Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 6, 2024

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

RE: CCN: 245510
Cycle Start Date: November 20, 2024

Dear Administrator:

On November 20, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by February 20, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 20, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

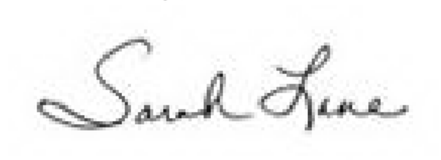
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process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

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

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

Feel free to contact me if you have questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245510	A. BUILDING _____ B. WING _____	11/20/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 11/18/24 through 11/20/24, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services	F 582		12/17/24

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

Electronically Signed | 12/12/2024

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

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F 582	Continued From page 1 specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 582	R22, R78, and R17 notified of the	

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F 582	Continued From page 2 facility failed to ensure the required Notice of Medicare Non-coverage (NOMNC) form-10123 was provided 48 hours prior to discharge for 2 of 3 residents (R22 and R78), and Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) form-10055 was provided timely to 1 of 3 residents (R17) reviewed for liability notices and resident rights. Findings include: Review of R22's Physical Therapy (PT) discharge summary and Occupational Therapy (OT) discharge summary dated 5/21/24, indicated R22 no longer required PT and OT services. R22's NOMNC indicated R22's last covered day for Medicare Part A was 5/29/24, and the form-10123 was signed 5/28/24. Review of R78's Therapy Discharge Notification dated 9/4/24, indicated R78's last covered day was 9/4/24. R78's NOMNC indicated R78's last covered day for Medicare Part A was 9/3/24, and the form-10123 was signed 9/3/24. Review of R17's Therapy Discharge Notification dated 11/11/24, indicated R17's last covered day was 11/13/24. R17's SNFABN indicated R17 may be responsible to pay for services beginning 11/14/24, however R17 dated the form-10055 11/24/24. During an interview on 11/18/24 on 3:19 p.m., Minimum Data Set (MDS) coordinator confirmed the above findings and indicated she was responsible for completing both forms. MDS coordinator stated once a resident received a discharge notification from PT/OT, she would complete the forms. MDS coordinator indicated	F 582	deficient practice. It was confirmed that the forms were submitted, and residents did not wish to appeal. Chart audits were completed for the last 6 months with no noted discrepancies. The Medicare log will be utilized as a weekly auditing tool and will be ongoing. A weekly Medicare meeting will be established to discuss discharge plans for residents receiving skilled services. Potential discharge dates will be established at the meetings. A flow sheet (Medicare log) will be used to document and review. Discharge notices will be formally submitted electronically to avoid a lag in communication. Notices will be submitted before noon 48-72 hours in advance to the MDS coordinator or designated personnel. MDS coordinator or designated personnel will submit the notification to the resident / resident representative upon receiving the discharge notice. A summary of the Medicare log will be reviewed at the QAPI meeting to assure ongoing compliance. Education was provided to the MDS coordinator. MDS coordinator will be responsible.	

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F 582	Continued From page 3 she was aware the forms needed to be provided at least 48 hours prior to the residents being discharged. MDS coordinator stated R17 put the wrong date on the form and it was supposed to be signed 11/11/24. MDS coordinator confirmed the signed date was incorrect, "I actually just caught that too, I didn't realize it was signed incorrectly". MDS coordinator was not able to locate any documentation in R22 or R78's electronic health record that identified the forms were provided 48 hours prior to discharge. During an interview on 11/19/24 at 11:52 a.m., administrator confirmed the above findings and confirmed the MDS coordinator was responsible for providing the forms to the residents who were being discharged from therapy. The administrator stated his expectation were the forms would be provided at least 48 hours in advance so residents had enough time to complete an appeal if they decided to. The administrator indicated progress notes should been placed in the residents file in addition to confirm proper notice had been provided. Review of facility policy titled Medicare Denial Notice Policy undated, identified the facility would meet the requirements of the centers for Medicare and Medicaid services (CMS) for residents to be notified.	F 582		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		12/17/24

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F 641	Continued From page 4 Based on observation, interview and document review, the facility failed to ensure accurate coding to reflect resident status on the Minimum Data Set (MDS) for 1 of 1 residents (R17) reviewed for assessments. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.18.11 10/23, identified Section J: Health Conditions was to be completed with the intent to document health conditions, such as falls, that impact a resident's functional status and quality of life. The manual indicated "Previous falls, especially recurrent falls and falls with injury, are the most important predictor of future falls and injurious falls". Further, the manual provided several assessment steps including: "Review all available sources for any fall since the last assessment... Include medical records generated in any health care setting since last assessment" and "It is important to ensure the accuracy of the level of injury resulting from a fall". R17's significant change Minimum Data Set (MDS) dated 10/14/24, identified R17 was moderately cognitively impaired and had diagnoses which included a recent hip fracture, diabetes, and anxiety. Indicated R17 required extensive assistance with activities of daily living (ADLs). R17's MDS Section J: Health Conditions dated 10/14/24, indicated the following: -Did the resident have a fall any time in the last month prior to admission/entry or reentry, checked "no".	F 641	The assessment on 10/14/24 was corrected to include the fall that occurred on 10/03/24. Correction to MDS was completed 12/11/24 to section A category E to reflect that this was the first assessment since the most recent admission/entry or reentry therefore opening questions J1700 in the MDS. Questions A., B., and C. were corrected to reflect recent falls. J1800 did not require correction. The RAI manual was referenced to ensure accuracy. The facility incident reports for falls have been reviewed against the MDS to ensure accuracy for all residents in the facility with the potential to be impacted. An audit was completed for the last 6 months with no discrepancies found. The MDS coordinator will continue to compare the incident reports for falls against the information submitted in the MDS. An audit form has been developed to track compliance. This audit tool will be reviewed at the QAPI meeting to assure ongoing compliance. Education was provided to the MDS Coordinator. MDS coordinator will be responsible.	

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F 641	Continued From page 5 -Did the resident have a fall anytime in the last 2-6 months prior to admission/entry or reentry, checked "no". -Did the resident have any fracture related to a fall in the 6 months prior to admission/entry or reentry, checked "no". -Has the resident had any falls since admission/entry or reentry or the prior assessment (OBRA or Scheduled PPS), whichever is more recent, checked "no". -Number of falls since Admission or Prior assessment - No Injury, checked "none". -Number of falls since Admission or Prior assessment - Injury (except major), checked "none". -Number of falls since Admission or Prior assessment - Major injury, checked "none". R17's significant change Care Area Assessment (CAA) for falls dated 10/14/24, was not triggered for falls and was left blank. R17's care plan dated 8/28/24, indicated R17 had decreased physical mobility with potential for falls related to unsteadiness and pain. R17 had interventions to provide the assistance of one and front wheeled walker for transfers. R17 was to wear proper and non slip footwear. Review of facility incident reports revealed the following: -8/15/24, R17 rang her pendant and was found laying on her left side in front of her recliner. R17 stated she was trying to take herself to the bathroom. R17 further stated she raised her recliner a small amount, tried to grab her walker to stand and slid from the recliner to the floor. -8/30/24, R17 rang her pendent and stated she was on the floor. R17 was sitting barefoot with	F 641		

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F 641	Continued From page 6 her back against the wall and her legs extended in front of her. R17's walker was to the left side of her. R17 stated she fell backwards while taking herself to the bathroom. -10/3/24, R17 rang her pendant and was found laying on the floor beside her bed. R17's four wheeled walker was tipped over beside her. R17 stated she was getting her pajamas off when she fell and landed on her left hip. R17 further stated she was unable to more her left leg. R17 was transported to the emergency room for evaluation. Review of R17's provider progress notes revealed the following: -10/3/24, R17 had been seen in the emergency room post fall on 10/3/24. R17's xray report indicated R17 had a left hip fracture and was admitted to the hospital. -10/4/24, R17 continued to be hospitalized and was scheduled for surgery on 10/5/24, to repair R17's left hip fracture. During an interview on 11/19/24 at 6:21 p.m., R17 stated she recently received a left hip fracture when she slipped and fell. R17 indicated she was standing at the head of the bed when she slipped and fell. During an interview on 11/19/24 at 6:28 p.m., family member (FM) stated R17 had fallen at the facility and sustained a left hip fracture. FM indicated R17 was planning to return home when she fell and now R17 would remain at the facility long term. During an interview on 11/20/24 at 3:32 p.m., RN-A reviewed R17's fall assessment dated 10/14/24, and confirmed in was completed	F 641		

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F 641	Continued From page 7 incorrectly by RN-A. RN-A stated the assessments should been completed accurately. During an interview on 11/20/24 at 4:15 p.m., director of nursing (DON) confirmed the above findings and indicated she was not aware the assessment had been completed inaccurately. DON stated her expectation was assessments were completed correctly as required. Requested facility policy on completing assessments however, DON confirmed the facility did not have a policy on completing assessments.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		12/17/24

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F 656	Continued From page 8 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed for 2 of 2 residents (R21, R17) reviewed for care planning. Findings include: R21 R21's admission Minimum Data Set (MDS) dated 10/21/24, identified R21 had intact cognition with diagnoses which consisted of atrial fibrillation, osteoarthritis, coronary artery disease. Identified	F 656	A comprehensive care plan was established for R21. The comprehensive care plan for R17 has been updated. All care plans within the facility have been reviewed and are up to date. A care plan auditing schedule has been established to include new admissions, significant changes and quarterly reviews. A care plan meeting will be held weekly to review, update/revise care plans. The audits will be conducted weekly and will be ongoing. Education was provided for all staff about how to utilize the care plan and Kardex.	

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	245510	A. BUILDING _____ B. WING _____	11/20/2024

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F 656	Continued From page 9 R21 required limited assistance with bed mobility, transfers, and toilet use. R21's admission Care Area Assessment (CAA) dated 10/28/24, identified R21 required limited assistance with transfers, toilet use and dressing. R21's electronic health record (EHR) lacked a comprehensive care plan. R21's admission record, undated, identified R21 admitted to the facility on 10/15/24. During an interview on 11/20/24 at 9:34 a.m., nursing assistant (NA)-A stated R21 required assistance with dressing and setup help with personal hygiene. NA-A stated she would ask a nurse if the care sheet did not provide direction on resident cares. During an interview on 11/20/24 at 2:14 p.m., licensed practical nurse (LPN)-A stated a registered nurse (RN) could update a care plan. LPN-A stated a resident's care plan would be circulated with the staff near care conference time to review and provide changes.	F 656	Managerial staff that are responsible for managing care plan material were updated on ensuring the interventions that are implemented in the assessment align with the care plan interventions and goals. A policy was established and was reviewed. The auditing tool will be reviewed at the QAPI meeting to assure ongoing compliance. Director of Nursing will be responsible.	

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F 656	Continued From page 10	F 656		

R17

R17's significant change MDS dated 10/14/24, identified R17 was moderately cognitively impaired and had diagnoses which included a recent hip fracture, diabetes, and anxiety. Indicated R17 required extensive assistance with activities of daily living (ADLs).

R17's significant change CAA dated 10/14/24, indicated R17 had a hip fracture, cognitive impairment, and anxiety. Identified R17 had pain, a recent surgical procedure, and poor nutrition.

R17's care plan dated 10/29/24, lacked updated recommendations from occupational therapy and dietary.

Review of R17's progress notes from 9/17/24 to 11/20/24, revealed the following:
-10/7/2024, occupational therapy (OT) recommended R17 to have no bending at the hips past 90 degrees, no crossing legs, no

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F 656	Continued From page 11 twisting, and no lifting. -10/18/24, dietary manager indicated R17 would be offered high calorie snacks R17 preferred. R17 was to receive ice cream at every meal and toppings could be added if R17 requested them. Additionally, R17 was to receive a 120 cubic centimeters (cc) mighty shake. -9/17/2024, dietary manager indicated staff were to promote fluids with calories at all meals and increase supplement of choice to 120cc's two times a day. During an observation on 1/19/24 at 6:21 p.m., R17 was laying back in her recliner with her legs crossed. During an observation on 11/20/24 at 12:04 p.m., R17 was sitting in her recliner in her room eating lunch. R17 did not have ice cream as ordered on her lunch tray. During an interview on 11/20/24 at 12:27 p.m., registered dietician (RD) confirmed the above findings and indicated R17 was to have a high calorie shake, high calorie foods and high calorie snacks. RD indicated R17's high calorie shake was increased to two times a day (BID). RD stated R17 was to have ice cream with every meal and she was not made aware R17 was not receiving ice cream every meal. During an interview on 11/20/24 at 1:44 p.m., dietary manager (DM) indicated R17 was to have high calorie shakes and ice cream with every meal. During an interview on 11/20/24 at 3:06 p.m., Minimum Data Set Coordinator (MDSC) confirmed the above findings and indicated R17's	F 656		

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F 656	Continued From page 12 care plan did not include the recommendations from OT or RD. MDSC stated it was important care plans contained the most up to date recommendations to facilitate person-center care. MDSC indicated it was important that care plans reflected the needs of the residents. During a follow-up interview on 11/20/24 at 3:14 p.m., MDSC verified after review of the EHR that R21 did not have a care plan. MDSC stated R21 was not on her list for a care plan review and that she did not have an audit system to ensure resident care plans were completed as required. During an interview on 11/20/24 at 4:15 p.m., director of nursing (DON) confirmed the above findings and stated her expectations were care plans were completed as required and contained the most up to date recommendations for residents. A facility policy on care plans was requested and one was not provided.	F 656		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/19/2024. At the time of this survey, Evansville Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 12/12/2024

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Evansville Care Center is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1968 and was determined to be of Type I(332) construction. In 1988, additions were added to the south of the Main Lounge and to the west of the North Wing that were determined to be of Type V(111) construction. In 1998 an addition was added to the end of West Wing that was	K 000		

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K 000	Continued From page 2 determined to be of Type V(111) construction. Because the original building and the additions meet the construction types allowed for existing buildings, the facility was surveyed as one building. The facility is completely fire sprinkler protected. The facility has a fire alarm system with smoke detectors in the corridors and areas open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 30 beds and had a census of 24 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler	K 353		11/25/24

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K 353	Continued From page 3 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation, and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.2(5). This deficient finding could have an isolated impact on residents within the facility. Findings include: On 11/19/2024 between 8:45 and 10:30 AM, it was revealed by observation that there are two lint covered sprinkler heads in the laundry room. An interview with the Administrator verified this deficient finding at the time of discovery.	K 353	Two sprinkler heads in the laundry room were found to have lint on them. Sprinkler heads in laundry room were cleaned to remove lint. Pictures of clean sprinkler heads were texted to Fire Marshal per his request on 11/25/24. An audit to check sprinkler heads in laundry room was added to the monthly maintenance log to ensure proper working order.	
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40	K 918		12/16/24

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K 918	Continued From page 4 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.9, and 8.3.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/19/2024 between 8:45 and 10:30 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing a four (4) hour load	K 918	The documentation showing the four-hour load bank test within last 36 months for generator was not found. A four-hour load bank test to be completed by outside entity was scheduled and will be conducted on Monday, December 16, 2024 by Ziegler Cat. Documentation of completed test will be sent to Fire Marshal when received by facility. Generator testing was added to the annual testing log to ensure all necessary tests are completed each year.	

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K 918	Continued From page 5 bank test has been completed within the last 36 months for the generator. An interview with the Administrator verified this deficient finding at the time of discovery.	K 918		