Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 4, 2023

Administrator
Hendricks Community Hospital
503 E Lincoln Street
Hendricks, MN 56136

RE: CCN: 245467
Cycle Start Date: April 19, 2023

Dear Administrator:

On April 19, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 19, 2023 (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 October 19, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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May 4, 2023

Administrator
Hendricks Community Hospital
503 E Lincoln Street
Hendricks, MN 56136

Re: State Nursing Home Licensing Orders
Event ID: 9M4211

Dear Administrator:

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

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

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

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

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

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

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245467	A. BUILDING _____ B. WING _____	C 04/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/17/23 through 4/19/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037		7/1/23

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

Electronically Signed | 05/12/2023

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

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E 037	Continued From page 1 staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 2 *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training	E 037		

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E 037	Continued From page 3 Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program.	E 037		

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E 037	Continued From page 4 The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure for 3 of 3 staff (nurse aides (NA)-D and NA-E) and the director of nursing (DON) received annual training on Emergency Preparedness (EP). This had the potential to	E 037	Corrective action will be completed to ensure the safety of any potentially affected residents in the future. On May 3, 2023, all-staff education on Emergency Preparedness was uploaded	

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E 037	Continued From page 5 affect all 45 residents, staff, and visitors. Findings include: Review of nurse aide (NA)-D's current training record identified their last EP training occurred on 10/22/21. There was no indication NA-D had any additional emergency preparedness training after 2021. Review of NA-E's current training record identified their last EP training occurred on 10/22/21. There was no indication NA-E had any additional emergency preparedness training after 2021. Review of director of nursing's (DON) current training record identified there was no documentation to support she had completed any EP training. Interview on 4/19/23 at 9:10 a.m., with infection prevention (IP) identified she was in charge of all staff training to include EP. Staff should be completing annual training on emergency preparedness.	E 037	online for staff to review. Additional measures to be put in place include: 1. It was noted that several current staff have not completed Emergency Preparedness education. All staff have been provided the Emergency Preparedness education and will have education completed by 6/27/23. 2. At the time of hire, all employees will be provided education on emergency preparedness. 3. A system has been put in place for HR to track completion of all annual mandatory staff education. This will include education on Emergency Preparedness. HR will notify mangers if education is not complete starting at one month prior to the due date. 4. Completion of the Emergency Preparedness education will be tracked for each new hire with a goal of 100%. Completion of annual education will be tracked to ensure completion with a goal of 100%. Tracking will be reassessed after one year. These items will be added to the quality scorecard for review at QAPI. E037 will be corrected by July 1, 2023	
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2),	E 039		7/1/23

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E 039	Continued From page 6 §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements,	E 039		

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E 039	Continued From page 7 directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions	E 039		

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HENDRICKS COMMUNITY HOSPITAL	503 E LINCOLN STREET HENDRICKS, MN 56136

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E 039	Continued From page 8 designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must	E 039		

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E 039	Continued From page 9 conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the	E 039		

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E 039	Continued From page 10 following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility,	E 039		

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E 039	Continued From page 11 ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual,	E 039		

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E 039	Continued From page 12 facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from	E 039		

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E 039	Continued From page 13 engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of	E 039		

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E 039	Continued From page 14 the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct exercises to test the emergency Plan at least twice per year. This had the potential to affect all 45 residents who currently reside in the facility, along with staff and visitors. Findings include: Review of the Emergency Preparedness Plan (EPP) identified the LTC facility would test their plan annually. There was no indication that the EPP had been tested in the LTC setting in the past year.	E 039	Corrective action will be completed to ensure the safety of any potentially affected residents in the future. Measures to be put in place include: 1. HCHA will conducted a missing person exercise on 5/18/23. This tested the facility on the need to activate the missing person plan, establish incident command, test internal communications, and identify the need for outside resources, such as law enforcement, EMS, and fire. 2. HCHA will have a facility wide tornado drill on 5/30/23.	

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E 039	Continued From page 15 Interview on 4/19/23 at 9:10 a.m., with Infection control (IC) who identified as the lead for Emergency Preparedness, confirmed that there had not been any full scale or table top events with analysis for LTC in the past year.	E 039	3. HCHA will conduct a fire drill with evacuation of residents on or before August 22, 2023. E039 will be corrected by July 1, 2023. 4. At the time of hire, all new employees will be instructed on the LTC facility annual Emergency Preparedness testing requirements. This will be accomplished with the Emergency Preparedness education. 5. The Emergency Preparedness/Safety Committee members will ensure compliance with the testing requirements. Members of the committee will be assigned to develop future drills with Emergency Preparedness Coordinator. Department managers will be tasked with identifying exercise needs for the facility in conjunction with the Emergency Preparedness Coordinator. 6. Emergency Preparedness testing requirements will be added to the quarterly facility QAPI meeting for review. E039 will be corrected by July 1, 2023.	
F 000	INITIAL COMMENTS On 4/17/23 through 4/19/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H54671118C (MN87737).	F 000		

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F 000	Continued From page 16 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to assess, identify interventions, and intervene for 2 of 2 residents (R21 and R28) and ensure they were free of physical abuse by 1 of 1 resident R22 who had a known history of arguing, screaming at other residents, and an increase in	F 600	It has been identified there is a potential lack of knowledge related to dementia and vulnerable adult reporting resulting in a delay in reporting of vulnerable adult incident to the state agency. Corrective action will be accomplished for	7/15/23

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F 600	Continued From page 17 physical behaviors. Findings include: Interview on 4/17/23 at 2:55 p.m., with R21 reported an incident occurred late last summer (2022), when R22 had come into her room after she was in bed. R21 reported R22 was "angry for some reason". R21 told R22 to leave. R22 began yelling, wheeled herself to the bed, and grabbed onto her right arm, digging her nails in, and causing scratches and bruising. R21 reported she had turned on her call light, and unidentified staff responded and removed R22 from her room. Licensed practical nurse (LPN)-A responded asked what happened then cleaned and dressed the scratches on her arm. R21 reported she was not afraid of R22 and was aware she had dementia and would not be aware of what she was doing. R21 reported R22 wandered in her wheelchair throughout the facility, but this was the first time she had come into her room or "bothered her". R21 reported the incident, but she had not been interviewed or questioned by any staff following the incident. Review of the nursing home reportable incidents identified there was no report made for the resident-to-resident altercation between R21 and R22 made to the State Agency (SA). R21's, 3/8/23 quarterly, MDS assessment indicated R21 had intact cognition and required extensive assistance of two staff for bed mobility, locomotion off the unit, dressing and toileting. She required total assistance of 2 staff with a Hoyer sling lift. R21 was incontinent of bowel and bladder and was dependent on staff for any repositioning, and a check and change of	F 600	those residents found to be affected as well as residents that have the potential to be affected by implementing new processes regarding identifying and reporting potential vulnerable adult situations. Measures have been put into place to prevent similar incidents from occurring: 1. On 4/18/23, the same date the DON was made aware of the situation from 8/2022, additional education was provided to staff on vulnerable adults including what a vulnerable adult is and how to identify a potential vulnerable adult situation. 2. On 4/18/23, care plans for the involved residents were updated to include any needed information regarding potential behavior issues as well as any safety precautions necessary. Additional measures will be put in place: 1. All care plans for residents will be reviewed and updated as appropriate with needed behavioral interventions and safety precautions. 2. Vulnerable adult policy will be reviewed and updated as appropriate. 3. Vulnerable adult policy will be educated on to all staff with any added updates at the June staff meetings. 4. Resident to Resident Altercations policy will be reviewed and updated as appropriate. 5. Resident to Resident Altercations policy will be educated on to staff with any updates at the June staff meetings. 6. DON, ADON, and/or nurse managers will review any new admits ensuring care plans contain necessary components for	

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F 600	Continued From page 18 incontinence products. R21 used a wheelchair for mobility and had diagnoses of chronic kidney disease, morbid obesity, seizure disorder, history of brain bleed, peripheral neuropathy, and physical deconditioning. Review of R21's current, undated care plan failed to identify any safety measures about her being vulnerable adult at times she was in bed due to requiring the assistance of 2 staff for ADLS and transferring to and from her bed. There was also no mention of interventions specific to R28's physical behaviors toward R21. Observation and interview on 4/17/23 at 2:55 p.m., identified R21 as able to move herself in her wheelchair, but when in bed was dependent on staff for turning and repositioning. R21 reported she was able to lift her arms but required the assistance of 2 staff for all repositioning, transfers, and ADLs. Interview on 4/18/23 at 10:45 a.m., with NA-A reported R21 was alert and oriented and able to direct her cares. R21 was very active in the facility and enjoyed visiting with the other residents and staff. She reported R21's room was located at the end of the East Hall, and she did like to have her door open. Other residents would wander into the area where her room was located. R21 was able to move herself in her wheelchair, but was dependent on staff for her Acivities of Daily Living (ADLs) and movement when in bed. Interview on 4/18/23 at 5:59 p.m., with licensed practical nurse (LPN)-A reported she had been working on 8/26/22 when the incident took place between R21 and R22. LPN-A reported she was	F 600	behavior and safety within 2 weeks of admission. This will be done monthly for 3 months then quarterly for 1 year. This will be added to the quality scorecard for review at QAPI meetings.	

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F 600	Continued From page 19 not able to recall the incident clearly but reported what she was able to recall. She reported she thought the incident took place at about 8:00 p.m. when R22 had transported herself into R21's room, became agitated, was screaming at R21, went over to R21's bed and grabbed her arm. LPN-A reported she had been called to R21's room by an unidentified NA and R21 reported what had occurred. LPN-A reported she did not feel the incident was intentional due to R22 had severe dementia and was not aware of what she was doing. LPN-A reported she had cleaned and dressed R21's skin tears and had made a note in the progress notes. LPN-A reported she had not reported the incident to the nursing supervisor or administration as she did not believe it was a reportable event. LPN-A reported she was aware the facility had a form that was to be completed to determine if a Vulnerable Adult (VA) report needed to be filed, and an incident report was to be completed. She reported she had not completed the forms because she had thought since R22 had dementia the incident was not reportable. Interview on 4/19/23 at 9:10 a.m., with the facility administrator reported he had been he had been notified on 4/17/23 of the August 2022 incident from the DON, following investigation. His expectation was all allegations of abuse were to be reported to facility administration and to the SA and/or law enforcement. R22's, 10/24/22, MDS assessment identified R22 had severe cognitive impairment, behaviors of hallucinations, verbal behavior directed toward others 1-3 days during the assessment reference period (ARD), wandering 1-3 days during the ARD, and refusal of cares 1-3 days during the	F 600		

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F 600	Continued From page 20 ARD. R22 had diagnosis of dementia and anxiety disorder. R22 was incontinent of bowel and bladder and used a wheelchair for mobility, although they would walk at times with limited assistance of staff. R22's undated, current care plan indicated she had chronic confusion because of her dementia and made verbally abusive statements, displayed social inappropriateness, and hallucinated. Staff were to encourage her to go to her room or guide her there when she was upset, provide hourly rounding, and continue routine monitoring. Following a previous resident to resident incident on 7/23/22 where R22 had slapped R28, staff were directed to remove R22 from stressful or agitated situations and provide 1:1 supervision with meals in the dining room. If R22 exhibited increased behaviors, staff were to remove her to the North lounge and provide 1:1 supervision. R22 was also being followed by Western Mental Health for medication management with appointments every 1 to 3 months. R22 was identified as wheeling herself in the halls and staff were to accompany her and facilitate interaction. There was no mention of other residents and the care plan (CP) such as to keep R22 away from R21. The CP also failed to mention R22 entered other resident rooms, and at times was known to be verbally and physically aggressive toward residents and staff. Interview on 4/18/23 at 10:45 a.m., with nursing assistant (NA)-A reported R22 required total assistance with all ADLs. NA-A reported R22 had severe cognitive impairment and was not able to communicate in an understandable manor. R21's room was located at the end of the hall and that she wanted to keep her door open and as a result	F 600		

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F 600	Continued From page 21 other residents were known to wander into her room at times. R21 did not usually have an issue with this and would turn on her call light to have staff come and remove the resident from her room. R22 wandered all over the facility in her wheelchair and did enter other resident rooms. R21 had behaviors of agitation and showed resistance to attempts of redirection. Observation on 4/18/23 at 11:46 a.m. of R22 who was in the dining room, seated across the table from R28 assisted to eat by an unidentified staff person. She made vocalizations at times to which the staff member responded and encouraged her to take another bite of her food. Observation on 4/19/23 at 2:30 p.m., of R22 as she transported herself in her wheelchair scooting herself along by using her feet and pulled herself along the handrail coming down the West Hall. R22 was redirected back toward the West wing and attempted to enter a resident room as she went down the hall. Staff redirected her out of the room and walked down the hall with her. Interview on 4/18/23 at 12:38 p.m., with the DON reported she was not working at the facility at the time of reported incident but reviewed the records and found no evidence facility policy had been followed for completion of an incident report, or notification of administration or the State Agency (SA). The DON did provide a nursing note dated 8/26/22 at 6:55 a.m., by licensed practical nurse (LPN)-which documented on 8/25/22 she had been called to R21's room by unidentified staff and R21 had reported while she was in bed, R22 had come into her room, reached for the bed and her arm causing a skin tear and had some mild bruising. LPN-A treated the skin tear, and R22	F 600		

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F 600	Continued From page 22 was directed to her room. The DON reported she would begin investigation into the incident and report to the SA. The DON agreed the facility policy had not been followed for completion on an incident report, and notification of administration and the SA within the required 2-hour timeframe. Interview on 4/18/23, at 4:31 p.m., with registered nurse (RN)-A identified she was aware of the policy for reporting a resident-to-resident incident to the DON and administrator, filling out an incident report and the incident would likely be reported to the SA. RN-A was aware of the 2-hour time frame for reporting an incident. RN-A had just received education on abuse and reporting within this last month on abuse, resident rights, and reviewed policies and procedures and completed a quiz. Interview on 4/18/23 at 5:59 p.m., with LPN-A reported she had been the charge nurse working on date 8/25/22 when the incident occurred between R21 and R22. The incident occurred during the evening hours at about 8:00 p.m. An unidentified staff member had called her to R21's room and reported R22 had gone into R21's room and grabbed R21's arm. R21 had then asked R22 to leave and R22 had begun yelling and "clawed" R21's arm. LPN-A thought R22 was "probably trying to stand". LPN-A inferred because she had dementia, she did not know what she was doing. R22 was removed from R21's room. R21 reported the incident to her. LPN-A stated she did not believe there was intent on R22's behalf and was not trying to harm R21 because R22 had severe dementia. LPN-A cleaned R21's arm, applied a dressing, and made a note in the nursing notes. LPN-A thought it was not necessary to fill out an incident report or notify	F 600		

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F 600	Continued From page 23 the DON or administrator. LPN-A did not recall if she had notified the family or R21's physician and agreed there was nothing in the documentation to indicate she had done so. Interview on 4/19/23 at 9:10 a.m., with the administrator identified he had been notified on 4/17/23 following the request for documentation on the incident by this surveyor. He was not certain of the time, but the DON had contacted him immediately after the request to determine if there was any record of this incident. The administrator had no prior knowledge or documentation about the August 2022 incident. Review of the 7/23/22 at 8:58 p.m., report to the State Agency identified R22 and R28 were seated across from each other during the supper meal arguing. R22 stood up from her wheelchair and grabbed R28's walker. R28 began yelling. R22 slapped R28 on the right side of her face. Staff immediately intervened and separated the residents. No injuries were noted, and staff continued to monitor. R28's, 6/24/22, quarterly Minimum Data Set (MDS) assessment indicated R28 had severe cognitive impairment and had delusions. His MDS did not identify any behaviors noted during the assessment reference date (ERD). R28 required extensive assistance of one staff for bed mobility, transfers locomotion on/off the unit, dressing, toileting, and personal hygiene. She used a walker for ambulation and required limited assistance from staff. R28 had diagnoses of dementia, heart failure, and high blood pressure. R28's undated, current care plan identified behaviors of verbally yelling and threatening staff.	F 600		

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F 600	Continued From page 24 Following the incident on 7/23/22, staff were to remove her from stressful or agitated situations and monitoring of the dining room table with meals. There were no safety measures identified to prevent additional altercations with R22. Observation and interview on 4/17/23 at 7:53 a.m., of R28 as she sat at the table in the dining room feeding herself breakfast. R28 did not attempt to converse with other residents, and when asked if she had concerns with any other residents stated, she was "fine". R28 did not respond to any additional questions as she continued to eat. Additional observation on 4/18/23 at 11:46 a.m. of R28 as she sat in the dining room identified she had a plate of food in front of her. Her chin was on her chest, and she made no attempt to eat. An unidentified staff person was seated between R22 and R28 attempted to prompt her, but R28 looked up and replied she was not hungry. She then appeared to doze off again. R22 was seated across the table from R28 not within arm's reach, and there was no interaction between the 2 residents. R28's 7/23/223 at 9:33 p.m., progress note identified R28 had been involved in an altercation with R22 during the supper meal when the 2 residents were arguing, and R22 slapped R28 on the right side of her face. There was no evidence of injury and staff noted they would continue to monitor for post-altercation injuries. R28's 7/28/22 at 8:48 a.m., physician progress note identified R28s medications and lab values had been reviewed. The provider was updated on the incident that had occurred between R22 and R28. R28 voiced concerns to the physician did not voice any concerns regarding pain or the	F 600		

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F 600	Continued From page 25 reported incident. There were no changes made to R28's plan of care at the routine visit. There was no mention staff had identified any interventions to prevent further abuse from R28 to other residents. Interview on 4/19/23 at 10:57 a.m., with nursing assistant (NA)-B reported R28 had behaviors of yelling and screaming at staff and other residents. R28 had dementia and was forgetful which caused anger and occurred almost daily. R28 became agitated with R22 due to her wandering and at the time of incident. Leading up to the incident, R22 and R28 were seated across the table across from each other. R22 was restless and was known to pick up objects off the table. R28 became upset and yelled at R22. NA-B reported staff immediately separated the two residents following the incident in June. R22 and R28's seating arrangement was not changed. R22 and R28 continued to sit across from each other as both needed assistance with meals and a staff person was to be always present at the table. R28 continued to have behavior directed toward staff, especially during the night shift, but there had not been any further incidents with other residents she was aware of. Interview on 4/19/23 at 11:18 a.m., with NA-C identified R28 often became angry, and her behaviors escalated in the evening. R28 would become angry and would often begin yelling and screaming for her daughter and would verbally threaten and make derogatory comments toward staff that attempted to redirect her. R28's behavior was usually the result of a person "not doing something as she thought it should be done". She would then escalate and become physically aggressive with staff. Staff were to	F 600		

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F 600	Continued From page 26 separate residents from R28 during her increased behaviors and monitor and avoid potential contact with the resident R28 was "upset with". Interview on 4/19/23 at 11:45 a.m., with the director of nursing (DON) reported the facility should have supervised R22 and R28 more closely due to their history of agitation with other residents and possibly avoided the incident. Review of the July 2021, facility policy Vulnerable Adult Abuse Prevention Plan identified the facility was to develop and implement an individualized abuse prevention plan for each resident. The plan was to include measures to minimize the risk of abuse to that resident in addition to other vulnerable residents. Abuse as conduct which was not an accident and had the potential to cause physical pain, injury, or emotional distress, with willful infliction of injury, and could have resulting harm, pain, or mental anguish. A resident with cognitive impairment may still commit a willful act. Response to an incident of abuse and/or neglect included an internal investigation of the incident, reporting the incidents to the SA, taking all necessary corrective actions, with review and analysis of the occurrence to determine if any changes needed in the plan to prevent further instances. Staff were to maintain a log of all abuse and/or neglect incidents. Review of the May 2022, Resident to Resident Altercations policy identified all incidents that were potential resident to resident abuse were to be investigated and reported to the nursing supervisor, the DON and administrator. Staff interventions were to include: 1) Separate the residents and attempt to calm the	F 600		

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F 600	Continued From page 27 situation. 2) Identify what happened, and what might have caused the action/reaction of the residents involved. 3) Notify each resident's representative and medical provider of the incident. 4) Review and develop the possible root cause with the supervisor and DON to avoid additional altercations. 5) Discuss with the physician to determine any needed treatment for medical conditions. 6) Update the care plan to include any new interventions, document in the record any new interventions and monitor for effectiveness. 7) Consult with psychiatric services if indicated to assist with assessment identifying potential causes, and development of an individualized care plan if directed by the physician and interdisciplinary team. 8) Complete an incident report and document the incident, investigation, and interventions in the resident's medical record. 9) Report incidents, findings, and interventions to the SA as outlined in the Abuse Prevention plan.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 609		7/15/23

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F 609	Continued From page 28 serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to report an allegation of resident-to-resident physical abuse for 1 of 3 residents (R21), to the State Agency (SA) within the required 2-hour time. Findings include: Interview on 4/17/23 at 2:55 p.m., with R21 reported an incident occurred late last summer (2022), when R22 had come into her room after she was in bed. R21 reported R22 was "angry for some reason". R21 told R22 to leave. R22 began yelling, wheeled herself to the bed, and grabbed onto her right arm, digging her nails in, and causing scratches and bruising. R21 reported she had turned on her call light, and unidentified staff responded and removed R22 from her room. Licensed practical nurse (LPN)-A responded asked what happened then cleaned and dressed	F 609	It has been identified there is a potential lack of knowledge related to dementia and vulnerable adult reporting resulting in a delay in reporting of vulnerable adult incident to the state agency. Corrective action will be accomplished for those residents found to be affected as well as residents that have the potential to be affected by implementing new processes regarding identifying and reporting potential vulnerable adult situations. Measures were put into place to prevent similar incidents from occurring: 1. On 4/18/23, the same date the DON was made aware of the situation from 8/2022, additional education was provided to staff on vulnerable adults including what a vulnerable adult is and how to identify a potential vulnerable adult	

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F 609	Continued From page 29 the scratches on her arm. R21 reported she was not afraid of R22 and was aware she had dementia and would not be aware of what she was doing. R21 reported R22 wandered in her wheelchair throughout the facility, but this was the first time she had come into her room or "bothered her". R21 reported the incident, but she had not been interviewed or questioned by any staff following the incident. Review of the nursing home reportable incidents identified there was no report made for the resident-to-resident altercation between R21 and R22 made to the State Agency (SA). Interview on 4/18/23 at 5:59 p.m., with licensed practical nurse (LPN)-A reported she had been working on 8/26/22 when the incident took place between R21 and R22. LPN-A reported she was not able to recall the incident clearly but reported what she was able to recall. She reported she thought the incident took place at about 8:00 p.m. when R22 had transported herself into R21's room, became agitated, was screaming at R21, went over to R21's bed and grabbed her arm. LPN-A reported she had been called to R21's room by an unidentified NA and R21 reported what had occurred. LPN-A reported she did not feel the incident was intentional due to R22 had severe dementia and was not aware of what she was doing. LPN-A reported she had cleaned and dressed R21's skin tears and had made a note in the progress notes. LPN-A reported she had not reported the incident to the nursing supervisor or administration as she did not believe it was a reportable event. LPN-A reported she was aware the facility had a form that was to be completed to determine if a Vulnerable Adult (VA) report needed to be filed, and an incident report was to	F 609	situation. 2. Vulnerable Adult policy will be reviewed and updated as appropriate. 3. Vulnerable Adult policy will be education on with staff with any new updates at the June staff meeting. 4. Additional education related to vulnerable adults will be added to the resident council meeting in June. 5. All potential complaints will be reviewed to ensure proper reporting. This will be added to quality score card for review at QAPI. Tracking/auditing will be reassessed after one year to determine frequency needed for audits going forward.	

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F 609	Continued From page 30 be completed. She reported she had not completed the forms because she had thought since R22 had dementia the incident was not reportable. Interview on 4/19/23 at 9:10 a.m., with the facility administrator reported he had been he had been notified on 4/17/23 of the August 2022 incident from the DON, following investigation. His expectation was all allegations of abuse were to be reported to facility administration and to the SA and/or law enforcement. Review of the July 2021, Vulnerable Adult Abuse Prevention Plan identified facility personnel who had knowledge of an incident must make an immediate report, as soon as possible but no longer than 24 hours from the time of initial knowledge to the administrator, designee, supervisor or directly to the SA. There was no specific mention of allegations of abuse being required to be reported to the administrator, SA and/or law enforcement within 2 hours.	F 609		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve	F 727		7/1/23

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F 727	Continued From page 31 as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a registered nurse (RN) was on duty a minimum of 8 consecutive hours per day for 13 of 106 days reviewed. Findings include: Review of the facility nursing staff schedules between February 2023 and April 2023 identified in: 1) February 2023, there was no RN coverage on 2/11/23 and 2/12/23. 2) March 2023, there was less than 8-hour non-consecutive RN coverage on 3/3/23, 3/23/23, 3/25/23, and 3/26/23. There was no RN coverage identified on 3/4/23 and 3/5/23. 3) April 2023, there was less than 8-hour non-consecutive RN coverage on 4/1/23, 4/2/23, and 4/7/23. There was no RN coverage identified on 4/15/23 and 4/16/23. Interview on 4/19/23 at 3:30 p.m., with the staffing coordinator reported she completed the schedule in 6-week blocks. There was to be an RN on-call that would report to the facility to cover shifts to meet the requirement if there was not an RN scheduled for 8 consecutive hours in a 24-hour timeframe. She was unaware of why the open shifts had not been covered. Interview on 4/19/23 at 4:00 p.m., with the director of nursing (DON) identified her expectation for the on-call RN staff was they were to report to work in the facility when the required 8 consecutive hours/24 hours was not filled. She	F 727	Corrective action will be completed to ensure the safety of any potentially affected residents in the future as a result of fewer RN hours. 1. The DON and ADON have reviewed the requirements to apply for an RN staffing waiver. DON will apply for waiver. 2. While waiting to see if the facility will qualify for a waiver, management staff will work to ensure 8 hours of RN coverage each day. 3. Policy regarding staffing requirements will be established and nursing staff will be educated on the policy at the June staff meeting. 4. RN coverage will be added to the quality scorecard and reviewed at QAPI. Additional information related to the request for a waiver: 1. HCHA long-term care will continue to have at least one full-time registered nurse who is regularly on duty 35-40 hours per week. 2. Policies and procedures will continue to be followed by the LPN staff under the direction of an RN with an expectation to report to the on-call RN with any potential issues. 3. The LPN staff are well trained to do a focused assessments and update care plans as necessary and report to the RN. 4. Licensed practical nursing staff will provide care in collaboration with a registered nurse within their scope of	

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(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 727	Continued From page 32 was aware the facility had had shifts that had not been filled but was unaware of the number of times it had occurred. She confirmed the requirement had not been met on the identified dates for the 3 months reviewed. A policy on staffing requirements was requested but not provided by the end of the survey period.	F 727	practice and experience. 5. HCHA long-term care, along with the medical director, do not feel the absence of an RN will endanger the health or safety of the residents. 6. Nursing management will continue to collaborate with licensed practical nursing staff to ensure preventative measures are in place to avoid poor quality of care outcomes and sudden changes in health status. All staff nurses are trained on outcomes and acute changes in condition. If such would happen the licensed practical nursing staff would report to a RN. 7. Sudden changes in residents' health status or emergency needs will be relayed to an RN or on-call provider via phone immediately. HCHA long-term care is also attached to hospital with an ER. Hospital staffs RN coverage 24 hours a day 7 days a week. 8. Residents and families will be notified of the facilities intent to waive having registered nurse coverage 8 hours/day 7 days per week once approval of the waiver has been obtained. 9. HCHA long-term care meets the requirements to obtain a RN waiver. 10. A RN or physician will be available to respond immediately to telephone calls when a RN is not available in house. 11. HCHA long-term care is currently advertising online, in the newspaper, and at local nursing schools. F727 will be corrected by July 1, 2023	
F 761 SS=F	Label/Store Drugs and Biologicals	F 761		7/15/23

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	245467	A. BUILDING _____ B. WING _____	C 04/19/2023

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F 761	Continued From page 33 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications were stored securely in 2 of 2 medication carts when staff were not present. This had the potential to affect all 45 residents. Findings include: Observation and interview on 4/17/23 at 9:20 a.m., of the medication cart outside the dining	F 761	Corrective action will be completed to ensure the safety of any potentially affected residents in the future as a result of medication carts not being locked. 1. A policy regarding medication storage will be established and nursing/TMA staff will be educated on the new policy at the June staff meeting. 2. Audits will be completed 3 times/week for 1 month, weekly for 2 weeks, monthly	

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F 761	Continued From page 34 room identified the top drawer of the medication cart was open with no staff present. Trained medication aide (TMA)-B returned to the cart and when asked about the open and unsecured cart, TMA-B pushed the drawer shut and locked it. TMA-B denied she left the medication cart unlocked and unsecured from unauthorized access and stated "Someone else that knew the medication cart code must have gotten something out of the cart and not locked the cart back up". Observation on 4/17/23 at 10:38 a.m., of an unattended medication cart located on the West hall the medication cart was unlocked and unsecured, allowing staff or residents in the area to potentially access to the medications stored inside. R35 was observed wandering in the hall and came over the medication cart looking at the items on the surface and reaching out toward the cart as if to open the drawer. At that time, the director of nursing (DON) came down the hall and redirected R35. When asked about the medication cart being unlocked, the DON opened the first 2 drawers confirming the cart was not locked and reported the medication cart was supposed to be locked if staff were not in attendance. LPN-C returned to the cart and reported she was not aware her cart had remained unlocked. LPN-C left the area before further interview could be obtained. Interview on 4/19/23 at 11:45 a.m., with director of nursing (DON) confirmed her expectation was for staff to always lock the medication cart when not present. A policy was medication storage was requested but not provided.	F 761	for 3 months, and then quarterly for 1 year. 3. Audits will be added to the quality scorecard for review at QAPI.	

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F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		7/15/23

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F 880	Continued From page 36 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure appropriate disinfection of 1 of 1 whirlpool tubs on the east wing in-between resident's baths. This had the potential to affect 42 of 45 residents (R18, R39, R4, R3, R30, R21, R28, R25, R32, R41, R27, R15, R10, R23, R1, R31, R6, R29, R36, R13, R5, R38, R17, R46, R37, R14, R11, R8, R16, R40, R24, R44, R33, R45, R42, R19, R34, R20, R22, R35, R7, R43) that utilized the east whirlpool tub.	F 880	Corrective action will be completed to ensure the safety of any potentially affected residents in the future as a result of improper disinfection of the tub. Measures put into place to prevent similar situations in the future: 1. On 4/19/23 the tub disinfection steps were updated indicating the correct “wet time” for disinfection per the manufacturer's directions. The updated instructions were placed in all three of the	

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F 880	Continued From page 37 Observation on 4/18/23 at 10:45 a.m., with trained medication assistance (TMA)-A as disinfected the Arjo Whirlpool tub identified TMA-A sprayed the tub surface with Penner Whirlpool Classic Disinfectant. TMA-A then scrubbed down the sides of the tub, wiped down with chair with a wet rag and then proceeded to immediately rinse off the disinfectant with water. Interview on 4/18/23 at 10:49 a.m., with TMA-A revealed the tub had pre-filled disinfectant and staff just pushed a button to dispense the disinfectant into the tub. Staff would then fill the tub over the intake at the bottom of the tub which will clean out the jet system. Staff would add Penner disinfectant and scrub the sides of the tub with a long handled brush, wipe the chair with a wet rag. TMA-A stated, "there is no need for a wet time, and it is okay to rinse off right away." TMA-A also said there was procedure on the wall of how to disinfect the whirlpool. Interview on 4/19/23 at 9:10 a.m., with Infection preventionist (IP) identified they had a disinfectant that was approved to clean the whirlpool tub. IP stated "It would be my hope that they allow the kill time before they washed off the disinfectant." Interview on 4/19/23 at 9:30 a.m., with director of nursing (DON) revealed she was unsure of the process of the tub cleaning as she had not reviewed the policy yet. The DON confirmed her expectation was staff would follow the instructions on the disinfectant bottle and ensure the wet contact time of 10 minutes to ensure appropriate disinfection. Review of undated, Tub Disinfection Steps policy and procedure posted on the inside of the cabinet	F 880	tub rooms. Education on updated procedure provided to the bath aides. 2. On 4/20/23, the infection control nurse laminated signs indicating the “we time” and posted on the outside of the tub room cupboard doors. 3. On 5/1/23 DON held staff meeting with CNAs and provided education on updated tub cleaning information with all CNA staff. Additional Measures to be put in place: 1. Tub disinfection section of new employee orientation checklist will be updated. 2. Infection control nurse or designee will audit the tub disinfection practices with LTC staff 1 time per week for one month, then 2 times per month for 1 month, then quarterly for 1 year. 3. Audits will be added to the quality scorecard for review at QAPI.	

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F 880	Continued From page 38 by the tub identified staff were to allow for disinfectant to act for instructed time. Review of directions on Penner Whirlpool Disinfectant Label identified the wet contact time to be 10 minutes. Review of April, 2023 Disinfection of Residents Use Bath Tubs policy identified it instructed staff to allow the disinfectant to act according to time instructed on disinfectant that was used.	F 880		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/17/23 through 4/19/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed during the survey: H54671118C (MN87737) with NO licensing orders issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 810	MN Rule 4658.0510 Subp. 3 Nursing Personnel; On-site coverage Subp. 3. On-site coverage. A nurse must be employed so that on-site nursing coverage is provided eight hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure a registered nurse (RN) was on duty a minimum of 8 consecutive hours a day 13 of 106 days reviewed. Findings include: Review of the facility schedule identified either no RN coverage or less than 8 consecutive hours of RN coverage as follows: January 2023, no concerns February 2023 had no RN coverage on 2/11/23, 2/12/23. March 2023 had nonconsecutive 8-hour RN coverage on 3/3/23. Less than 8 consecutive hours on 3/23/23, 3/25/23, and 3/26/23. No RN coverage on 3/4/23, and 3/5/23. April 1, 2023, to April 17, 2023, had less than 8 hours RN coverage on 4/1/23, 4/2/23, and	2 810	Corrected	7/15/23

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2 810	Continued From page 3 4/7/23. No RN coverage on 4/15/23 and 4/16/23. Interview on 4/19/23 at 3:30 p.m., with the staffing coordinator reported she completed the schedule in 6-week blocks and there was an RN on call that was supposed to report to the facility to cover the opening if there was not an RN scheduled for 8 consecutive hours in 24 hours. She reported she was not aware of why the open shifts had not been covered. Interview on 4/19/23 at 4:00 p.m., with the director of nursing (DON) reported her expectation for on call RN staff to report to work in the facility when the required 8 consecutive hours/24 hours was not filled. She reported she was aware the facility had had some openings but was not aware of the number of times it had occurred. She confirmed the requirement had not been met on the identified dates for the 4 months reviewed. A policy on staffing requirements was requested but not provided by the end of the survey period. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could develop policies and procedures to ensure nursing coverage is provided 8 hours per day, 7 days per	2 810		

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2 810	Continued From page 4 week. The DON or designee could educate staff regarding these polices, and audit staff schedules for compliance. The DON or designee could take the results of these audits to the QAPI committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 810		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure appropriate disinfection of 1 of 1 whirlpool tubs on the east wing in-between resident's baths. This had the potential to affect 42 of 45 residents (R18, R39, R4, R3, R30, R21, R28, R25, R32, R41, R27, R15, R10, R23, R1, R31, R6, R29, R36, R13, R5, R38, R17, R46, R37, R14, R11, R8, R16, R40, R24, R44, R33, R45, R42, R19, R34, R20, R22, R35, R7, R43) that utilized the east whirlpool tub. Observation on 4/18/23 at 10:45 a.m., with trained medication assistance (TMA)-A as disinfected the Arjo Whirlpool tub identified TMA-A sprayed the tub surface with Penner Whirlpool Classic Disinfectant. TMA-A then scrubbed down the sides of the tub, wiped down	21375	Corrected	7/15/23

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21375	Continued From page 5 with chair with a wet rag and then proceeded to immediately rinse off the disinfectant with water. Interview on 4/18/23 at 10:49 a.m., with TMA-A revealed the tub had pre-filled disinfectant and staff just pushed a button to dispense the disinfectant into the tub. Staff would then fill the tub over the intake at the bottom of the tub which will clean out the jet system. Staff would add Penner disinfectant and scrub the sides of the tub with a long handled brush, wipe the chair with a wet rag. TMA-A stated, "there is no need for a wet time, and it is okay to rinse off right away." TMA-A also said there was procedure on the wall of how to disinfect the whirlpool. Interview on 4/19/23 at 9:10 a.m., with Infection preventionist (IP) identified they had a disinfectant that was approved to clean the whirlpool tub. IP stated "It would be my hope that they allow the kill time before they washed off the disinfectant." Interview on 4/19/23 at 9:30 a.m., with director of nursing (DON) revealed she was unsure of the process of the tub cleaning as she had not reviewed the policy yet. The DON confirmed her expectation was staff would follow the instructions on the disinfectant bottle and ensure the wet contact time of 10 minutes to ensure appropriate disinfection. Review of undated, Tub Disinfection Steps policy and procedure posted on the inside of the cabinet by the tub identified staff were to allow for disinfectant to act for instructed time. Review of directions on Penner Whirlpool Disinfectant Label identified the wet contact time	21375		

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21375	Continued From page 6 to be 10 minutes. Review of April, 2023 Disinfection of Residents Use Bath Tubs policy identified it instructed staff to allow the disinfectant to act according to time instructed on disinfectant that was used. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications were stored securely in 2 of 2 medication carts when staff were not present. This had the potential to affect all 45 residents.	21610	Corrected	7/15/23

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	00340	A. BUILDING: _____ B. WING _____	C 04/19/2023

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21610	Continued From page 7 Findings include: Observation and interview on 4/17/23 at 9:20 a.m., of the medication cart outside the dining room identified the top drawer of the medication cart was open with no staff present. Trained medication aide (TMA)-B returned to the cart and when asked about the open and unsecured cart, TMA-B pushed the drawer shut and locked it. TMA-B denied she left the medication cart unlocked and unsecured from unauthorized access and stated "Someone else that knew the medication cart code must have gotten something out of the cart and not locked the cart back up". Observation on 4/17/23 at 10:38 a.m., of an unattended medication cart located on the West hall the medication cart was unlocked and unsecured, allowing staff or residents in the area to potentially access to the medications stored inside. R35 was observed wandering in the hall and came over the medication cart looking at the items on the surface and reaching out toward the cart as if to open the drawer. At that time, the director of nursing (DON) came down the hall and redirected R35. When asked about the medication cart being unlocked, the DON opened the first 2 drawers confirming the cart was not locked and reported the medication cart was supposed to be locked if staff were not in attendance. LPN-C returned to the cart and reported she was not aware her cart had remained unlocked. LPN-C left the area before further interview could be obtained. Interview on 4/19/23 at 11:45 a.m., with director of nursing (DON) confirmed her expectation was	21610		

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21610	Continued From page 8 for staff to always lock the medication cart when not present. A policy was medication storage was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of properly securing medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or	21980		7/15/23

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21980	Continued From page 9 (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to report an allegation of resident-to-resident physical abuse for 1 of 3 residents (R21), to the State Agency (SA) within the required 2-hour time.	21980	Corrected	

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21980	Continued From page 10 Findings include: Interview on 4/17/23 at 2:55 p.m., with R21 reported an incident occurred late last summer (2022), when R22 had come into her room after she was in bed. R21 reported R22 was "angry for some reason". R21 told R22 to leave. R22 began yelling, wheeled herself to the bed, and grabbed onto her right arm, digging her nails in, and causing scratches and bruising. R21 reported she had turned on her call light, and unidentified staff responded and removed R22 from her room. Licensed practical nurse (LPN)-A responded asked what happened then cleaned and dressed the scratches on her arm. R21 reported she was not afraid of R22 and was aware she had dementia and would not be aware of what she was doing. R21 reported R22 wandered in her wheelchair throughout the facility, but this was the first time she had come into her room or "bothered her". R21 reported the incident, but she had not been interviewed or questioned by any staff following the incident. Review of the nursing home reportable incidents identified there was no report made for the resident-to-resident altercation between R21 and R22 made to the State Agency (SA). Interview on 4/18/23 at 5:59 p.m., with licensed practical nurse (LPN)-A reported she had been working on 8/26/22 when the incident took place between R21 and R22. LPN-A reported she was not able to recall the incident clearly but reported what she was able to recall. She reported she thought the incident took place at about 8:00 p.m. when R22 had transported herself into R21's room, became agitated, was screaming at R21,	21980		

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21980	Continued From page 11 went over to R21's bed and grabbed her arm. LPN-A reported she had been called to R21's room by an unidentified NA and R21 reported what had occurred. LPN-A reported she did not feel the incident was intentional due to R22 had severe dementia and was not aware of what she was doing. LPN-A reported she had cleaned and dressed R21's skin tears and had made a note in the progress notes. LPN-A reported she had not reported the incident to the nursing supervisor or administration as she did not believe it was a reportable event. LPN-A reported she was aware the facility had a form that was to be completed to determine if a Vulnerable Adult (VA) report needed to be filed, and an incident report was to be completed. She reported she had not completed the forms because she had thought since R22 had dementia the incident was not reportable. Interview on 4/19/23 at 9:10 a.m., with the facility administrator reported he had been he had been notified on 4/17/23 of the August 2022 incident from the DON, following investigation. His expectation was all allegations of abuse were to be reported to facility administration and to the SA and/or law enforcement. Review of the July 2021, Vulnerable Adult Abuse Prevention Plan identified facility personnel who had knowledge of an incident must make an immediate report, as soon as possible but no longer than 24 hours from the time of initial knowledge to the administrator, designee, supervisor or directly to the SA. There was no specific mention of allegations of abuse being required to be reported to the administrator, SA and/or law enforcement within 2 hours.	21980		

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21980	Continued From page 12 SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. Those audits should be ongoing and random after compliance is determined by QAPI to ensure compliance is being maintained. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/17/23 through 4/19/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed during the survey: H54671118C (MN87737) with NO licensing orders issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 810	MN Rule 4658.0510 Subp. 3 Nursing Personnel; On-site coverage Subp. 3. On-site coverage. A nurse must be employed so that on-site nursing coverage is provided eight hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure a registered nurse (RN) was on duty a minimum of 8 consecutive hours a day 13 of 106 days reviewed. Findings include: Review of the facility schedule identified either no RN coverage or less than 8 consecutive hours of RN coverage as follows: January 2023, no concerns February 2023 had no RN coverage on 2/11/23, 2/12/23. March 2023 had nonconsecutive 8-hour RN coverage on 3/3/23. Less than 8 consecutive hours on 3/23/23, 3/25/23, and 3/26/23. No RN coverage on 3/4/23, and 3/5/23. April 1, 2023, to April 17, 2023, had less than 8 hours RN coverage on 4/1/23, 4/2/23, and	2 810	Corrected	7/15/23

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2 810	Continued From page 3 4/7/23. No RN coverage on 4/15/23 and 4/16/23. Interview on 4/19/23 at 3:30 p.m., with the staffing coordinator reported she completed the schedule in 6-week blocks and there was an RN on call that was supposed to report to the facility to cover the opening if there was not an RN scheduled for 8 consecutive hours in 24 hours. She reported she was not aware of why the open shifts had not been covered. Interview on 4/19/23 at 4:00 p.m., with the director of nursing (DON) reported her expectation for on call RN staff to report to work in the facility when the required 8 consecutive hours/24 hours was not filled. She reported she was aware the facility had had some openings but was not aware of the number of times it had occurred. She confirmed the requirement had not been met on the identified dates for the 4 months reviewed. A policy on staffing requirements was requested but not provided by the end of the survey period. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could develop policies and procedures to ensure nursing coverage is provided 8 hours per day, 7 days per	2 810		

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2 810	Continued From page 4 week. The DON or designee could educate staff regarding these polices, and audit staff schedules for compliance. The DON or designee could take the results of these audits to the QAPI committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 810		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure appropriate disinfection of 1 of 1 whirlpool tubs on the east wing in-between resident's baths. This had the potential to affect 42 of 45 residents (R18, R39, R4, R3, R30, R21, R28, R25, R32, R41, R27, R15, R10, R23, R1, R31, R6, R29, R36, R13, R5, R38, R17, R46, R37, R14, R11, R8, R16, R40, R24, R44, R33, R45, R42, R19, R34, R20, R22, R35, R7, R43) that utilized the east whirlpool tub. Observation on 4/18/23 at 10:45 a.m., with trained medication assistance (TMA)-A as disinfected the Arjo Whirlpool tub identified TMA-A sprayed the tub surface with Penner Whirlpool Classic Disinfectant. TMA-A then scrubbed down the sides of the tub, wiped down	21375	Corrected	7/15/23

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21375	Continued From page 5 with chair with a wet rag and then proceeded to immediately rinse off the disinfectant with water. Interview on 4/18/23 at 10:49 a.m., with TMA-A revealed the tub had pre-filled disinfectant and staff just pushed a button to dispense the disinfectant into the tub. Staff would then fill the tub over the intake at the bottom of the tub which will clean out the jet system. Staff would add Penner disinfectant and scrub the sides of the tub with a long handled brush, wipe the chair with a wet rag. TMA-A stated, "there is no need for a wet time, and it is okay to rinse off right away." TMA-A also said there was procedure on the wall of how to disinfect the whirlpool. Interview on 4/19/23 at 9:10 a.m., with Infection preventionist (IP) identified they had a disinfectant that was approved to clean the whirlpool tub. IP stated "It would be my hope that they allow the kill time before they washed off the disinfectant." Interview on 4/19/23 at 9:30 a.m., with director of nursing (DON) revealed she was unsure of the process of the tub cleaning as she had not reviewed the policy yet. The DON confirmed her expectation was staff would follow the instructions on the disinfectant bottle and ensure the wet contact time of 10 minutes to ensure appropriate disinfection. Review of undated, Tub Disinfection Steps policy and procedure posted on the inside of the cabinet by the tub identified staff were to allow for disinfectant to act for instructed time. Review of directions on Penner Whirlpool Disinfectant Label identified the wet contact time	21375		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	Continued From page 7 Findings include: Observation and interview on 4/17/23 at 9:20 a.m., of the medication cart outside the dining room identified the top drawer of the medication cart was open with no staff present. Trained medication aide (TMA)-B returned to the cart and when asked about the open and unsecured cart, TMA-B pushed the drawer shut and locked it. TMA-B denied she left the medication cart unlocked and unsecured from unauthorized access and stated "Someone else that knew the medication cart code must have gotten something out of the cart and not locked the cart back up". Observation on 4/17/23 at 10:38 a.m., of an unattended medication cart located on the West hall the medication cart was unlocked and unsecured, allowing staff or residents in the area to potentially access to the medications stored inside. R35 was observed wandering in the hall and came over the medication cart looking at the items on the surface and reaching out toward the cart as if to open the drawer. At that time, the director of nursing (DON) came down the hall and redirected R35. When asked about the medication cart being unlocked, the DON opened the first 2 drawers confirming the cart was not locked and reported the medication cart was supposed to be locked if staff were not in attendance. LPN-C returned to the cart and reported she was not aware her cart had remained unlocked. LPN-C left the area before further interview could be obtained. Interview on 4/19/23 at 11:45 a.m., with director of nursing (DON) confirmed her expectation was	21610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00340	A. BUILDING: _____ B. WING _____	C 04/19/2023

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21610	Continued From page 8 for staff to always lock the medication cart when not present. A policy was medication storage was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of properly securing medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or	21980		7/15/23

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21980	Continued From page 9 (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to report an allegation of resident-to-resident physical abuse for 1 of 3 residents (R21), to the State Agency (SA) within the required 2-hour time.	21980	Corrected	

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21980	Continued From page 10 Findings include: Interview on 4/17/23 at 2:55 p.m., with R21 reported an incident occurred late last summer (2022), when R22 had come into her room after she was in bed. R21 reported R22 was "angry for some reason". R21 told R22 to leave. R22 began yelling, wheeled herself to the bed, and grabbed onto her right arm, digging her nails in, and causing scratches and bruising. R21 reported she had turned on her call light, and unidentified staff responded and removed R22 from her room. Licensed practical nurse (LPN)-A responded asked what happened then cleaned and dressed the scratches on her arm. R21 reported she was not afraid of R22 and was aware she had dementia and would not be aware of what she was doing. R21 reported R22 wandered in her wheelchair throughout the facility, but this was the first time she had come into her room or "bothered her". R21 reported the incident, but she had not been interviewed or questioned by any staff following the incident. Review of the nursing home reportable incidents identified there was no report made for the resident-to-resident altercation between R21 and R22 made to the State Agency (SA). Interview on 4/18/23 at 5:59 p.m., with licensed practical nurse (LPN)-A reported she had been working on 8/26/22 when the incident took place between R21 and R22. LPN-A reported she was not able to recall the incident clearly but reported what she was able to recall. She reported she thought the incident took place at about 8:00 p.m. when R22 had transported herself into R21's room, became agitated, was screaming at R21,	21980		

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21980	Continued From page 11 went over to R21's bed and grabbed her arm. LPN-A reported she had been called to R21's room by an unidentified NA and R21 reported what had occurred. LPN-A reported she did not feel the incident was intentional due to R22 had severe dementia and was not aware of what she was doing. LPN-A reported she had cleaned and dressed R21's skin tears and had made a note in the progress notes. LPN-A reported she had not reported the incident to the nursing supervisor or administration as she did not believe it was a reportable event. LPN-A reported she was aware the facility had a form that was to be completed to determine if a Vulnerable Adult (VA) report needed to be filed, and an incident report was to be completed. She reported she had not completed the forms because she had thought since R22 had dementia the incident was not reportable. Interview on 4/19/23 at 9:10 a.m., with the facility administrator reported he had been he had been notified on 4/17/23 of the August 2022 incident from the DON, following investigation. His expectation was all allegations of abuse were to be reported to facility administration and to the SA and/or law enforcement. Review of the July 2021, Vulnerable Adult Abuse Prevention Plan identified facility personnel who had knowledge of an incident must make an immediate report, as soon as possible but no longer than 24 hours from the time of initial knowledge to the administrator, designee, supervisor or directly to the SA. There was no specific mention of allegations of abuse being required to be reported to the administrator, SA and/or law enforcement within 2 hours.	21980		

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21980	Continued From page 12 SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. Those audits should be ongoing and random after compliance is determined by QAPI to ensure compliance is being maintained. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		

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	245467	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/18/2023**

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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 04/18/2023. At the time of this survey, Hendricks Community Hospital Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 05/12/2023

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. Hendricks Community Hospital Nursing Home was constructed as follows: The original building was constructed in 1969, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The first addition was constructed in 1987, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The second addition was constructed in 1993, is	K 000		

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K 000	Continued From page 2 one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The facility has a capacity of 48 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES)	K 923		7/15/23

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K 923	Continued From page 3 STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper oxygen cylinder storage per NFPA 99 (2012 edition)Health Care Facilities Code, section 11.6.2.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/18/2023 at 11:10AM, it was revealed by observation that a oxygen cylinder was observed unsecured in an upright position in the oxygen storage room. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	Corrective action will be completed to ensure the safety of any potentially affected residents in the future as a result of improperly secured oxygen tanks. Measure put in place: 1. On 5/1/23 and 5/2/23 education was provided to staff at staff meeting on proper storage of oxygen tanks. 2. On 5/3/23 a video containing additional education on proper storage of oxygen tanks was uploaded for staff to view. There is also a short quiz following the video to ensure understanding of the content. Measures to be put in place: 1. Staff education on appropriate storage of oxygen tanks will be provided as part of our all-staff annual education. This will be done via a training video that has been uploaded for staff to watch and fill out a short quiz following to ensure understanding of the content. 2. Maintenance staff will monitor the oxygen storeroom weekly for one month, then twice monthly for 1 month and the quarterly for one year to ensure they are properly contained.	

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K 923	Continued From page 4	K 923	K923 will be completed by July 15, 2023	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 9, 2023

Administrator
Hendricks Community Hospital
503 E Lincoln Street
Hendricks, MN 56136

RE: CCN: 245467
Cycle Start Date: April 19, 2023

Dear Administrator:

On June 22, 2023, we notified you a remedy was imposed. On July 17, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 15, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 19, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 22, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 19, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 15, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us