failed to have a identify her ability to medications.							
	During observation 11:52 a.m. R5 was room table with a p on the table in fron crushed medication were three other re	observed sea plastic medica t of her which n mixed in ap	ated at the dining ition cup located contained plesauce. There					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			E SURVEY PLETED
		00340	B. WING		08/	06/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO		ICOLN STREE KS, MN 5613			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21565	Continued From pa	age 42	21565			
	throughout the noo administered the m Licensed practical leave the dining roo observation and wa unable to visualize During observation 8/4/15, at 5:15 p.m have a plastic med table in the dining r seated. It contained applesauce. There seated at the table the medications at (RN)-G, who left th table, left the dining was unable to mon visualize R5 during When the medical any assessment re administer medicat R9 failed to have a identify her ability to medications. During observation at 5:27 p.m. R9 was wheelchair at the d paper medication of that contained med with her chin restin- were three other re with her. R9 was of	<ul> <li>of the evening meal on</li> <li>R5 was again observed to ication cup located on the room table where she was ed crushed medication in were three other residents with her. R5 self administered 5:32 p.m. Registered nurse e medications placed on the groom area multiple times and itor and/or continuously the observation.</li> <li>record was reviewed, it lacked elated to R5's ability to self tions.</li> <li>n assessment conducted to o safely self administer</li> <li>of the supper meal on 8/4/15, s observed seated in her ining room table with a white sup on the table in front of her dication while R9 was sleeping g against her chest. There esidents seated at the table observed to have the</li> </ul>				
innesota D	meal came at 5:53	on the table until her supper p.m. Staff proceeded to wake ien R9 proceeded to self				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00340	B. WING		08/	06/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	ISPITAT	NCOLN STREE CKS, MN 5613			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21565	Continued From pa	ige 43	21565			
	to eating supper. F placed on the table	redications independently prior RN-G, who left the medications , left the dining room area did not have R9 within view tion.				
	During review of R9's medical record it was noted R9 lacked an assessment to identify her ability to self administer medications.					
	indicated R9 may s	ders were reviewed, they elf administer AM (morning) ter set up by nurse.				
	confirmed R9 lacked assessment and or self administer AM nurse. RN-C verified be left on the table there was an assest was safe and when stated "this is unsat	8/6/15 at 2:13 p.m. RN-C ed a self administration hly had physician orders to: oral meds after set up by ed the medications should not for self administration unless ssment to identify the resident the resident was sleeping and fe practice and the medication en left with the resident."	b			
	Administration Orie which was used to standard for medica on the orientation s observe residents of	veloped a Medication entation worksheet, undated, train staff on the facility ation administration. Item 8. d. heet identified staff were to during the administration to tion was taking appropriately.				
	The Director of Nur the appropriate ass ensure the safe add The DON could enso on the importance of	THOD OF CORRECTION: rsing (DON) or desigee ensure ressments are conducted to ministration of medications. sure the staff were educated of the assessment process. nee could randomly audit				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00340	B. WING		08/	06/2015
NAME OF I	PROVIDER OR SUPPLIER	STRE	EET ADDRESS, CITY,	STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	OSPITAI	E LINCOLN STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21565	Continued From pa	age 44	21565			
	and documentation could random audit left with residents u interdisciplinary tea	ensure adequate monitor was in place. The DON of ts to ensure medication is unless deemed safe by the am. R CORRECTION: Twenty-	could not			
21695	MN Rule 4658.141	5 Subp. 4 Plant eration, & Maintenance	21695			9/15/15
	provide housekeep necessary to maint comfortable interio	eeping. A nursing home m bing and maintenance serv tain a clean, orderly, and r, including walls, floors, fixtures, equipment, lightin	rices			
	by: Based on observat failed to ensure res repair for 4 of 56 re	ent is not met as evidence ion and interview the facili sident rooms were kept in esident (R18, R35, R8 and rere reviewed during the	ty good	Corrected		
	Findings include:					
	the facility was con	p.m. an environmental tou ducted with the director of I maintenance supervisor (	:			
	findings: (1) It was noted wh	confirmed the following ien entering R18's room th the left wall above the bas				

STATE FORM

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00340	B. WING		08/	06/2015
AME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, ST	TATE, ZIP CODE		00/2013
ENDRIC	CKS COMMUNITY HO	ISDITAL	INCOLN STREE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21695	Continued From pa	age 45	21695			
	exposed sheet rock measured two and (2 1/2 ft x 6 in).	areas of missing paint and k, which approximately half feet long by 6 inches wic	le			
	(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).					
	by 1 foot wide (3 ft located next to the wall was noted to h	ge area measuring 3 feet lon x 1 ft) above the base board TV stand in R8's room. The ave black, scuffed areas with k was exposed on the entire				
	observed on the wa approximately five 2 ft). The wall had i	several large areas were all above the bed measuring feet long by 2 feet wide (5 ft > multiple tears in the wall pape and missing from the wall and prock.	er,			
	(MS) confirmed he and reported by eit MS indicated he wa during the tour, he currently is not con tours. MS stated "I they should be fixed	b.m. the maintenance staff fixes issues which are written her staff and/or housekeeping as unaware of the areas note does not keep a work log and ducting routine environmenta I should know about this and d; I don't feel the system is ed to come up with something	g. d d l			
	(DON) confirmed th	p.m. the director of nursing ne findings and was not awar but stated "there is always	e			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT COM	e survey IPleted
		00340	B. WING		08/	06/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO	SPITAL	NCOLN STRE CKS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21695	Continued From pa	ge 46	21695			
	room for improvem	ent."				
	The director of nurs educate staff regard clean, functional an DON or designee, of maintenance and h periodic audits of a ensure a safe, clea	HOD OF CORRECTION: sing (DON) or designee, could ding the importance of a safe, d homelike environment. The could coordinate with ousekeeping staff to conduct reas residents frequent to n, functional and homelike ntained to the extent possible.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			9/15/15
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	by: Based on observati review the facility fa dining experience b Styrofoam plates an utensils for 24 of 24 R8, R9, R11, R13,	ent is not met as evidenced on, interview and document illed to promote a dignified by serving breakfast on nd bowls and using plastic residents (R4, R5, R6, R7, R16, R22, R23, R25, R27, 1, R44, R45, R47, R51, R52,		Corrected		

	ta Department of He					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00340	B. WING		08/	06/2015
IAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
IENDRIG	CKS COMMUNITY HO	ISPITAL	COLN STREE KS, MN 5613			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE	(X5) COMPLET DATE
21805	Continued From pa	age 47	21805			
	R56 and R61) observed being served breakfast in their rooms.					
	Findings include:	Findings include:				
	stainless steel cart were located in the the East and West contained oatmeal, milk cartons, yogur assistants were ob items located on th items onto Styrofoa white plastic silver cart with the food it resident located on who preferred to ea breakfast meal;(R4 R13, R16, R22, R2 R41, R44, R45, R4 During observation breakfast items we the carts in the dini halls. Styrofoam p plastic silverware w west hall carts as p	a on 8/3/15, at 9:30 a.m. three s containing breakfast items e dining room and at the end of hallways. Each of the carts , bread for toast, 1/2 gallon t and various juices. Nursing served to prepare breakfast he carts and place the food am plates and/or bowls. Thin, ware was retrieved from the tem and delivered to each the east and west halls and at in their room for the I, R5, R6, R7, R8, R9, R11, 23, R25, R27, R28, R31, R34, 47, R51, R52, R56 and R61) on 8/5/15, at 7:30 a.m. the delivered to residents via ing room and East and West lates/bowls and the thin, white were available on the east and oart of the breakfast meal m. nursing assistant (NA)-B,				
	located on the wes items from the cart the Styrofoam dish	t wing prepared breakfast and served the residents with				
	contained regular of reusable silverware	ceramic dishes and metal e that were utilized for serving ne residents who were eating				
nonota D		a.m. NA-C prepared food from				
TE FORM	epartment of Health M		6899 47	TBH11	lf continuati	on sheet 48 o

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED			
		00340	B. WING		- 08/06/201				
IAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, ST	ATE, ZIP CODE		00/00/2013			
IENDRIG	CKS COMMUNITY HO	)SPITAI	INCOLN STREE						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE			
21805	Continued From pa	age 48	21805						
	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".								
			re						
	verified that resider Styrofoam dishes a silverware was utiliz was the practice. N	on 8/5/15, at 9:00 a.m. NA-B hts were served breakfast on and thin, white plastic zed on a daily basis as that IA-B indicated she felt there using Styrofoam and plastic, say in the matter.							
	also verified that St silverware were use residents located in NA-C indicated she using disposable ve NA-C further indica	v on 8/5/15, at 9:30 a.m. NA-C tyrofoam dishes and plastic ed to serve breakfast to in their rooms on a daily basis. was not aware of a reason for erses reusable dishware. atted she thought it would be gular dishes related to safety andling the plates.	or						
	dietary manager (D Styrofoam disposal	on 8/05/15, at 8:19 a.m. the 0M) indicated the use of the ble dishes and plastic spoons carts as "that is what the							

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IENDRIC	CKS COMMUNITY HO	ISPITAL	NCOLN STREE CKS, MN 5613			
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21805	Continued From pa	ige 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.					
	(DON) stated she w concerns regarding and plastic silverwa didn't think it was a that she has a fami didn't feel it was ap	2 a.m. the director of nursing vas not aware of resident's the use of Styrofoam dishes are but further indicated she ppropriate. She also added ly member living in facility and propriate. She stated that presented a safety concern he risk of spills.	4			
	indicated she didn't plastic silverware b busy but stated she paper/Styrofoam pl prefer to have glass further indicated sh	ates/bowls at home and would s or ceramic dishes. R50 le had noticed the silverware uality as it was very thin and	f			
	Manual Hendricks Association Subjec Dietary Policy No: Revised 01/09 05/1 Procedure: 3.1.1 Breakfast car	ty policy: Policy and Procedure Community Hospital t: Breakfast Cart Section 8711.145.01 effective 7/03, 5 ts are stocked by dietary with asses/cups and condiments	9			
	3.1.7 D. Staff are to dirty bus tubs once breakfast. The fac	p pick up dirty dishes & put in resident is done with ility policy makes no reference e dishes or utensils.	;			
		THOD OF CORRECTION: sing or designee, could				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		00340	B. WING		08/	06/2015
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21805	Continued From pa	age 50	21805			
	the provision of dig Employees could b policies. A system consistent impleme be developed, with being brought to th Committee for revie	ies and procedures related to prified care and services. See re-educated on these for evaluating and monitoring entation of these policies could the results of these audits re facility's Quality Assurance ew. R CORRECTION: Twenty-one				