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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: FEFF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00340

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245467**
2.STATE VENDOR OR MEDICAID NO.
(L2) **204342400**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/24/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie Unit Supervisor I 07/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/29/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/21/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245467

July 29, 2014

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

Dear Mr. Gollaher:

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

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

Effective July 14, 2014 the above facility is certified for:

58 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 29, 2014

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

RE: Project Number S5467024

Dear Mr. Gollaher:

On June 20, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 5, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 24, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 5, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 14, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 5, 2014, effective July 14, 2014 and therefore remedies outlined in our letter to you dated June 20, 2014, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure:
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245467	A. Building B. Wing	7/24/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **07/14/2014**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **07/14/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **07/14/2014**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **07/14/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **07/14/2014**	ID Prefix **F0412** Reg. # **483.55(b)** LSC	Correction Completed **07/14/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **07/14/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/KFD	07/29/2014	22113	07/24/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/5/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: FEFF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00340

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(L1) **245467**
2.STATE VENDOR OR MEDICAID NO.
(L2) **204342400**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/05/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Connie Brady, HFE NE II 07/09/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/18/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/21/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN-24-5467

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F). Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4967

June 20, 2014

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

RE: Project Number S5467024

Dear Mr. Gollaher:

On June 5, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, MN 56258
Office: (507) 537-7158
Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 14, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 14, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original

deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 5, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 5, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

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 _____	06/05/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280	approved Kms 7/9/14 RECEIVED JUL 07 2014 Minnesota Department of Health Marshall	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE CEO | (X6) DATE 7-3-14

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.

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

PRINTED: 06/20/2014
FORM APPROVED
OMB NO. 0938-0391

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 _____	06/05/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 1 by: Based on observation, interview and document review the facility failed to revise the plan of care for the use of siderails for 1 of 3 residents (R4) reviewed for siderail use; failed to revise the pan of care for 1 of 1 resident (R26) reviewed for appropriate splint device use; and failed to revise the plan of care to include non pharmacological interventions prior to the administration of as needed anti-anxiety medication for 3 of 3 residents (R60, R59 & R61) reviewed who received as needed anti-anxiety medications. Findings include: R4 was observed throughout the survey to have two half siderails in the up position whenever she was resting in bed. R4 was observed to be transferred with the use of a mechanical lift and was not observed to participate in bed mobility or transferring. R4 was unable to move independently. R4's quarterly minimum data set (MDS) dated 3/5/14, identified diagnosis of dementia. R4 was identified as needing total assistance from staff with bed mobility and transfers. R4's BIMS (brief interview for mental status) was not completed due to R4 being severely cognitively impaired. Review of the care area assessment (CAA) dated 12/17/13 identified that R4 was total assist with all activities of daily living (ADL'S) and was a moderate risk for falls although "she makes no attempts to move on her own at all.; She sits or lies just as she is positioned." The siderails assessment completed which was initially done on 12/5/12 and reviewed quarterly identified that resident has 2 half siderails, needs assist to turn, is nonambulatory, is unable to sit up without	F 280	b. The Policy for Care Planning Processes was reviewed and is current. c. Education for nursing staff was conducted on July 8th and 10th to education on the care planning policy, the need to provide non-pharmacologic interventions prior to the use of an "as needed" medication related to psychotropic medications. And the need for tracking target behaviors and sleep monitoring for sleep medications. 3. All Corrective Actions will be completed by: July 14th, 2014 4. Reoccurrence will be prevented by: a. Audits of Residents who have splints will be done on 2 residents per week to review for proper equipment, placement, and care planning. b. Audits of Residents on anti-anxiety medications will be completed on 3 residents per week to determine if non-pharmacologic interventions were tried prior to PRN dosing, if appropriate care planning is in place, and if target behaviors and hours of sleep are being monitored. c. Audits will continue for 90 days and the results brought to the Quality Assurance (QA) Team for review and to determine the need for further audits. d. Audits will be conducted by an RN. 5. The Correction will be monitored by: a. The Director of Nursing or designee.	

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

PRINTED: 06/20/2014
FORM APPROVED
OMB NO. 0938-0391

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 _____	06/05/2014

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F 280	Continued From page 2 support and needs assistance to arise. The assessment also identified that R4 had bilateral contractures of upper and lower extremities. The assessment was reviewed on 3/5/14 with no changes noted. The care plan dated 6/15/12 identified limited mobility and use of 2 half rails that are up for safety during care provision to assist with bed mobility. During interview on 6/5/14 at 8:32 a.m. registered nurse (RN)-A stated the side rails are positioned in the "up" position for staff comfort, if they are afraid to have an open side of the bed while doing cares. RN-A verified that R4 does not move independently while in bed. During interview with nursing assistant (NA)-B on 6/4/14, at 1:32 p.m. she stated that R4 does not move nor does she hold onto the rail when repositioned in bed. On 6/5/14 at 8:39 a.m. CNA-B stated that when providing cares for R4, she puts the rail in the "down" position as she does not use them. She stated that when the rail is "up", she places a pillow between R4 and the siderail to protect her face since R4 is unable to reposition herself independently if her face is against the rail. During interview on 6/5/14 at 9:37 a.m. the director of nursing on 6/5/14 at 9:37 a.m. verified the appropriate use of R4's siderail would need to be care planned. R26's care plan dated 5/20/14, directed staff to apply R26's left hand palm protector; however, the care plan did not address the usage of a palm protector with finger separators as recommended by the occupational therapy assessment dated 5/25/12.	F 280	**F280** 1. Corrective Action: a. Resident R4 is having her need for side rails re-evaluated as she cannot use them on her own anymore. b. Resident R26's appropriate splint with finger separators was located and is currently care planned and in use. c. Resident R 59 has chronic conditions of anxiety and psychosis and the use of the anti-anxiety medication is appropriate as deemed by the care team. The resident's dose of anti-anxiety medication is scheduled to be given now at 1400. She does have a PRN dose as well, but there are care planned non-pharmacological interventions that will be tried prior to administering. R60's use of the anti-anxiety medication for help during the late evening hours will be planned to be scheduled for the resident's frequent use and history of use of the medication. The resident will not have an "as needed" dose of anxiety medication. R61's effectiveness of his anti-anxiety medication is being tracked by reviewing the hours of sleep the resident is getting. His care plan is updated to reflect this use of the medication. 2. Corrective Action as it applies to others: a. All resident with anti-anxiety medications were reviewed for diagnosis, "as needed" status with appropriate non-pharmacologic interventions care planned. Resident with medications given for sleep were reviewed for monitoring the effectiveness of the medication.	

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F 280	Continued From page 3 On 6/4/14, at 1:45 p.m. R26 was observed in her wheel chair with a left palm protector that did not have a palm protector with finger separators. The left hand fingers were observed in a fist formation. At that time resident did open left hand when asked upon command however, R26 was not able to completely open and fingers were not able to be straightened completely. On 6/5/14, at 7:15 a.m. NAR-A stated she can recall R26 having a hand splint with finger separators on several months ago but currently had a plain sheep skin palm protector on the left hand. On 6/5/14, at 8:10 a.m., RN-B verified R26 should have a left hand, finger separator hand splint on vs. a sheep skin palm protector. RN-B stated the care plan needed to be revised regarding the palm protector. R60's POC was not revised to address non-pharmacological interventions to be attempted prior to the administration of anti-anxiety medications. R60's Psychotropic Drug Use- care area assessment (CAA) dated 3/18/2014, indicated the daily use of anti-anxiety and antidepressant. The CAA indicated R60 had an as needed (PRN) order for Alprazolam at bed time due to anxiety and has taken this medication consistently every night. The CAA indicated the medication added to R60's fall risk. The 3/12/14, the Fall Risk assessment indicated R60 was at risk for falls. R60's Physician orders dated 3/17/14, indicated Alprazolam (anti-anxiety) 0.5 milligrams (mg) orally at bed time (HS) as needed for anxiety.	F 280		

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F 280	Continued From page 4 R60's Medication Administration Records (MAR) dated 3/17/14-3/31/14, indicated the PRN Alprazolam had been administered every day. The MAR dated 4/1/14- 4/30/2014, indicated the PRN Alprazolam had been administered 27 out of 30 days. The 5/1/14-5/31/14, MAR indicated the PRN Alprazolam had been administered 23 out of 31 days for anxiety. The MAR dated 6/1/14-6/4/14, indicated the PRN Alprazolam had been administered 3 out of 4 day for anxiety. The PRN was given per R60's request. During review of R60's plan of care (POC) dated 3/12/14, it identified the use of anti-anxiety medication related to an anxiety disorder; however, it lacked any non-pharmacological interventions for R60's anxiety. Interview on 6/4/14 at 3:00 p.m. with RN-A, it was verified the care plan lacked any non-pharmacological interventions and would be adding. R59's diagnoses were documented as: dementia with behavioral disturbances and depressive disorder. R59's psychotropic drug use assessment care area assessment (CAA) dated 3/11/14, indicated the following: R59 had a long history of mental illness, including depression. R59 is currently on alprazolam 0.25 mg. (milligrams) every 8 hours PRN (as needed) for anxiety/sleep. R59 is also on venlafaxine (a medication used for depression) 75 mg BID (two times a day) for depression. PHQ9 (a tool used to identify the severity of depressive symptoms) score was a 2 (which indicated a low depressive symptoms) with BIMS (brief interview of mental status) score of 14. Documentation indicated the family stated that R59 has been on depression medications for years and were afraid of her	F 280		

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F 280	Continued From page 5 response if the venlafaxine (antidepressant) was discontinued. The initial MDS dated 3/11/14 identified that R59 was cognitive with a BIMS (Brief Interview of Mental Status) score of 14/15. Also documented was 1 episode of feeling down, depressed or hopeless and no identified behaviors and R59 received an anti-anxiety medication 6 out of 7 days. The admitting physician's orders, dated 3/5/14, included alprazolam (anti-anxiety medication) 0.25 mg. (milligrams) by mouth every 8 hours PRN (as needed) for dementia with behavioral disturbances. A post-it note (undated) and hand written, was attached to the April 2014 MAR (medication administration record) over the days of the month next to the alprazolam medication order. The hand written note read: Need to offer resident alprazolam daily at 1400 (2:00 p.m.) per family request. R59 received the PRN (as needed) anti-anxiety medication at approximately 2:00 p.m. daily from 4/3/14 until 6/5/14. The PRN medication sheet lacked documentation by the licensed staff which indicated the rationale for the administration of the PRN medication, the symptoms R59 exhibited and/or any non-pharmacological interventions attempted prior to the administration of the medication, nor the response. Observation of R59 on 6/4/14 at various times during the day, noted R59 as not displaying any symptoms of anxiety. On 6/4/14 at 9:01 a.m. R59 was just coming out of the dining room. She was noted to be smiling and wheeling towards her room in her wheelchair.	F 280		

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F 280	Continued From page 6 Review of R59's interdisciplinary progress notes (nurses notes) from 3/5/14 - 6/4/14, lacked documentation that non-pharmacological interventions were attempted prior to the administration of the anti-anxiety medication, alprazolam daily around 2 p.m. Review of the plan of care dated 4/7/14 identified that R59 was on an antidepressant (venlafaxine HCL), antipsychotic (abilify) and anti-anxiety (alprazolam) medication related to depression. Beyond education to R59 and family/caregivers related to risks, benefits and side effects and/or toxic symptoms of the above identified medications, nothing further was documented in the plan of care related to the use of the anti-anxiety medication, alprazolam and/or non-pharmacological interventions to reduce anxiety. Interview with RN-B on 6/5/14 at 8:51 a.m., verified that non-pharmacological interventions had not been care planned, prior to the administration of alprazolam daily at 2:00 p.m. and the care plan had not been revised to include this information. R61 was admitted to the facility on 3/12/14 with diagnoses that included depression and anxiety. Review of R61's admission assessment revealed a BIMS (brief interview for mental status) score of 14 indicating R61 to be cognitively intact. Review of the physician orders dated 3/17/14 included the following: alprazolam (an anti-anxiety medication) 0.5 mg (milligrams) po (by mouth) QHS (every bedtime) for a diagnosis of insomnia. A fax to the physician dated 3/17/14 indicated: "Wants anti-anxiety ordered. Used to take Ativan. Slept poorly this weekend." There was no	F 280		

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F 280	Continued From page 7 documentation found in R61's record to indicate that sleep monitoring was being tracked. R61's care plan dated 4/1/14 did not address the use of an anti-anxiety medication for issues with sleep. The facility policy, Care Planning Process, revised 8/2009, indicated a resident's care plan would be revised when any change or update was noted in a resident's plan of care. The policy indicated each discipline was responsible to conduct periodic audits to assure the care was delivered to the resident as designed in the care plan	F 280	**F318** 1. Corrective Action: a. Resident R26's appropriate splint with finger separators was located and is currently care planned and in use 2. Corrective Action as is applies to others: a. All residents with splints were reviewed, observed, and care plans updated to determine if they met the regulation. b. A Policy and Procedure for the use of Splints was developed and implemented. c. Education for nursing staff was completed July 8th and 10th. The education included the appropriate use of splints, care planning for splints, and the new policy and procedure. 3. All Corrective Actions will be completed by: July 14th, 2014 4. Reoccurrence will be prevented by: 1. An RN will be responsible for audits of residents who have splints and will be conducted on 2 residents per week to review for proper equipment, placement, and care planning. 2. Audits will continue for 90 days and the results brought to the Quality Assurance (QA) Team for review and to determine the need for further audits. 5. The Correction will be monitored by: a. The Director of Nursing or designee.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the correct splint device was applied to minimize contractures (a condition of fixed high resistance to passive stretch of a muscle) for 1 of 1 resident (R26) reviewed with usage of a splint device. Findings include: It was noted on the annual minimum data set (MDS) dated 5/14/14 that R26's diagnoses	F 318		

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F 318	Continued From page 8 included diabetes mellitus, Bells Palsy, osteoporosis and was cognitively impaired. The MDS indicated R26 required extensive assist with bed mobility, ambulation, personal cares and used a walker and wheel chair. The 5/14/14, activities of daily living (ADL) care area assessment (CAA) indicated R26 wore a palm protector on the left hand, and was able to move hand, wrist, and fingers slowly, but normally. The 4/13/14, occupational therapy plan of treatment indicated on 5/25/12, R26 was discontinued from services with recommendations of wearing a left hand palm protector with finger separators to minimize contractures. At that time nursing staff was educated on R26 ' s splint wearing schedule. The 6/2014, nursing assistant care sheet indicated R26 was to have palm protector to left hand and "off" for cleaning. R26's care plan dated 5/20/14, directed staff to apply R26's left hand palm protector however the plan of care did not address the usage of a palm protector with finger separators. On 6/4/14, at 1:45 p.m. R26 was observed in her wheel chair with a left palm protector that did not have finger separators. Left hand fingers were observed in a fist formation. At that time R26 did open the left hand when requested; however, R26 was unable to completely extend the fingers when opened her hand. During interview on 6/5/14, at 7:15 a.m. NAR-A stated she could recall R26 having a hand splint with finger separators on several months ago but currently utilized a plain lamb skin palm protector	F 318		

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F 318	Continued From page 9 on the left hand. During interview on 6/5/14, at 8:10 a.m., RN-B verified R26 should have a left hand, finger separator hand splint on vs. a lamb skin palm protector. RN stated they had one finger separator hand splint but it gets soiled and that was probably the reason the plain fussy palm protector got applied to R26's left hand. RN stated the care plan needed to be revised to reflect accurately the use of the finger separator hand splint. A policy on the use of splints was requested but none was provided.	F 318	**F329** 1. Corrective Action: a. Resident's R61 and R59 had sleep monitoring initiated to help determine the effectiveness of the medication. R61 had used the anti-anxiety medication at home and found it helped his sleeping. R59 was trying a new Over the Counter Medication (OTC) to see if that helped improve her sleep pattern. Both residents are cognitively intact and able to verbalize their feelings about the effectiveness/need for the medication. b. Resident R 59 has chronic conditions of anxiety and psychosis and the use of the anti-anxiety medication is appropriate as deemed by the care team.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329	The Resident dose of anti-anxiety medication is scheduled to be given now at 1400. She does have a PRN dose as well, but there are care planned non-pharmacological interventions that will be tried prior to administering. R60's use of the anti-anxiety medication for help during the late evening hours will be planned to be scheduled for the resident's frequent use and history of use of the medication. The resident will not have an "as needed" dose of anxiety medication at this time. 2. Corrective Action as is applies to others: a. All residents on medications for anxiety and for sleep were reviewed and evaluated for appropriate diagnosis and care planning. Any "as needed" medication was care planned for non-pharmacologic interventions as appropriate for the individual. Target behavior tracking and	

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F 329	Continued From page 10 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to monitor the effectiveness of sleep medication for 2 of 5 residents (R61 & R59) reviewed for unnecessary medications; and failed to adequately identify, assess and monitor clinical indications for the continued use of anti-anxiety for 2 of 2 residents (R59 & R60) who received as needed (PRN) anti-anxiety medication routinely. Findings include: R61 was admitted to the facility on 3/12/14 with diagnoses that included depression and anxiety. Review of R61's admission assessment revealed a BIMS (brief interview for mental status) score of 14 indicating R61 to be cognitively intact. Review of the physician orders dated 3/17/14 included the following: alprazolam (an anti-anxiety medication) 0.5 mg (milligrams) po (by mouth) QHS (every bedtime) for a diagnosis of insomnia. A fax to the physician dated 3/17/14 indicated: "Wants anti-anxiety ordered. Used to take Ativan. Slept poorly this weekend." There was no documentation found in R61's record to indicate that sleep monitoring was being tracked. R61's care plan dated 4/1/14 did not address the use of an anti-anxiety medication for issues with sleep. During interview on 6/4/14 at 3:20 p.m., registered nurse (RN)-A confirmed that sleep	F 329	hours of sleep monitoring was initiated for those who did not have it. b. The policy for Unnecessary Medication was reviewed and is current. c. Education for nursing staff was completed July 8th and 10th on the policy and the need for appropriate non-medication interventions prior to PRN doses of psychotropic medications. And for the monitoring and tracking of sleep and target behaviors. 3. All Corrective Actions will be completed by: July 14th, 2014 4. Reoccurrence will be prevented by: 1. An RN will conduct audits of 2 residents per week on anti-anxiety or sleep medications to determine if they meet the requirements for those medication classes under the unnecessary medication regulations. 2. Audits will continue for 90 days and the results brought to the Quality Assurance (QA) Team for review and to determine the need for further audits. 5. The Correction will be monitored by: a. The Director of Nursing and Consultant Pharmacist or designee.	

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F 329	Continued From page 11 monitoring had not been tracked for R61 since initiation of the alprazolam and stated that it should have been. During interview on 6/4/14 at 9:15 a.m., the director of nursing (DON) confirmed she would have expected sleep monitoring to be conducted with the initiation of alprazolam for insomnia. R59 received a medication for sleep without adequate monitoring of the efficacy of the medication. R59 received a medication ordered for insomnia but the facility failed to complete a sleep study or document hours of sleep to ensure that the sleep medication was effective. On 4/10/14 an order was received by the physician for melatonin 6 mg. (milligrams) orally at HS (hour of sleep) for insomnia. Review of the MAR's (medication administration record) from 4/10/14 to present, identified that R59 received this medication every evening from 4/10/14 to present. Observation of R59 on 6/4/14 at 8:30 a.m., identified R59 as sleeping soundly in her bed. Interview with RN-B on 6/5/14, at 8:51 a.m. verified a sleep assessment had not been conducted for R59 nor had response to medication been documented to determine effectiveness of medication as ordered for insomnia. R59 received an anti-anxiety medication on a daily basis without being assessed for anxiety symptoms and without identified indications for use. R59's diagnoses were documented as: dementia with behavioral disturbances and	F 329		

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

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F 329	Continued From page 12	F 329		

depressive disorder. R59's psychotropic drug use assessment care area assessment (CAA) dated 3/11/14, indicated the following: R59 had a long history of mental illness, including depression. R59 is currently on alprazolam 0.25 mg. (milligrams) every 8 hours PRN (as needed) for anxiety/sleep. R59 is also on venlafaxine (a medication used for depression) 75 mg BID (two times a day) for depression. PHQ9 (a tool used to identify the severity of depressive symptoms) score was a 2 (which indicated a low depressive symptoms) with BIMS (brief interview of mental status) score of 14. Documentation indicated the family stated that R59 has been on depression medications for years and were afraid of her response if the venlafaxine (antidepressant) was discontinued.

The initial MDS dated 3/11/14 identified that R59 was cognitive with a BIMS (Brief Interview of Mental Status) score of 14/15. Documentation also identified that R59 had 1 episode of feeling down, depressed or hopeless and had no identified behaviors. It was documented that R59 received an anti-anxiety medication 6 out of 7 days.

The admitting physician's orders, dated 3/5/14, included alprazolam (anti-anxiety medication) 0.25 mg. (milligrams) by mouth every 8 hours PRN (as needed) for dementia with behavioral disturbances. A post-it note (undated) and hand written, was attached to the April 2014 MAR (medication administration record) over the days of the month next to the alprazolam medication order. The hand written note read: Need to offer resident alprazolam daily at 1400 (2:00 p.m.) per family request. R59 received the PRN (as needed) anti-anxiety medication at approximately

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F 329	Continued From page 13 2:00 p.m. daily from 4/3/14 until 6/5/14. The PRN medication sheet lacked documentation by the licensed staff which indicated the rationale for the administration of the PRN medication, the symptoms R59 exhibited and/or any non-pharmacological interventions attempted prior to the administration of the medication, nor the response. Review of R59's interdisciplinary progress notes (nurses notes) from 3/5/14 - 6/4/14, lacked documentation that non-pharmacological interventions were attempted prior to the administration of the anti-anxiety medication, alprazolam daily around 2 p.m. Interview with RN -B on 6/5/14 at 8:51 a.m., verified that R59 was not assessed for anxiety symptoms prior to being medicated with alprazolam. The 3/24/14, the admission minimum data set (MDS) indicated R60's diagnoses included coronary heart disease, Parkinson's disease, anxiety disorder, and arthritis. The MDS indicated R60 had intact cognition and that R60 reported no hallucinations, delusions or behavioral symptoms during the assessment period. R60's Psychotropic Drug Use Care Area Assessment (CAA) dated 3/18/2014, indicated it was triggered due to daily use of anti-anxiety and antidepressant. The CAA indicated R60 had an as needed (PRN) order for Alprazolam (antianxiety) at bed time and had taken consistently every night and had diagnosis of anxiety. The CAA indicated the Alprazolam added to R60's fall risk. The 3/12/14, Fall Risk	F 329		

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F 329	Continued From page 14 Assessment indicated R60 was at risk for falls. R60's Physician orders dated 3/17/14, indicated Alprazolam 0.5 milligrams (mg) orally at bed time (HS) as needed for anxiety. On 6/3/14, throughout the day from 8:00 a.m. to 4:00 p.m. R60 was observed. R60 was observed to follow directions given to her by the staff, she was cooperative while receiving cares and was able to sit quietly in her room and attend activities. R60 was not observed to display any type of disruptive behavior. R60's MAR dated 3/17/14-3/31/14, indicated the PRN Alprazolam had been administered daily. The MAR dated 4/1/14- 4/30/2014, indicated the PRN Alprazolam had been administered 27 of 30 days. The 5/1/14-5/31/14, MAR indicated the PRN Alprazolam had been administered 23 of 31 days for anxiety. The MAR dated 6/1/14- 6/4/14, indicated the PRN Alprazolam had been administered 3 of 4 days for anxiety. The PRN was given per R60's request. Review of R60's interdisciplinary progress notes dated 3/17/14 through 6/4/14, revealed no documentation of non-pharmacological interventions prior to the administration of the antianxiety medication. During interview on 6/4/13, at 12:05 p.m. with the pharmacist consultant, it was stated the nurses should be providing non-pharmacological interventions prior to the administration of the PRN Alprazolam for anxiety. However, when R60's medical records were reviewed by the pharmacist, documentation of any non-pharmacological interventions was lacking. On 6/4/14, at 3:00 p.m. RN-A verified that non-pharmacological interventions had not been implemented nor documented in R60's clinical record prior to administration of the PRN	F 329		

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F 329	Continued From page 15 Alprazolam for anxiety. On 6/5/2014, at 10:55 a.m. the DON provided the policy dated 11/09, Medication Regimen Reviews. It indicated the consultant pharmacist reviews each resident's medication regimen monthly. The review included all drugs currently ordered, assured that all diagnostic and monitoring was available in the resident's medical record, and documented all comments. The policy indicated each resident's medication regimen must be free from unnecessary drugs.	F 329	**F356** 1. Corrective Action: a. The Nurse Staffing Data form was updated to include any of the short/middle shifts that are regularly used in the nursing home. The form was devised to include all the required components. 2. Corrective Action as is applies to others: a. This form affects all residents, families, and the public to share our staffing hours and census for each day. b. The policy for Daily Posting of Staff Hours was reviewed and revised. c. Education for nursing staff was completed July 8th and 10th on the policy and the need for shift updates and how to complete the form. 3. All Corrective Actions will be completed by: July 14th, 2014 4. Reoccurrence will be prevented by: 1. Audits will be conducted by the House hold coordinator or DON of the forms twice per week to determine compliance and will be checked against the daily staff assignment sheet. 2. Audits will continue for 90 days and the results brought to the Quality Assurance (QA) Team for review and to determine the need for further audits. 5. The Correction will be monitored by: a. The Director of Nursing or Administrator or their designee.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community	F 356		

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F 356	Continued From page 16 standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the required daily nurse staffing information included the facility name and actual hours worked by each category of nursing staff. This had the potential to affect all 56 current residents in the facility, as well as family members, and the general public who may wish to review this information. Findings include: During the initial tour of the facility on 6/2/14 at 2:45 p.m., an observation was made of posted nursing staff hours for the facility. The posting included the current date, current census, and the total hours worked on the day, evening, and night shifts for registered nurses (RN), licensed practical nurses (LPN), and nursing assistants (NA). The posting included the the total hours for each shift but did not include shorter shifts worked within each 8 hour shift for each discipline. The posting also did not include the name of the facility. During interview on 6/2/14 at 2:45 p.m., registered nurse (RN)-A confirmed that on the evening shift (2:00 p.m. - 10:30 p.m.) there was also a scheduled middle shift from 4:00 p.m. - 9:30 p.m. for 2 NA's.	F 356		

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F 356	Continued From page 17 During interview on 6/5/14, at 11:49 a.m. the director of nursing (DON) confirmed there was a middle shift within the scheduled evening shift and further confirmed there was a 7:00 a.m. - 10:00 a.m. middle shift within the day shift hours to assist residents during dining.	F 356	**F371** 1. Corrective Action: a. The cooking utensils were properly cleaned and dried. The fan was immediately removed and cleaned and not placed back in the kitchen.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assure that cooking utensils were dried prior to storage and failed to properly clean the fan . This had the potential to affect all 57 residents who were served from the dietary department. Findings include: During the initial tour of the kitchen on 6/2/14 at 2:40 p.m., with cook-A the following deficient practices were identified: 3 of 3 steam table pans, 6 inch square, that were on the shelf and ready for use, revealed to have standing water in them. When cook-A picked up the pans and turned them over for observation, water ran down	F 371	2. Corrective Action as is applies to others: a. The dietary staff was educated and provided written information on the proper procedure for dishwashing and drying. Written information was also posted for staff. b. A policy for Dishwashing was developed to include the proper drying of dishes. 3. All Corrective Actions will be completed by: July 14th, 2014 4. Reoccurrence will be prevented by: 1. Audits by the Dietary Manager or designee will be conducted 3 times per week to determine compliance with proper dishwashing and drying of utensils. 2. Audits will continue for 90 days and the results brought to the Quality Assurance (QA) Team for review and to determine the need for further audits. 5. The Correction will be monitored by: a. The Dietary Manager or designee.	

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F 371	Continued From page 18 her arms and dripped on the floor; 1 of 3 oblong pans used in the steam table, that was ready for use, was noted to have standing water inside the pan; 1 of 3 scoops that was clean and ready for use was wet; 1 of 8 cutting boards that was clean and ready for use was noted to have water on it; 4 of 10 preparation bowls that were identified as being clean and ready for use had standing water inside them; and the large mixer bowl had about 1-2 inches of standing water inside the bowl with the clean mixer agitator arm touching the water. The above was verified by cook-A on 6/2/14 at 2:59 p.m. On 6/2/14 at 3:03 p.m. during the initial kitchen tour with the assistant dietary manager-A in the clean dish room, a fan was identified to be running on high, blowing air over clean dishes and utensils. During an inspection of this fan, it was identified that 3 blades inside the fan had approximately 3 inches of greasy grim on them and the outer casing had a grimy debris that was blowing out about 1/2 inch from the casing. Review of the documented cleaning schedule with assistant dietary manager-A on 6/2/14 at 3:07 p.m., noted that cleaning of the fan was not on the cleaning schedule. This was verified by assistant dietary manager-A at the same date and time. When asked about policies and procedures relating to putting kitchen items, used for food preparation, away clean and dry, the assistant dietary manager-A stated that there was no policy available that she was aware of, but staff had been trained to put clean items away dry. She did hand me a Demonstration of Knowledge Guidelines: A Manager's Food Safety Handbook:	F 371		

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F 371	Continued From page 19 Based on the Minnesota Food Code but I was unable to find any information in the document relating to storage of cooking items. Cook-A stated on 6/2/14 at 3:07 p.m. "we're just so busy and short of time".	F 371	**F412** 1. Corrective Action: a. Resident R41's son decided he did not want the resident to have a dental appointment. Resident R41 also did not desire a dental appointment. 2. Corrective Action as is applies to others: a. All resident's were reviewed for their last dental visit and if a dental visit was offered in the last year. Residents are being scheduled as appropriate for appointments if desired. b. The policy on Dental Services was reviewed and is current. c. Education for nursing staff was completed July 8th and 10th on the policy and they were educated on the procedure for scheduling a dental exam. 3. All Corrective Actions will be completed by: July 14th, 2014 4. Reoccurrence will be prevented by: 1. Audits by an RN will be conducted on 3 residents per week to determine if their dental visits are up to date and if this has been evaluated with the quarterly assessments/care conference. 2. Audits will continue for 90 days and the results brought to the Quality Assurance (QA) Team for review and to determine the need for further audits. 5. The Correction will be monitored by: a. The Director of Nursing or designee.	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to communicate with family and offer a dental appointment to a resident with cognition impairment for 1 of 3 residents (R41) reviewed for dental. Findings include: During observation/interview on 6/03/14 at 10:26 a.m., R41 was observed seated in his wheelchair in the common area outside of his bedroom. R41 was missing several teeth and the remaining teeth were discolored with apparent decay. R41 denied mouth or tooth pain.	F 412		

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F 412	Continued From page 20 R41's record was reviewed. Review of the annual comprehensive assessment dated 2/12/14 indicated the brief interview for mental status (BIMS) assessment was unable to be conducted as the resident was rarely or never understood. Review of the Oral/Dental Status assessment with an original date of 2/14/13 and last reviewed 2/12/14 included the following: resident has 3 teeth top right, 2 teeth top left, and no teeth on the bottom. The statement, "If own teeth: Are teeth broken, loose or have decay?" indicated "yes". The date of the last dental exam indicated, "unknown". The assessment further indicated: "If it has been a year or more since the last exam, offer an appointment to the resident of [sic] check with the family. Document the date you asked and indicate whether or not an appointment was scheduled: Resident states he doesn't want a dental exam et (and) he has no oral c/o (complaints of) pain or discomfort. However, will discuss at care conference with family whether they would like him to have a dental appointment due to his cognitive impairment." Review of the care conference records dated 5/29/13, 8/28/13, 11/27/13, 2/26/14, and 5/28/14 did not indicate that R41's family had been consulted related to the desire for R41 to see a dentist. During interview on 6/5/14, at 10:40 a.m., the director of nursing (DON) and registered nurse (RN)-A confirmed there was no evidence in the chart that family had been asked if a dental appointment was desired for R41. During interview on 6/5/14 at 10:48 a.m., family member (FM)-B confirmed he had never been questioned whether his father (R41) would like to see a dentist.	F 412		

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F 412	Continued From page 21 During interview on 6/5/14 at 10:54 a.m., RN-A stated she had just talked with R41's son (FM-B) who shared that his father had seen a dentist years ago and was told by the dentist that he did not want to pull R41's remaining teeth due to Coumadin (an anticoagulant medication) use. RN-A stated that when she questioned FM-B if he wanted R41 to see a dentist, he indicated it was ok with him but wanted R41 to have the final say.	F 412	**F428** 1. Corrective Action: a. The pharmacist reviews all residents medication regimens on a monthly basis. The resident cited, R59, 60, and 61 were missing some information in those reviews related to monitoring for sleep and use of non-pharmacologic interventions prior to use of a PRN medication for anxiety. The Pharmacist did review these residents for June and assured the required procedures were being followed for them. R59's sleep medication is being monitored for effectiveness and her anxiety medication is being scheduled, R60's anxiety medication was scheduled, R61's medication for sleep and anxiety is being monitored.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the pharmacist reported medication irregularities related to the use of as needed (PRN) anti-anxiety medication without non pharmacological interventions in place and/or monitor the effectiveness of an anti-anxiety medication prescribed for sleep for 3 of 5 residents (R59, R60 & R61) reviewed for unnecessary medications. Findings include: R60 received PRN anti-anxiety medication and	F 428	2. Corrective Action as is applies to others: a. All residents' on medications for anxiety and for sleep had their pharmacy reviewed evaluated for appropriate recommendations related to unnecessary medications policy and procedure. b. The policy for Medication Regimen Reviews and Unnecessary Medication was reviewed and are current. c. Education for nursing was completed July 8th and 10th on the policies and the need for appropriate non-medication interventions prior to PRN doses of psychotropic medications. And for the monitoring and tracking of sleep and target behaviors. The Pharmacist and DON will review the policies and determine if there is a need for further education for the pharmacist.	

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F 428	Continued From page 22 the consultant pharmacist did not identify nor report that non-pharmacological interventions had not been attempted prior to the administration of the medication. The 3/24/14, the admission minimum data set (MDS) indicated R60's diagnoses included coronary heart disease, Parkinson's disease, anxiety disorder, and arthritis. The MDS indicated R60 had intact cognition and that R60 reported no hallucinations, delusions or behavioral symptoms during the assessment period. R60's Psychotropic Drug Use Care Area Assessment (CAA) dated 3/18/2014, indicated it was triggered due to daily use of anti-anxiety and antidepressant. The CAA indicated R60 had an as needed (PRN) order for Alprazolam (antianxiety) at bed time and had taken consistently every night and had diagnosis of anxiety. The CAA indicated the Alprazolam added to R60's fall risk. The 3/12/14, Fall Risk Assessment indicated R60 was at risk for falls. R60's Physician orders dated 3/17/14, indicated Alprazolam 0.5 milligrams (mg) orally at bed time (HS) as needed for anxiety. On 6/3/14, throughout the day from 8:00 a.m. to 4:00 p.m. R60 was observed. R60 was observed to follow directions given to her by the staff, she was cooperative while receiving cares and was able to sit quietly in her room and attend activities. R60 was not observed to display any type of disruptive behavior. R60's MAR dated 3/17/14-3/31/14, indicated the PRN Alprazolam had been administered daily. The MAR dated 4/1/14- 4/30/2014, indicated the PRN Alprazolam had been administered 27 of 30	F 428	3. All Corrective Actions will be completed by: July 14th, 2014 4. Reoccurrence will be prevented by: 1. The DON or designee will conduct audits of 6 residents per month and review their pharmacy reviews to see if all criteria is being met for the Unnecessary Medication Policy and the Medication Regimen Reviews. 2. Audits will continue for 90 days and the results brought to the Quality Assurance (QA) Team for review and to determine the need for further audits. 5. The Correction will be monitored by: a. The Director of Nursing and Administrator or designee.	

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F 428	Continued From page 23 days. The 5/1/14-5/31/14, MAR indicated the PRN Alprazolam had been administered 23 of 31 days for anxiety. The MAR dated 6/1/14- 6/4/14, indicated the PRN Alprazolam had been administered 3 of 4 days for anxiety. The PRN was given per R60's request. Review of R60's interdisciplinary progress notes dated 3/17/14 through 6/4/14, revealed no documentation of non-pharmacological interventions prior to the administration of the antianxiety medication. Review of R60's Pharmacist Drug Regimen Review forms dated 3/31/14, revealed a lack of documentation related to the lack of identification and implementation of non-pharmacological interventions to be used by staff prior to the administration of anti-anxiety medications. On 6/4/13, at 12:05 p.m. the pharmacist consultant verified he had not addressed non-pharmacological interventions on the monthly drug regimen reviews prior to the administration of the PRN medication, Alprazolam. On 6/4/14, at 3:00 p.m. registered nurse (RN)-A confirmed the pharmacist had not identified any concerns related to non-pharmacological interventions prior to the administration of the medication. On 6/5/2014, at 10:55 a.m. the DON provided a policy Medication Regimen Reviews dated 11/09, indicated the consultant pharmacist reviews each resident's medication regimen monthly. The review included all drugs currently ordered, assured that all diagnostic and monitoring was available in the resident's medical record, and documented all comments. The policy indicated each resident's medication regimen must be free from unnecessary drugs.	F 428		

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 24 R59's diagnoses were documented as: dementia with behavioral disturbances and depressive disorder. The admitting physician's orders, dated 3/5/14, included alprazolam (anti-anxiety medication) 0.25 mg. (milligrams) by mouth every 8 hours PRN (as needed) for dementia with behavioral disturbances. A post it note (undated) was noted to be attached to the April 2014 MAR (medication administration record) over the days of the month next to the alprazolam medication order. This was a hand written note that read: Please (Please crossed off) Need to offer resident alprazolam daily at 1400 (2:00 p.m.) per family request.-Jennie. R59 received the PRN (as needed) anti-anxiety medication daily at approximately 2:00 p.m., daily since 4/3/14 to present. The PRN Medication Sheet was never documented on by the administering staff as to what symptoms R59 was displaying to require the administration of the medication, what non-pharmacological interventions were attempted prior to administering the medication and what results R59 received from the medication. Review of R59's Interdisciplinary Progress Notes (nurses notes) from 3/5/14 - 6/4/14, lacked any identified anxiety symptoms prior to administering the alprazolam. Interview with RN (registered nurse) -B on 6/5/14 at 8:51 a.m., verified that R59 was not assessed for anxiety symptoms prior to being medicated with alprazolam. During a telephone interview on 6/6/14 at 12:36 p.m., with the consulting pharmacist, verified that any time a PRN medication is given, it should be	F 428		

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F 428	Continued From page 25 for a documented reason that related to the class of medication ordered. On 4/10/14 an order was received for R59, by the physician, for melatonin 6 mg. (milligrams) orally at HS (hour of sleep) for insomnia. Review of the MAR's (medication administration record) from 4/10/14 thru 6/4/14, revealed R59 received this medication every evening from 4/10/14 to present. Interview with RN-B on 6/5/14 at 8:51 a.m., verified that R59's response to the use of melatonin had not been documented to monitor effectiveness. During a telephone interview on 6/6/14 at 12:36 p.m. the consulting pharmacist verified he never considered conducting a sleep study or documenting hours of sleep, as this is was a medication that can be purchased over the counter. During a telephone interview on 6/6/14 at 12:36 p.m. the consulting pharmacist verified he was unsure of the reason R59 received the medication , adding, "it might be for her skin or hair"; "I'm just not sure". The consulting pharmacist also verified this had not been identified for a potential drug irregularity during monthly drug regimen review and therefore had not alerted the DON or physician. R61 was admitted to the facility on 3/12/14 with diagnoses that included depression and anxiety. Review of R61's admission assessment revealed a BIMS (brief interview for mental status) score of 14 indicating R61 to be cognitively intact. Review	F 428		

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F 428	Continued From page 26 of the physician orders dated 3/17/14 included the following: alprazolam (an anti-anxiety medication) 0.5 mg (milligrams) po (by mouth) QHS (every bedtime) for a diagnosis of insomnia. A fax to the physician dated 3/17/14 indicated: "Wants anti-anxiety ordered. Used to take Ativan. Slept poorly this weekend." There was no documentation found in R61's record to indicate that sleep monitoring was being tracked. R61's care plan dated 4/1/14 did not address the use of an anti-anxiety medication for issues with sleep. During interview on 6/4/14 at 3:20 p.m., RN-A confirmed that R61's sleep had not been monitored the initiation of the alprazolam, stating "it should have been". During interview on 6/4/14 at 9:15 a.m. the DON confirmed it would have been an expectation for staff to monitor sleep behavior prior to the initiation of alprazolam for insomnia. During interview on 6/6/14, at 4:06 p.m. the consulting pharmacist confirmed that R61's hours of sleep should have been monitored after the initiation of alprazolam to assess effectiveness and monitor for side effects.	F 428		

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	245467	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/04/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on June 04, 2014. At the time of this survey, Hendricks Community Hospital Nursing Home was found be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Hendricks Community Hospital Nursing Home was constructed as follows: The original building was constructed in 1969, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The first addition was constructed in 1987, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The second addition was constructed in 1993, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The nursing home is separated from a critical access hospital by a two-hour fire wall, and the opening protective consisted of a labeled, self-closing, positive latching, 90-minute fire rated door assembly. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the	K 000		

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

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K 000	Continued From page 1 corridors which is monitored for automatic fire department notification. Resident Rooms are protected with automatic smoke detectors which are interconnected to the building fire alarm control panel [FACP]. The facility has a capacity of 58 beds and had a census of 57 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		